Oxford handbook of clinical medicine

R. A. HOPE AND J. M. LONGMORE

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Preface

This book, written by junior doctors, is intended principally for medical students and house officers. The student becomes, imperceptibly, the house officer. For him we wrote this book not because we know so much, but because we know we remember so little. For the student the problem is not simply the quantity of information, but the diversity of places from which it is dispensed. Trailing eagerly behind the surgeon, the student is admonished never to forget alcohol withdrawal as a cause of post-operative confusion. The scrap of paper on which this is written spends a month in the white coat pocket before being lost for ever in the laundry. At different times, and in inconvenient places a number of other causes may be presented to the student. Not only are these causes and aphorisms never brought together, but when, as a surgical house officer, the former student faces a confused patient, none is to hand.

This book is intended for use on the ward, in the lecture-theatre, library, and at home. Each subject only occupies one page and opposite is a blank page for additions, updatings, and refinements. If they face the relevant page of print they will be automatically indexed. As a guide, the more practically orientated pages are designated 'help for housemen', and topics presented more formally are designated 'subjects for students'. Rarities are included separately at the end of each section.

Clinical medicine has a habit of partly hiding as well as partly revealing the patient and his problems. We aim to encourage the doctor to enjoy his patients: in so doing we believe he will prosper in the practice of medicine. For a long time now, house officers have been encouraged to adopt monstrous proportions in order to straddle simultaneously the diverse pinnacles of clinical science and clinical experience. We hope that this book will make this endeavour a little easier by moving a cumulative memory burden from the mind into the pocket, and by removing some of the fears that are naturally felt when starting a

career in medicine, thereby freely allowing the doctor's clinical acumen to grow by the slow accretion of many, many days and nights.

R. A. H.
J. M. L.

Note

Numbers in square brackets on right-hand pages are cross-references to the relevant sections of the *Oxford Textbook of Medicine*.

Foreword

Stephen Lock, Editor, British Medical Journal

'The textbook is dead: long live the textbook!' Even before Professor Tony Mitchell's scathing book review comparing the textbook of medicine to the dinosaur, doctors had been muttering that it no longer served their needs, either for preparing for higher examinations or for quick reference. As usual, Tony Mitchell was right, but only partly so: what most of us preparing for the MRCP a quarter of a century ago disliked about British textbooks in particular was their verbosity and their vagueness ('attention should be paid to the bowels', 'morphine should be given hypodermically'—when, how much, and for how long? we muttered, knowing that these were the questions we would have to answer). As a result, the British balance of payments suffered from large-scale purchase of the down-to-earth and terse US product *Cecil and Loeb's textbook of medicine.*

I say that Tony Mitchell was only partly right, because I believe that his words applied to the textbook edited by the single person. Just as the days of the single-editor/referee journal died with Virchow, and those of the single-author textbook died with Osler, so the single-editor textbook died with Price, or should have done. The splendid new *Oxford textbook of medicine* recognized this when it commissioned no fewer than three physicians in separate disciplines to edit it.

And now Tony Hope and Murray Longmore have followed this new pattern by producing a handbook aimed at junior doctors which not only answers those questions: when, how much, for how long? but allows space to incorporate new notes.

I have enjoyed this book, feeling thankful that I do not have to know all these facts in today's technological, and litigious society. Now we have this book to guide diagnosis and management; the next development must be guidance on prevention. Perhaps this calls for another textbook, *The Oxford handbook of preventative medicine,* and I should patent my idea before the Delegates get there first.

I wish this *Handbook* well, am flattered by the frequent references to the *BMJ,* and am delighted that, far from being dead, the phoenix textbook is now appearing in new guises.

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Abbreviations and symbols

►	this is important
−ve	negative
+ve	positive
↓	decreased
↑	increased
↔	normal
ac	ante cibum (before food)
ACTH	adrenocortico-trophic hormone
ADH	antidiuretic hormone
AF	atrial fibrillation
Alk phos	alkaline phosphatase
ANF	antinuclear factor
ASO	antistreptolysin O
ATN	acute tubular necrosis
AXR	abdominal X-ray (plain)
Ba	barium
BMJ	*British Medical Journal*
BP	blood pressure
Ca	carcinoma
CBD	common bile duct
CCF	congestive cardiac failure (ie RVF with LVF)
CI	contraindications
CLL	chronic lympho-cytic leukaemia
CML	chronic myeloid leukaemia
CMV	cytomegalovirus
CNS	central nervous system
CSF	cerebrospinal fluid
CT	computerized tomography
CVP	central venous pressure
CVS	cardiovascular system
CXR	chest X-ray
DIC	disseminated intravascular coagulation
DIP	distal inter-phalangeal
dl	decilitre
DM	diabetes mellitus
D&V	diarrhoea and vomiting
DVT	deep venous thrombosis
EBV	Ebstein Barr virus
ECG	electrocardiograph
eg	for example
EM	electron microscope
ENT	ear,nose, and throat
ESR	erythrocyte sedi-mentation rate
FBC	full blood count
FEV_1	forced expiratory volume in 1st second
FSH	follicle-stimulating hormone
FVC	forced vital capacity

