英汉对照

物理诊断学

ections of Physical Diagnosis

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English-Chinese Bilingual Physical Diagnosis

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Preface

The only aim of copiling this "Selections of Physical Diagnosis" (English Chinese Bilingual) is expected to be an aid to the medical students, interns, and clinicians who want to learn English words and technical terms commonly used in the history-taking and physical examination of patients. For this purpose, it is thought necessary this book should be written in close linking to the contents and lay-out of titles of the standard textbook and lecture-notes of diagnostics currently used in the medical schools here and abroad. The whole book consists of two sections and some added materials. The first section discusses the history-taking. The physical examination is narrated in the second section. In the last part of the book there are some appendixes in which names of departments of hospital and medical college as well as academic and hospital ranks are available for reference and example of standard case history.

Because of our poor competency either in English or Chinese, mistakes and errors in this book are hard to avoid. Readers are begged to point out and correct them, which we cordially welcome.

We owe great debt to the Training Division of the

Third Military Medical University and the South-west Hospital, which provided the impetus and opportunity for the writing of this book, and a more particular debt to the comrades from the Department of Foreign Languages, who have taken great trouble to type, transcribe and proofread the whole materials.

The Authors
Chongqing
December, 1989

引　言

《英汉对照物理诊断学》的编写目的是想协助医科学生、临床实习生和临床工作者学习物理诊断学的一些常用医学英语单词和术语。为了密切配合物理诊断学的学习和临床教学，本书的主要内容与形式是摘要选择某些中、英文诊断学教科书和讲义章节。全书共分二篇并加有附录。第一篇是问诊和病历的简介；第二篇是体格检查。附录有病历示范、医院部别名称和医务人员称谓以及医学院校部别名称和院校人员称谓。

由于我们中英文水平有限，书中错误在所难免，谨请各位读者不吝批评指正。

本书编写得到了第三军医大学训练部和西南医院的大力支持，尤其要提及的是外语教研室的同志们在书稿的打印、誊抄和校对方面付出了不少的劳动，特此表示深深谢意。

编者　　1989年12月于重庆

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SECTION ONE
THE CLINICAL INTERVIEW
(HISTORY – TAKING)

§1. The Importance of the Clinical Interview and Its Basic Structure

The importance of the clinical interview

The medical history is the foundation of diagnosis. Although paramedical personnel, standarized questionnaires, and computers have become increasingly useful in obtaining clinical information, the physician must still assume the major responsibility for assuring that the information is as complete and as accurate as possible. As medical students you are the physicians of tomorrow and therefore you must learn how to take down a medical history.

In addition to the accumulation of essential medical information the clinical interview is the beginning of the patient-physcian relationship, an interaction during which the patient is evaluating the patience, thoroughness, and skill of the physician, and the physician is seeking subtle clues, such as appearance, voice, expression,

mannerism, position in bed, breathing pattern of patient. The doctor may also learn much about the illness from the way the patient tells the story than from the story itself. This is unobtainable by the standard questionnaires and computers.

Medical history-taking is not confined to a single time or location; it is the continuing accumulation of information throughout the entire patient-physician relationship. Ideally, a single period of time should be available during the initial visit to explore the medical history in depth. A data base form constructed by the physician or by the hospital for their patients, allows essential information to be collected at different times yet recorded in one, easily accessible place.

A physician should be a medical detective, and try to obtain information from every source possible to enable him to unravel the mystery of the patient's illness. The two most fundamental skills—investigation and examination—should be cultivated and practiced diligently until the physician reaches a high degree of proficiency. The development or lack of development of these skills differentiates the topflight clinician from the mediocre physician.

To obtain a good history requires considerable experience and fundamental knowledge of medicine. A good case history taken by an experienced clinician is a true and an invaluable componoent of the patient's

record. On the other hand, a poor history is useless, in fact, it may be misleading, and become detrimental to the record.

It is extremely difficult for the beginning student to take down a medical history since his knowledge of medicine is naturally limited and the mere task of eliciting information itself is complex. Yet, as with the other situations in life, the student must start out, even though with faltering steps. Thoughtful guidance is needed.

Eliciting the information is not merely patient response to a sterotyped list of questions. Furthermore, information must be carefully weighted as to its clinical significance and its possible relationship to the patient's complaints. These facts alone, in our opinion, make the computerised history inaccurate and inappropriate.

A patient consults his physician because of an unpleasant or an uneasy daily functions. Alterations in function or structure (sign) are produced by disease. Signs are the objective evidence of an illness that a physician detects by a physical examination.

It is essential that the physician be familiar with the normal so that he can detect or determine which signs and symptoms are abnormal. Most patients consider all of their symptoms to be abnormal which in turn give them reasons for concern. Other patients either minimize or fail to recognize important symptoms, and

some even conceal the symptoms or signs.

It is often helpful to initiate the history-taking by asking the patient to mention all current symptoms or problems. These problems can be explored in detail separately; or if there is an apparent association, the symptoms can be grouped together for analysis.

