AN INTRODUCTION TO THE SYMPTOMS AND SIGNS OF SURGICAL DISEASE

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Symptoms and Signs of Surgical Disease

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An Edward Arnold Publication
Distributed by
Year Book Medical Publishers, Inc.
35 E. Wacker Drive, Chicago

First published 1978
by Edward Arnold (Publishers) Ltd
41 Bedford Square, London WC1B 3DQ

Distributed in the United States of America by
Year Book Medical Publishers, Inc.

Printed in Great Britain.

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To my wife

Preface

I believe that the main object of basic medical education is to train the student to talk to and to examine a patient in such a way that he can discover the full history of the patient's illness, elicit the abnormal physical signs, make a differential diagnosis and suggest likely methods of treatment. The object of further medical training is to amplify these capabilities in range and depth through practical experience and specialist training.

It is surprising, but a fact, that some students present themselves for their qualifying examination unable to take a history or to conduct a physical examination in a way that is likely to detect all the abnormal symptoms and signs. Even more are unable to interpret and integrate the facts they do elicit. I think there are two reasons for these deficiencies. First, and most important, students do not spend enough time seeing patients and practising the art of history taking and clinical examination. It is essential for them to realize at the beginning of their training that the major part of medical education is an **apprenticeship**, an old but well proven system whereby the apprentice watches and listens to someone more experienced than himself and then tries it himself under supervision. The second reason is the lack of books which describe how to examine a patient and explain how the presence or absence of particular symptoms and signs lead the clinician to the correct diagnosis.

In this book I have attempted to describe in detail the relevant features of the history and physical signs of the common surgical diseases in a way which emphasizes the importance of the routine application of the techniques of history taking and examining.

The details of these techniques are fully described, and headings such as age, sex, symptoms, position, site, shape and surface are constantly repeated — in an unobtrusive way. I hope that when you have finished reading the book you will have these headings so deeply imprinted in your mind that you will never forget them. If so, I will consider that the book has succeeded, for you will always take a proper history and perform a correct and complete examination.

Because the main object of the book is to emphasize the proper techniques of history taking and clinical examination, I have described only the common conditions that a surgeon is likely to see in an outpatient clinic. Indeed the whole book is presented in a manner similar to that used by most teachers when they are in the presence of the patient. Special investigations and treatment are completely excluded because neither can be applied sensibly if you get the history and physical signs wrong.

To make the book useful for revision I have put a number of the lists and classifications into special grey-backed panels and, when possible, kept them to the right-hand page. Some of the descriptions of techniques, and diagnosis flow charts, are treated in a similar way. The photographs are close to the relevant text but their legends contain enough information to make the picture-plus-legend a useful revision piece.

I hope this book will be more of a teach-book than a text-book, which will be read many times during your basic and higher medical training. There is a well known saying — 'A bad workman always blames his tools'. The doctor cannot make this excuse because his basic tools are his five senses. If he has not trained his senses properly in the manner described in this book and kept them finely honed by constant practice, he will practise bad medicine but he will have only himself to blame.

N.L.B.

Acknowledgements

This book owes its existence to three groups of people, my surgical mentors and my patients, my secretaries and the staff of Edward Arnold, and my family.

Throughout my own undergraduate and post-graduate career I have had the good fortune to work with surgeons whose clinical abilities have been outstanding. This book is the distillation of their teaching and example, and like them it puts the bedside contact of doctor and patient above all other considerations and stresses that patients are human beings to be respected and supported at all times. Some of my teachers are famous men, others less well known, but one thing they had in common — they were all good 'doctors'.

It is easy to have ideas about writing a book, but difficult to get it onto paper. The text would never have been completed without the secretarial help of my wife and Mss G. Clemenson, L. Masden, S. Edgley, E. Miles and P. Milton. I am extremely grateful to them for all their hard work and to the staff of Edward Arnold, especially Mr Paul Price, who was the first to encourage me to turn my ideas into reality, and Miss Barbara Koster who transformed my manuscript into a book.

The photographs have all been taken by the Department of Photography of St Thomas' Hospital, directed by Mr T. Brandon. Most of the photographs are of my own or Professor J. B. Kinmonth's patients, but some are of patients under the care of other colleagues at St Thomas', surgeons and physicians, who all gladly gave their consent to their use.

Teachers, patients, students and secretaries all contributed their part — some knowingly, others incidentally — but only one person has been present from the book's conception to its completion — typing, criticizing, reading but above all encouraging and supporting — my wife. Words cannot express my gratitude for her help and understanding.

