

美国著名医学院校教材系列

The History And Physical Examination Casebook

病史和查体

(英文影印版)

Diane L. Elliot, M.D.
Linn Goldberg, M.D.



中国协和医科大学出版社



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The History and Physical Examination Casebook

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Preface

"So, how do you put this case together?" is a question we have asked countless medical students and house officers. Interpreting a patient's medical history and physical findings, synthesizing information, and arriving at a working diagnosis are critical skills for physicians. As medical students move into their clerkship experiences, they are expected to re-order their disease-focused learning and apply it to patients presenting with undiagnosed problems—problems that often relate to several organ systems and the interaction of different illnesses. This book results from more than fifteen years of teaching physical diagnosis and helping students make the transition from disease-oriented pathophysiology and mechanical patient evaluation skills to assessment of patients.

Each chapter contains the following sections. The chapter **Objectives** are a listing of the key concepts covered in the chapter, including terms to understand, symptoms and signs of common illnesses (such as, aortic stenosis and temporal arteritis) and differential diagnosis of frequent presenting complaints, (for example, unintentional weight loss, back pain and lower extremity swelling). The list previews the chapter's contents and allows readers to self-assess their mastery of the material. The **Pertinent Points** section presents the critical elements of patient assessment for that chapter. They are a guide to specific questions and physical findings when evaluating patients with problems in that chapter's domain. The **Vignettes**, drawn from actual clinical cases, are edited accounts of patients whose illness exemplifies disorders in the chapter. The cases are designed to interest readers, encourage application of content, and provide a vicarious clinical experience that enhances retaining the content. The **Vignette Objectives** are learning points covered in that section of the chapter, and all are items that clinicians (including third year medical students) would be expected to know.

The **Content** focuses on information related to evaluating patients, such as how the history and physical examination are used to distinguish among diagnoses, what findings might be anticipated with particular disorders, and the sequence of findings as an illness progresses. The text assumes that readers are familiar with the "how to" of performing basic physical examination skills. We have included information concerning the reliability and utility of specific physical assessment maneuvers. Much of the material is organized into tables and algorithms to increase clarity and clinical application.

The **Vignette Follow-up** describes the patient's outcome and subsequent course. Each section of a chapter begins with one or more vignettes. An average of 12 patients are presented in each chapter. Following all the vignettes and content, chapters conclude with the **Objectives Review**, and with annotated **References**, concerning specific topics from that chapter. The review is a compilation of the chapter's **Vignette Objectives**, designed to promote self-assessment and review of material covered in the chapter.

This book may be used in several ways. Students may read its chapters coincident with their pathophysiology courses. The vignettes illustrate common disorders and demonstrate how patient assessment can define illnesses from the patient's complaint(s). In this way, the

chapters illustrate the relevance of pathophysiology teaching and can increase a student's understanding and retention of course work. The book also can be read as students begin their clinical experiences. The casebook format makes interesting reading, and the information reviews important skills and concepts used in patient care.

This book can be a reference when evaluating patients. It is portable, and the chapter structure and index allow easy access to its content. For common disorders and patient complaints, the book outlines the relevant history and physical examination components and identifies the pertinent positive and negative findings to be identified. In addition, disorders are placed in context with other conditions with similar findings. Finally, the book is appropriate reading for clinicians at all levels of training and experience. The information is important for patient care, and the vignettes (as with all patient encounters) are interesting and illustrate the unique biologic variability of illnesses and how clinical manifestations are not as clear cut as a "classic presentation" suggests.

Acknowledgments

Our deepest gratitude goes to the patients who have allowed us the privilege of caring for them, learning from them, and sharing their stories and physical findings with others. We also want to thank the many individuals who have been our students. Their questions increase our understanding with each encounter. Their awe and excitement with patient assessment constantly renew our own interest in these enduring abilities.