The basic structure of the clinical interview

Once the basic symptoms have been identified, they must be separated and looked at sharply from all angles. This is accomplished by exploring seven basic properties that may separate a symptom of one disease from a symptom of another disease. These seven basic properties are: body location, quality, quantity, chronology, setting, aggravating or alleviating factors, and associated symptoms.

1. *Bodily Location* This includes defining the area of origin of the symptom and the area of radiation, as precisely as possible.

2. *Quality* The quality is the degree or kind of pain such as sharp or cramping or tingling. The inability to describe the quality may also be informative.

3. *Quantity* This includes the severity of the symptom, the number of time experienced, and the duration of the symptom.

4. *Chronology* The chronology of a symptom implies the onset of the symptom, as exactly as possible, and its sequential development until the present.

5. *Setting* The symptom should be related to the time of the day or night, whether the patient was active or resting, emotionally upset or relaxed, at home or at work.

6. *Aggravating or alleviating factors* The symptoms should be further clarified by asking what was done to gain relief, what position was sought, the effect of movement, respiration and medication.

7. *Associated Symptoms* Many diseases manifest themselves as a constellation of associated symptoms that support a diagnosis when linked together. The patient should be asked to describe other sensations occuring before, during or after the major symptom.

Through the use of the seven basic properties the diagnostician can characterize the symptoms and begin to evaluate possible disease entities.

The history must then probed to provide the information necessary to include or to exclude these etiological possibilities. For example, if the symptom is "coughing up blood", then the intermediate possible causes might include bronchitis, pneumonia, tuberculosis, pulmonary embolus, lung tumor, mitral stenosis or lung flukes (paragonimiasis).

After the symptom is delineated as completely as possible, the patient is questioned in depth for information that would produce a more specific diagnosis or that would eliminate several possibilittes. The patient is asked to elaborate

upon each symptom or illness. Questions such as: "when were you last feeling well? or did you consider your health to be excellent prior to—?" may be useful. If it is desirable to trace the illness forward, beginning with its symptoms and progressing to the present time. Some patients accomplish this with great skill, embellishing the story with vivid description. Many patients, however, are unable to remember dates with accuracy, but many become confused or frustrated if pressed for exact details. On occassion, a patient is not able to supply the physician with a clear idea of the illness and its chronological development. In this situation, the physician must sacrifice chronology for a better comprehension of the nature of the symptoms. For example, the physician might ask "Describe a typical attack", "How long is the shortest attack?" —the longest? —the usual?" Tell me approximately how many attacks of chest pain you have each week? Have these increased in frequency lately?"

The experienced physician carefully prompts the patient with appropriate questions so that all necessary information, both positive and negative, is collected before a different topic is pursued. Since it is the physician, not the patient, who has the knowledge of the disease processes and their clinical presentation, the clinical interview should be structured by the physician. This structure should allow a thorough objective analysis of the symptoms but not lead the patient into responses that fit the physician's

predetermined conception of the illness.

It is very important to recognize emotional and psychological impact of the symptoms. The physician should also understand his own biasis so that he interacts objectively with the patient.

The previous illness, past and current therapy, habits, allergies, family history, occupational and daily living history, are carefully documented and reviewed. At the close of the interviews, it is often valuable for the physician to summarize his understanding of the information so that the patient can make any necessary corrections before the information is placed on the record.

The history from the patient may be supplimented by informations gathered from relatives and friends, and from charts and comments made by other physicians who might have cared for the patient.

On occasion, the patient may be so acutely ill that the initial history and examination have to be limited to the essential information needed to begin therapy. After the immediate needs of patient are met, additional information can be obtained. An extensive history is usually too exhausting to the acutely ill patient and should be deferred until the patient is stable enough to be fully questioned and examined.

In the process of obtaining a history, the physician may encounter a number of obstacles, the majority of which are not intentional on the part of the patient.

Such obstacles include fear, mental cloudiness or incoherence, language barriers and rambling and talkativeness.

The incoherent, irrational or comatose patient constituts a real problem. Obviously, the history, if it is to be meaningful, must be obtained from a relative or a friend who is familiar with the patient's illness. The situation even becomes more frustrating when neither relative nor friend is available to supply the information, and when there is no identification cards (identity card) or descriptive card of one's disease, and in addition, the patient was found and sent to the hospital by a passerby.

One must remember, a proper physician-patient relationship must be established in order to obtain the best history. There are many intangible but extremely important factors involved in establishing a good physician-patient relationship. When the physician approaches the patient he should be cheerful, neat in his attire, courteous, considerate of the patient and modest in attitude, and show a professional demeanour. In addition he should be constantly observant of the various actions and reactions of the patient.

In summary, the fundamental principles involved in taking down a medical history are listening and questioning, observation and interogation, plus the intangible factors of personality of the physician. The mechanics and skills of the history taking can be perfected only by repetition and extensive clinical experience. Practice makes perfect! The obstacles