Contents

Chapter 1

An Introduction to History Taking and Clinical Examination

You must be constantly alert from the moment you first see the patient, and employ your eyes, ears and hands in a systematic fashion to collect the information from which you can deduce the diagnosis. The ability to appreciate an unusual comment or minor abnormality which may lead you to the correct diagnosis will only develop from the diligent and frequent practice of the routines outlined in this chapter.

Always give the patient your whole attention and **never** take 'short-cuts'.

In the outpatient clinic try to see the patient walk into the room rather than meet him undressed on a couch, in a cubicle. General malaise and debility, breathlessness, cyanosis, and difficulty with particular movements are much more obvious when the patient is exercising than when he is at rest.

It is also helpful to see the person accompanying the patient. A mother, wife or friend can often provide valuable information about changes in health and behaviour not noticed by the patient.

Patients like to know to whom they are talking. They are probably expecting to see Mr Bloggs, the surgeon. If you are not Mr Bloggs, tell the patient your name and explain why you are deputizing for him. It is particularly important for medical students to do this.

Talk with the patient or, better still, let him talk to you. Guide the conversation but do not dictate it (at first). Treat patients as the rational, intelligent human beings they are. They know more about their complaints than you, but cannot interpret their significance. Explain what you are doing, and why you are doing it, at all stages of their care.

All textbooks say that you should not ask leading questions, that is to say, questions which imply that there is only one answer. All questions should leave the patient with a free choice of answers. If you say, 'The pain moves to the right-hand side, doesn't it?' you imply that it should have moved in that direction and an obliging patient will answer 'Yes' to please you. The question should be, 'Does the pain ever move?' and if the patient answers 'Yes', you must then ask the supplementary question, 'Where does it go?'. However, if communications are difficult you may have to suggest to the patient the possible answers so that he can confirm or reject them.

When a patient is having difficulty communicating with you, remember that a question which is not a leading one in your mind may be interpreted as one by the patient if he does not realize that there is more than one answer. For example, 'Has the pain changed?' can be a bad question. You may know of a variety of ways in which the pain can change — severity, nature, site, etc. — but the patient may be so disturbed by the intensity of the pain that he thinks only of its severity and forgets other features of it that may have changed. In such situations it often helps to include the possible answers in the question. For example, 'Has the pain moved to the top, bottom, or side of your abdomen or anywhere else?', 'Has the pain got worse, better or stayed the same?', or 'Can you walk as far, less far, or the same distance as you could a year ago?'.

The patient will provide the true answer provided you ask the question in the right way; all that matters is that you discover the truth. So do not be over-concerned about the questions — worry about the answers, and accept that it will sometimes take a long time and a great deal of patience and perseverance to get them.

The history should be taken in the order set out below. Do not write and talk to the patient at the same time — you will make mistakes.

Make sure you know the patient's name, age, sex, ethnic group, marital status and occupation.

1 The present complaint

It is customary to ask the patient 'What are you complaining of?' and to record the answer in the patient's own words. If you ask, 'What is the matter?' the patient will probably tell you his diagnosis, but it is better not to know the diagnosis made by the patient, or another doctor, because both might be wrong; so seek out the patient's complaints. If there is more than one complaint, list them in order of severity and, when possible, indicate why the patient is concerned with one complaint more than another.

2 The history of the present complaint

Next record the full details of the history of the main complaint or complaints. It is important to get right back to the beginning of the trouble. For example, a patient may complain of a sudden attack of indigestion. If further questioning reveals similar attacks some years previously, include their description in this section.

3 Remaining questions about the abnormal system

If the patient complains of indigestion it is sensible, after recording the history of the indigestion, to continue with the remainder of the alimentary system questions because many of the replies will throw light on the cause of the main complaint.

4 Systematic direct questions

These are direct questions that you must ask every patient, because the answers will not only amplify your knowledge about the main complaint, but often reveal the presence of other disorders of which the patient was unaware, or thought irrelevant. Negative answers are as important as positive answers.

The questions are described in detail because they are so important. It is essential to know them by heart because it is very easy to forget to ask some of them. When you have to go back to the patient to ask a forgotten question, you invariably find the answer to be very important. The only way to memorize this list is by taking as many histories as possible and writing them out in full, giving the answer to every question, whether it be positive or negative.