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1. Well Individuals and Special Situations

Objectives

List history and physical examination findings relating to the following issues:

- Screening physical examination
- Adolescent health care, including major health risks and confidentiality concerns
- Sports physical examination
- Falls and the elderly
- Advanced directives
- Risks for HIV infection
- Asymptomatic patients with HIV infection

Pertinent Points

History

Introduction: "small talk," calibration, set agenda
 Chief complaint
 Identify patient concerns and problems to address
 Survey for other problems: ongoing medical problems? medications?
 History of present illness (HPI)
 Time line, symptoms, PQRST
 (palliate/provoke, quality, location/radiation, associated symptoms, tempo/timing), affect on function/life-style, patient's attributes (what the patient thinks is going on and concerns about particular diagnoses)
 Pertinent positives that support and negatives that oppose diagnostic possibilities
 Past medical history (PMHx)
 Childhood problems
 Medical illnesses
 Hospitalizations (medical, surgical, trauma, OB/GYN, psychiatric)
 Medications
 Allergy to medications

Family history
 Habits: diet, smoking, alcohol, illicit drugs, exercise
 Sexual history
 HIV risk factors (sexual partners, including male-male contact, prostitutes, and those from high-risk groups; IV drug use; prior blood transfusion [1978-1985], and hemophiliacs receiving non-heat-treated concentrate [1978-1985])
 Immunizations (childhood, tetanus, Pneumovax, hepatitis A and B, influenza)
 Injury risk (seat belt, firearms, drinking-driving, helmet use)
 Abuse
 Occupational history (initial screening questions such as problems related to work, followed by more specific questions about exposure to chemicals, dust, noise, repeated musculoskeletal trauma, or infectious illnesses)
 Review of systems
 Social history/life-style

Physical Examination

(Modify on the basis of the patient's history and any conditions more prevalent in the patient's demographic group)

Inspection

Nutritional state, height, weight
 Observe skin

Vital signs

Blood pressure, heart rate

Integument

Inspect skin, hair, nails

HEENT

Inspect face and head
 Assess visual acuity, inspect fundi
 Test hearing
 Inspect oral cavity and pharynx
 Palpate neck for thyroid, cervical and supraclavicular adenopathy, carotid pulsations, and mass

Chest

Auscultate lung fields

Cardiac

Palpate point of maximal impulse (PMI)
 Auscultate precordium

Breasts

Inspect and palpate (include axillary nodes)

Abdomen

Percuss liver span
 Palpate for abdominal tenderness, liver edge, splenomegaly, and masses
 Digital rectal exam

Pelvic exam

When indicated for Papanicolaou smear

Musculoskeletal

Inspect for symmetry, deformities, and edema

Palpate popliteal, dorsal pedal, and posterior tibial pulses

Neurological

Mental status if more than 70 years old, confusion, neurologic complaint, or "a poor historian"

cranial nerves: II (visual acuity), VII (symmetry of facial movement), VIII (hearing), XII (tongue movement)

Inspect symmetry of muscle bulk and movements

Observe gait

Vignette 1

Reliability: refers to the reproducibility or concordance between the findings of two examiners (interobserver reliability) or the findings from repeated examinations performed by the same observer (intraobserver reliability); this is an index of the degree of confidence and diagnostic certainty that can be placed in a finding; sources contributing to unreliability relate to the examiner, the patient, and the examination setting

Routine or screening physical examination: once advocated to be done annually for maintaining health and preventing illness; the utility of physical examination components has been critically assessed, and various health organizations have recommended the components of and the frequency with which these examinations should be performed (see Table 1-1).

AS is a second-year medical student who is visiting her parents during the winter break. While at home, two events occur that make AS wonder if what she has learned in medical school applies to the "real" world. First, she is unable to answer her mother's question about whether she needs a "complete" check-up and what procedures she should expect the physician to do. Then, while demonstrating her diagnostic equipment, AS cannot hear a murmur that her 16-year-old sister asks her to examine. Her sister's pediatrician noted a murmur years ago during a sports physical examination, and the sister wants to know if it is still present.

Vignette Objectives

1. What portions of the physical examination should be included in an adult, well-patient "screening" exam?
2. List factors that contribute to disagreement about physical examination findings and, for each, provide ways to increase exam reliability.