g	gram
GB	gall bladder
GC	gonococcus
GFR	glomerular filtration rate
GI	gastrointestinal
GP	general practitioner
G6PD	glucose 6-phosphate dehydrogenase
h	hour
Hb	haemoglobin
HB_sAg	hepatitis B surface antigen
Hct	haematocrit
HOCM	hypertrophic obstructive cardiomyopathy
IDA	iron-deficiency anaemia
IDDM	insulin-dependent diabetes mellitus
Ig	immunoglobulin
IM	intramuscular
IPPV	intermittent positive pressure ventilation
ITP	idiopathic thrombocytopenic purpura
ITU	intensive therapy unit
iu	international unit
IV	intravenous
IVI	intravenous infusion
IVC	inferior vena cava
IVU	intravenous urography
JVP	jugular venous pressure
kg	kilogram
kPa	kiloPascal
L	left
l	litre
LBBB	left bundle branch block
LFT	liver function test
LH	luteinizing hormone
LIF	left iliac fossa
LMN	lower motor neurone
LP	lumbar puncture
LUQ	left upper quadrant
LVF	left ventricular failure
LVH	left ventricular hypertrophy
µg	micrograms
MCV	mean cell volume
mg	milligrams
min	minute(s)
ml	millilitre
mm Hg	millimetres of mercury
MS	multiple sclerosis
MSU	midstream urine
NB	nota bene (note well)
NBM	nil by mouth
ND	notifiable disease

Abbreviations and symbols

NEJM	*New England Journal of Medicine*
NG	nasogastric
NSAID	non-steroidal anti-inflammatory drugs
NSGI	non-specific genital infections
OTM	*Oxford Textbook of Medicine* (OUP 1983)
$Paco_2$	partial pressure of CO_2 in arterial blood
Pao_2	partial pressure of O_2 in arterial blood
PAN	polyarteritis nodosa
PCV	packed cell volume
PE	pulmonary embolism
PEFR	peak expiratory flow rate
PIP	proximal inter-phalangeal
PR	per rectum (rectal examination)
PL	prolactin
pnd	paroxysmal nocturnal dyspnoea
PO	per orum (by mouth)
PRL	prolactin
PRV	polycythaemia rubra vera
PTH	parathyroid hormone
PTT	prothrombin time
QJM	*Quarterly Journal of Medicine*
R	right
RA	rheumatoid arthritis
RBBB	right bundle branch block
RBC	red blood cell
RhF	rheumatic fever
RIC	raised intracranial pressure
RIF	right iliac fossa
RUQ	right upper quadrant
RVF	right ventricular failure
s	second(s)
SBE	subacute bacterial endocarditis
SC	subcutaneous
SE	side-effects
SL	sublingual
SLE	systemic lupus erythematosus
SVC	superior vena cava
SXR	skull X-ray
T_3	triiodothyronine
T_4	thyroxine
TB	tuberculosis
TIA	transient ischaemic attack
TPR	temperature, pulse, and respirations count

TSH	thyroid stimulating hormone	**UTI**	urinary tract infection
u	units	**WBC**	white blood cell
UC	ulcerative colitis	**WCC**	white cell count (total)
U&E	urea and electrolytes	**wk**	week(s)
UMN	upper motor neurone	**WR**	Wassermann reaction
URT	upper respiratory tract	**XR**	X-ray
URTI	upper respiratory tract infection	y	year(s)

Note

While every effort has been made to check drug dosages in this book, it is still possible that errors have been missed. Furthermore, dosage schedules are being continually revised and new side-effects recognized. For these reasons the reader is strongly urged to consult the *British National Formulary* or the drug companies' printed instructions before administering any of the drugs recommended in this book.

Contents

Note: The content of individual chapters is detailed on each chapter's first page

1. An introduction to medicine

Professor Cottard[1]