(a) Alimentary system

Appetite Has the appetite increased, decreased, or remained unchanged? If it has decreased, is this due to a lack of desire to eat, or to apprehension because eating always causes pain? Has the patient developed any food fads; what are his special new likes or dislikes?

Diet What type of food does the patient eat? When does he eat his meals? How long do the meals take?

Weight Has the patient's weight changed? How much? How quickly? Many patients never weigh themselves but will have noticed if their clothes have got tighter or looser, or friends may have told them of a change in physical appearance.

Teeth and taste Can the patient chew his food? Does he have his own or false teeth? Does he get odd tastes and sensations in the mouth? Does he get water brash or acid brash, the sudden filling of the mouth with watery or acid-tasting fluid (saliva and gastric acid respectively)?

Swallowing If the patient has difficulty in swallowing (dysphagia), ask about the type of food that causes difficulty, the level at which the food sticks, and the duration and progression of these symptoms. Is swallowing painful?

Regurgitation This is the effortless return of food into the mouth. It is quite different to vomiting, which is associated with a powerful although often involuntary contraction of the abdominal wall. Does the patient regurgitate? What comes up? How often does it occur and does anything, such as stooping or straining, precipitate it?

Flatulence Does the patient belch frequently? Does this affect any of his other symptoms?

Heartburn Patients may not realize that this symptom comes from the alimentary tract and they may have to be asked about it directly. It is a burning sensation behind the sternum caused by the reflux of acid into the oesophagus. How often does it occur? What makes it happen?

Vomiting How often does the patient vomit? What is the nature and volume of the vomitus? Is it recognizable food from previous meals, digested food, clear acidic fluid or bile-stained fluid? Is the vomiting preceded by another symptom such as pain, headache or giddiness; does it follow eating?

Haematemesis Always ask the patient if he has ever vomited blood because it is such an important symptom. Old, altered blood looks like 'coffee grounds'. Some patients have difficulty in differentiating between vomited or regurgitated blood and coughed-up blood (haemoptysis). The latter is usually pale pink and frothy.

Indigestion or abdominal pain Some people call all abdominal pains indigestion; the difference between a discomfort after eating and a pain after eating may be very small. Concentrate on the features of the pain, its site, time of onset, severity, nature, progression and duration, precipitating, exacerbating and relieving factors, radiation and course (see page 6).

Abdominal distension Has the patient noticed any abdominal distension? What brought this to his attention? When did it begin and how has it progressed? Is it constant or variable? What factors are associated with any variations? Is it painful? Does it affect respiration? Is it relieved by belching, vomiting or defaecation?

Defaecation How often does the patient defaecate? What are the physical characteristics of the stool?

Colour: brown, black, pale, white or silver?
Consistence: hard, soft or watery?
Size: bulky, pellets, string- or tape-like?
Specific gravity: does it float of sink?
Smell?

Beware of the terms 'diarrhoea' and 'constipation'. They are lay words and mean different things to different people. Never use these words in your notes without also recording the frequency of bowel action and the consistence of the faeces.

Has the patient ever passed any blood? How much? Is the blood mixed with or on the surface of the stool, or does it appear after passing the stool? Has the patient ever passed mucus or pus? Is defaecation painful? When does the pain begin — before, during, after, or at times unrelated to defaecation?

Colour of skin Has the patient ever turned yellow (jaundiced)? When? How long did it last? Were there any other accompanying symptoms such as abdominal pain or loss of appetite? Did the skin itch?

(b) Respiratory system

Cough How often does the patient cough? Does the coughing come in bouts? When? Does anything precipitate or relieve the coughing? Is it a dry or wet cough?

Sputum What is the quantity, colour, taste and smell of the sputum? Some patients only produce sputum in the morning or when they are in a particular position.

Haemoptysis Has the patient ever coughed up blood? Was it frothy and pink, red streaks in the mucus, or clots of blood? What quantity is produced? How often does the haemoptysis occur?

Dyspnoea Does the patient get breathless? How many stairs can he climb? How far can he walk on a level surface before the dyspnoea interferes with the exercise? Is the dyspnoea present at rest? Is it present when sitting or lying down? How many pillows does the patient need at night? Does the breathlessness get worse if the patient slips off his pillows? Does the patient wake at night short of breath?