The Well-Patient Screening Examination ---

What Constitutes a Routine Exam?

Several excellent texts on physical examination are available (see the Preface, vii), and these books provide explicit instructions for performing physical examinations. However, most do not include recommendations for an expedient "screening examination," and physicians differ greatly on the exam procedures they usually perform. This variability among practitioners was demonstrated by a study in which similar new patients (trained by the investigators to present a consistent history) were evaluated by several different physicians. Despite comparable histories and patient characteristics, the interactions lasted from 5 to 60 minutes and providers performed from 16% to 89% of the potential physical examination components.

Some of the variability among practitioners may be due to changes in the recommendations for routine physical exams. The American Medical Association first endorsed periodic physical examinations in the early 1920s, and an annual check-up continued to be advocated into the 1970s. However, in recent years, specific physical examination maneuvers have been studied to define how useful they are for identifying illness. Table 1-1 lists physical examination components and the recommendations of four expert panels or reviewers with regard to whether each should be performed routinely. Only two examination procedures, (blood pressure measurement and clinical breast exam after 40 years of age), were recommended consistently.

Despite evidence that only a few exam features have been documented to be useful in detecting illness, physicians continue to perform examinations that include many features less useful in detecting illness. Luckmann and Melville found that more than 90% of family physicians think adults need to undergo periodic complete physical examinations, and more than 95% of these clinicians included the following components in their routine exams: weight and blood pressure measurement; mouth inspection; palpation of the lymph nodes and thyroid gland; abdominal examination; and auscultation of the lungs and heart. The observed discrepancy between what has been shown to be useful and what is done could be due to several factors: (1) habits are difficult to change; (2) practitioners do not believe or know current recommendations; (3) patients expect "complete" exams; and (4) the prior chance finding of an abnormality that affected patient care may cause a physician to continue to use that exam component(s).

An additional factor may be that physical examinations enhance physician-patient rapport in a way not appreciated by determining its utility for finding disease. This was substantiated by a study of physician-patient interactions, which showed that the time spent on physical assessment was positively related to patient satisfaction. Extrapolating from study of the medical interview, patient satisfaction is enhanced by maintaining patient comfort, avoiding patient embarrassment, and demonstrating facility with exam maneuvers.

Table 1-1. Recommended physical examination maneuvers

Maneuver	Canadian Task Force (1988, 1989)	U.S. Preventive Services Task Force (1989)	Oboler and LaForce (1989)	American Colleges of Physicians (1991)
Blood pressure	At least every 5 years and beginning at age 65 every 1 to 2 years	At least every 1 to 2 years and beginning at age 65 every year	At least every 1 to 2 years	At least every 1 to 2 years and annually if positive risk factors for coronary artery disease
Height and weight	Adolescents, women of low socioeconomic status, or those with unusual dietary habits	Each 1 to 3 years after age 40 and annually after age 65	Every 4 years	Not considered
Skin inspection	Annually after age 18 in those with excess sun exposure or dysplastic nevi	After age 18 if excess sun exposure, dysplastic nevi, or history of skin cancer	Evaluate for dysplastic nevi at initial visit; annually for high-risk patients	Not considered
Oral cavity	After age 65 and begin at age 18 if uses tobacco	After age 18 if uses tobacco or alcohol	Not recommended	Annual dental exam; mouth exam not recommended
Visual acuity	Not considered	Annually after age 65	Annually after age 60	Not considered
Hearing	After age 18 or if noise exposure	Annually after age 65 and begin at age 19 if noise exposure	Annually after age 60 by audioscope	Not considered
Auscultate carotids	Not recommended	Perform if (1) positive risks for or symptoms of atherosclerotic vascular disease, (2) every 1 to 3 years after age 40, and (3) annually after age 65	Not recommended	Not considered
Clinical breast examination	Annually after age 40 and after age 35 if family history of breast cancer	Annually after age 40 and after age 35 if family history of breast cancer	Annually after age 40 and after age 18 if family history of breast cancer	Annually after age 40 and after age 18 if family history of breast cancer
Chest and pulmonary exam	Not considered	Not considered	Not recommended	Not considered