It is not enough that a physician who is called in to treat cases of this sort should be learned. Confronted with symptoms which may be those of three or four different complaints, it is in the long run his flair, his instinctive judgement, that must decide with which, despite the more or less similar appearance of them all, he has to deal. This mysterious gift does not imply any superiority in the other departments of the intellect, and a person of the utmost vulgarity, who admires the worst pictures, the worst music, who is without the slightest intellectual curiosity, may perfectly well possess it. In my case, what was physically evident might well have been caused by nervous spasms, by incipient tuberculosis, by asthma, by a toxi-alimentary dyspnoea with renal insufficiency, by chronic bronchitis, or by a complex state into which more than one of these factors entered. Now, nervous spasms required to be treated firmly, and discouraged, tuberculosis with infinite care and the sort of 'feeding-up' which would have been bad for an arthritic condition such as asthma and might indeed have been dangerous in a case of toxi-alimentary dyspnoea, this last calling for a strict diet which, in turn, would be fatal to a tubercular patient. But Cottard's hesitations were brief and his prescriptions imperious: 'Purges, violent and drastic purges; milk for some days, nothing but milk. No meat. No alcohol.' My mother murmured that I needed, all the same, to be 'built up', that I was already very nervy, that drenching me like a horse and restricting my diet would make me worse. I could see in Cottard's eyes, as anxious as if he was afraid of missing a train, that he was wondering whether he had not succumbed to his natural gentleness. He was trying to think whether he had remembered to put on his mask of coldness, as one looks for a mirror to see whether one has forgotten to tie one's tie. In his uncertainty, and in order to compensate just in case, he replied brutally: 'I am not in the habit of repeating my prescriptions. Give me a pen. Now remember, milk! Later on, when we've got the breathlessness and the agrypnia under control, I'm prepared to let you take a little clear soup, and then a little broth, but always with milk; *au lait*!'

1 M Proust *Remembrance of things past* Vol 1 p 536 Chatto & Windus. Translated by C. Scott Moncrieff and T. Kilmartin 1981, by kind permission.

The bedside manner

The examiner's manner influences the signs he elicits in a number of interesting ways.

- **Through anxiety reduction or intensification** Simple explanation of what you are going to do often defuses what can be a highly charged affair. With children more subtle techniques are required such as examining the abdomen using the child's own hands, or examining their teddy bear first.
- **Through pain reduction or intensification** Compare: 'I'm going to press your stomach. If it hurts just cry out' with 'I'm going to touch your stomach. Let me know what you feel' and 'Now I'll lay a hand on your stomach. Sing out if you feel anything'. The examination can be made to sound frightening, neutral, or joyful, and the patient will relax or tense up accordingly.
- **Through the tactful or clumsy invasion of interpersonal space** During ophthalmoscopy, for example, the examiner must get much nearer to the patient than is acceptable in normal social intercourse. Both he and the patient may end up holding their breath, which is not conducive to keeping the eyes still, or a careful examination. Simply explain 'I need to get very close to your eye for this'. (Not '*We* need to get very close for this'—one of the authors was kissed repeatedly while conducting ophthalmoscopy in a patient with frontal lobe signs. There are dangers in suggesting too much familiarity.)
- **Through induction of a trance-like state** Watch a skilful practitioner at work palpating the abdomen. His hand rests idly on the abdomen, far away from the distempered part. He meets the patient's gaze: 'Have you ever been to the sea-side?' (his hand caresses rather than penetrates) . . . 'Imagine you are back on the beach now, perfectly at ease, gazing up at the blue blue sky' (he presses as hard as he needs) . . . 'Tell me now, where were you born and bred?' If the patient stops talking and frowns only when the examiner's hand is over the right iliac fossa he will already have found out something useful.

Questions and answers

Leading questions On seeing a patient's blood-stained handkerchief you ask 'For how long have you been coughing up blood?' 'Six weeks, doctor.' So you assume he has been having haemoptysis for six weeks. In fact it could all be due to an infected finger or nose bleeds. With leading questions patients are not given an opportunity to deny your assumptions.

Questions which suggest the answer 'Was the vomit red, yellow, or black—like coffee grounds?' (doctor thinking of haematemesis). 'Yes, black, like coffee grounds doctor.' The doctor's expectations have so tarnished this patient's history as to make it useless.

Neutral questions 'What was the vomit like?' 'Dark.' 'How dark?' 'Dark bits in it.' 'Like . . .?' 'Like bits of soil in it.' This information is pure gold, although it is not cast in the traditional mould of 'coffee grounds'.

Imperatives 'Tell me some more about the pain . . .' does not impose any false pattern on the patient's story.

Reticular questions probe the network of causes and enabling conditions which allow nebulous symptoms to function in family life. Until these questions are asked they may remain refractory to treatment. Eg: 'Who is present when your headache starts? Who notices it first, you or your wife? Who worries about it most (or least)? What does your wife do when (or before) you get it?'
Think to yourself 'Who is his headache?'

Comments 'This is most complex . . . I can only just grasp what you are saying' allows you to interrupt politely.

Echoes The doctor repeats the last few words the patient has said, prompting new intimacies, otherwise inaccessible, as the doctor fades into the background and the patient soliloquizes. 'I've always been suspicious of my wife' 'wife' 'my wife . . . and her father together' 'together' 'I've never trusted them together' 'trusted them together . . .' 'no . . . well . . . I've always felt I've known who Bert's real father was . . . I can never trust those two together.' Without any questions you may unearth the unexpected, important clue which throws a new light on the history. If you only ask questions you will only receive answers in reply.