It is possible to grade dyspnoea numerically but it is better to describe the conditions that produce the dyspnoea rather than write down a number. Dyspnoea on lying flat is called **orthopnoea**. Is the dyspnoea induced or exacerbated by external factors such as allergy to animals, pollen or dust? Does the difficulty with breathing occur with both phases of respiration or just with expiration?

Pain in the chest Ascertain the site, severity and nature of the pain. Chest pains can be continuous, pleuritic (made worse by inspiration), constricting or stabbing.

(c) Cardiovascular system

Cardiac symptoms

Breathlessness Ask the same questions as those described under the 'Respiratory system'.

Orthopnoea (breathlessness when lying down) and **paroxysmal nocturnal dyspnoea** (sudden attacks of dyspnoea in the middle of the night that waken the patient) are the common forms of dyspnoea associated with heart disease.

Pain Cardiac pain is usually retrosternal and its nature is often constricting, band-like or squeezing.

Does the pain radiate to the neck or to the left arm?

Palpitations These are episodes of tachycardia which the patient appreciates as a sudden fluttering or thumping of the heart in the chest.

Cough and sputum The same questions as asked for the respiratory system.

Dizziness and headaches These symptoms are often associated with hypertension.

Ankle swelling Do the ankles or legs swell? When?

How much? What is the effect of bed-rest and/or elevation of the leg on the swelling?

Peripheral vascular symptoms
Does the patient get pain in the leg muscles on exercise (intermittent claudication)? Which muscles are involved? How far can he walk before the pain begins? Is the pain so bad that he has to stop walking? How long does the pain take to wear off? Can he walk the same distance again?

Is there any pain in the limb at rest? Which part of the limb is painful? Does the pain interfere with sleep? What analgesic drugs give relief? What positions relieve the pain? Are the extremities of the limbs cold? Are there colour changes in the skin, particularly in response to a cold environment? Does the patient experience any paraesthesiae in the limb, such as tingling or numbness?

(d) Urogenital system

Urinary tract symptoms
Pain Has there been any pain in the loin, groin or suprapubic region? What is its nature and severity? Does it radiate to the groin or scrotum?
Oedema Do any parts of the body, not just the ankles, swell?
Thirst Is the patient thirsty? Does he drink excessive volumes of water?
Micturition How often does the patient pass his urine? Express this as a day/night ratio. How much urine is passed? Is micturition painful? What is the nature and site of the pain? Is there any difficulty with micturition such as a need to strain or to wait? Is the stream good? Can it be stopped at will? Is there any dribbling at the end of micturition?
Urine What is the colour, smell and quantity of the urine? Has the patient ever passed blood in the urine? When and how often? Has he ever passed gas bubbles with the urine (**pneumaturia**)?

The presence of headache, drowsiness, visual disturbance, fits and vomiting should be sought because they are the symptoms of uraemia.

Genital tract symptoms
Scrotum and urethra Has the patient any pain in the penis or urethra, at rest, during micturition or intercourse? Is there any difficulty with retraction of the prepuce or any urethral discharge? Has the patient noticed any swelling of the scrotum? Can he achieve an erection and ejaculation?
Menstruation When did menstruation begin (menarche)? When did it end (menopause)? What is the duration and quantity of the menses? Is menstruation associated with pain (dysmenorrhoea)? When? What is the nature and severity of the pain? Is there any abdominal pain midway between the periods (mittelschmerz)?
Pregnancies Record details of the patient's pregnancies — number, dates and complications.
Dyspareunia Is intercourse painful?
Breasts Do the breasts change during the menstrual cycle? Are they ever painful or tender? Are there any swellings or lumps in the breasts? Did the patient breast-feed her children?
Secondary sex characteristics When did these appear?

(e) Nervous system
Mental state Is the patient placid or nervous? Has he noticed any changes in his behaviour or reactions to others? Patients will often not appreciate such changes themselves and these questions must be asked of close relatives. Does the patient get depressed and withdrawn, or excitable and extroverted?
Brain and cranial nerves Does the patient ever become unconscious or stuporous?

Does he ever have **fits**? What happens during a fit? Has there been any change in the senses of smell, vision and hearing?

Is the face ever weak or paralysed?
Peripheral nerves Are any limbs or part of a limb weak or paralysed? Is there ever any loss of cutaneous sensation — pain, light touch and temperature?

Does the patient experience any paraesthesiae (tingling, 'pins and needles') in the limbs?

(f) Musculoskeletal system
Ask if the patient suffers from **pain, swelling,** or **limitation of the movement of any joint.** What precipitates or relieves these symptoms?