Table 1-1. Recommended physical examination maneuvers (*continued*)

Maneuver	Canadian Task Force (1988, 1989)	U.S. Preventive Services Task Force (1989)	Oboler and LaForce (1989)	American Colleges of Physicians (1991)
Cardiac exam	Not considered	Not considered	Auscultate for valvular disease at initial visit and when age 60	Not considered
Abdominal exam* *Evaluation for hepatomegaly, splenomegaly, and ascites included in Chapter 7	Not considered	Not considered	Palpate for abdominal aortic aneurysm annually in men over age 60	Not considered
Stool for occult blood	Annually after age 40 if family history of colon cancer	Annually after age 40 if family history of colon cancer	Annually after age 50 and begin at age 40 if family history of colon cancer	Annually after age 50 and begin at age 40 if family history of colon cancer
Lymph nodes	Not considered	Not considered	Not recommended	Not considered
Musculoskeletal exam	Not considered	Not recommended	Back exam not recommended	Not considered
Bimanual pelvic examination and cervical cytology	Not considered	Cervical cytology every 1 to 3 years; routine pelvic exams not recommended	Cervical cytology if sexually active; after two negative annual cytologic exams, cervical cytology at least every 3 years; palpation of ovaries not recommended	Pelvic exam not considered; cervical cytology every 1 to 3 years
Digital prostate palpation	Not recommended	Not recommended	Not recommended	Not considered
Mental status	Not recommended	Not recommended	Not recommended	After age 65

How Reliable Are Physical Examination Findings?

Clinicians frequently disagree on their reported physical exam findings. This inconsistency is due to differences in the patient, examiner, and clinical setting (Table 1-2). Table 1-2 also lists ways to increase the **reliability** of examination findings. Bias can be minimized by asking a colleague, who is provided with minimal clinical information, to repeat portions of the exam. In addition, comparing findings with objective test results helps calibrate and refine an examiner's abilities. Similarly, repeated assessments of a patient over time acquaint clinicians with the potential variability in physical findings.

Table 1-2. Reliability of physical examination findings

Variables	Factors that decrease reliability	Methods to increase reliability
Patient	Biologic variation among people Effects of patient positioning Changes due to an illness's natural history and management	Examine many people to calibrate the range of normal variation Repeat assessments to evaluate the tempo of an illness and expected changes in a patient's findings
Examiner	Biologic variation in the senses Tendency to record inference rather than evidence Biased by prior experiences Incorrect use of diagnostic tools	Seek corroboration of key findings (repeating oneself and examination by others) Ask "blinded" (nonbiased) examiners to assess the patient Confirm key clinical findings with appropriate tests Report specific findings rather than inferences
Clinical setting	Disruptive examination environments (patient comfort and cooperation; setting's noise level and lighting) Malfunction or absence of examination equipment	Establish rapport before the examination Match environment to diagnostic task Use appropriate, well-functioning examination tools

Vignette Follow-up



Once back at school, AS sends her mother the current screening recommendations and then calls her to clarify her understanding. In addition, AS reviews the section of her physical diagnosis text on cardiac assessment and concludes that her sister probably has a flow murmur. However, AS examined her sister sitting up in a noisy living room, rather than supine in a quiet office, and these factors may have contributed to her not hearing a murmur.

Vignette 2

Clinical breast examination: breast examination performed by a health care provider, as opposed to breast self-examination and mammography.



GLC is a 23-year-old woman with a clinic appointment as a new patient who needs a Pap smear. Her older sister had an abnormal Pap smear several years ago, and Ms. C is therefore somewhat apprehensive. Being new to the clinic, she is unsure about what is expected of her. The clinic aide escorts Ms. C to the exam room and asks her to change into a gown. Ms. C is not sure which way the gown closes, but guesses the opening goes in the front. After several minutes, the aide returns and instructs Ms. C to go to the bathroom, located down the clinic hallway, and "empty your bladder." The aide also tells Ms. C that her

gown is on "backward." Ms. C adjusts her gown before leaving the room but still feels uncomfortable walking to the bathroom wearing only the gown. She waits several minutes for one of the bathrooms to become available and, after using it, returns to her assigned clinic room. She waits another 20 minutes before the resident physician appears.

The resident is late because of ward responsibilities, and the clinic nurse informs Dr. M that his patient is waiting as soon as he arrives in the clinic. A medical student, who is assisting in clinic, and Dr. M enter Ms. C's room and introduce themselves. The resident physician apologizes for being late and tells Ms. C that the pelvic exam will be done as quickly as possible. Her heels are placed in the metal stirrups, and with the medical student sitting at his side, the physician tells her to "spread your legs." This is followed by a rapid external genitalia exam that includes inspection of the labia, the urethral meatus, and the perineum. The resident inserts the double-blade metal speculum into the introitus to visualize the vaginal walls and cervix. A Pap smear is obtained, and the speculum is withdrawn. He then completes a bimanual and rectovaginal examination. No discussion takes place during the entire procedure, other than a few hushed words between the resident and medical student.

When the exam is completed, the resident tells Ms. C, who is still positioned with her feet in the stirrups, that the results will be mailed to her in a few days, and then he and the medical student leave the room. The aide helps the patient out of the stirrups and tells her she can dress and leave.

Vignette Objectives

1. List ways to decrease a woman's anxiety during a pelvic examination.
2. How does a woman's confidence in her ability to do breast self-examination relate to how likely she is to obtain a mammogram?

Breast, Pelvic, and Genitourinary Examinations

The breast, pelvic, and genitourinary examinations are most likely to cause a patient to feel embarrassed and vulnerable, and each requires special attention to patient comfort. Table 1-3 lists means to reduce a woman's anxiety during a pelvic examination. Women's preferences and physicians' practices vary concerning the presence of a chaperon during the pelvic examination. In general, younger women have a greater preference for a chaperon, and approximately half of women overall prefer to have a chaperon with a male examiner. Unlike

Table 1-3. Procedures that reduce patient anxiety during pelvic examination

Obtain the history before the patient disrobes
Elevate the head of the exam table to facilitate eye contact
Monitor patient comfort
Use an unhurried manner
Inform patient about findings

women's reaction to the pelvic examination, men's reactions to a genitourinary exam have not been well studied. When assessed, male adolescents have shown a preference not to have a chaperon present during the genitourinary examination.

The **breast examination** offers an opportunity to review exam technique with the woman and to emphasize the importance of mammography. Expressing the need for mammography is important, because the factors that most influence women to undergo mammography are a physician's personal recommendation and enthusiasm about its utility. Because women with more confidence in their breast self-exam abilities may think mammography is not needed, it is important to emphasize that both mammography and clinical or breast self-examination are useful. The use of one type of screening tool does not reduce the requirement for the other.

Vignette Follow-up



Ms. C receives a note from the clinic telling her that the Pap smear was normal. She is told to make another appointment in 2 years, but she chooses not to return to this clinic.

Vignette 3



AV is 17 years old, and he comes with his mother to the clinic to have a pre-college physical examination. They bring a form that needs to be completed. AV's parents have been patients for a couple of years, but previously AV has been seen only by a pediatrician. You know something about AV from interactions with his parents. He has done well in school and will be going out of state to a small private college.

Both AV and his mother are in the exam room, and she adds information to his answers to your questions. However, she spontaneously excuses herself when you announce the need to do a physical examination. Later the nurse enters the examination room and hands you a note that Mrs. V has written. In it she expresses her concern that AV may be using drugs and wonders if you could perform a urine drug screen without telling her son.

Vignette Objectives

1. What aspects of patient assessment are most useful when evaluating an adolescent?
2. What medical history questions relate to the leading cause of death among adolescents?