Are any limbs or groups of muscles weak or painful?

Can he walk normally?

Has he any congenital musculoskeletal deformities?

(g) Metabolism
Record the patient's weight and appetite, and any recent changes in either one.

Ask if growth has been normal in rate and quantity.

Has the patient noticed any abnormality of body growth and development?

Revision Panel 1.1

Synopsis of a history

1. *Names Age and Date of birth Sex Marital status Occupation Ethnic group Religion Hospital or Practice Record No.*

2. *Present complaint* (PC, CO)
   (In the patient's own words)

3. *History of present complaint* (HPC)
   Include the answers to the direct questions concerning the abnormal system.

4. *Systematic direct questions*
   (a) *Alimentary system and abdomen* (AS)
   Appetite. Diet. Weight. Taste. Swallowing. Regurgitation. Flatulence. Heartburn. Vomiting. Haematemesis. Indigestion. Abdominal pain. Abdominal distension. Bowel habit. Nature of stool. Jaundice.

   (b) *Respiratory system* (RS)
   Cough. Sputum. Haemoptysis. Dyspnoea. Hoarseness. Wheezing. Tachypnoea. Chest pain.

   (c) *Cardiovascular system* (CVS)
   Dyspnoea. Paroxysmal nocturnal dyspnoea. Orthopnoea. Palpitations. Chest pain. Cough. Sputum. Dizziness. Headaches. Ankle swelling. Pain in limbs. Walking distance. Temperature and colour of hands and feet.

   (d) *Urogenital system* (UGS)
   Loin pain. Symptoms of uraemia: headache, drowsiness, fits, visual disturbances, vomiting. Oedema of ankles, hands or face. Frequency of micturition. Urgency. Precipitancy. Painful micturition. Polyuria. Thirst. Fluid intake. Colour of urine. Haematuria.
   Problems with sexual intercourse: dyspareunia or impotence. Date of menarche or menopause. Frequency, quantity and duration of menstruation. Dysmenorrhoea. Previous pregnancies and their complications. Breast symptoms.

   (e) *Nervous system*
   Nervousness. Excitability. Tremor. Fainting attacks. Blackouts. Fits. Loss of consciousness. Muscle weakness. Paralysis. Sensory disturbances. Paraesthesiae. Changes of smell, vision, or hearing. Headaches. Changes of behaviour or psyche.

   (f) *Musculoskeletal system*
   Aches or pains in muscles, bones and joints. Swelling of joints. Limitation of joint movements. Weakness. Disturbances of gait.

   (g) *Metabolism*
   Change of weight. Appetite. General body build and appearance. Presence and time of development of secondary sex characteristics.

5. *Previous history* (PH)
   Previous illnesses, operations or accidents. Diabetes. Rheumatic fever. Diphtheria. Bleeding tendencies. Asthma. Hayfever. Allergies. Tuberculosis. Syphilis. Gonorrhoea. Tropical diseases.

6. *Drug history*
   Especially insulin, steroids, mono-aminoxidase inhibitors and the contraceptive pill.

7. *Immunizations*
   BCG. Diphtheria. Tetanus. Typhoid. Whooping cough. Measles.

8. *Family history* (FH)
   Cause of death of close relatives and presence of any serious illnesses.

9. *Social history* (SH)
   Marital status. Living accommodation. Occupation. Travel abroad. Leisure activities.

10. *Habits*
    Smoking, drinking and eating habits.

5 Previous history of other illnesses, accidents or operations

Record the history of those conditions which are not directly related to the present complaint. Ask specifically about tuberculosis, diabetes, rheumatic fever, allergies, asthma, tropical diseases, bleeding tendencies, diphtheria, gonorrhoea and syphilis.

6 Drug history

Ask the patient if he is taking any drugs. Specifically, enquire about steroids, monoamine oxidase inhibitors, insulin, diuretics, antihypertensives, ergot derivatives, hormone replacement therapy and the contraceptive pill.

Is the patient sensitive to any drugs or any topical applications such as adhesive plaster?

7 Immunizations

Most children are now immunized against diphtheria, tetanus, whooping cough and poliomyelitis. Ask about these, and smallpox, typhoid and tuberculosis vaccination.

8 Family history

Enquire about the health and age, or cause of death if not alive, of the patient's parents (sometimes grandparents), brothers and sisters, and children. If relevant, draw a family tree. If the patient is a child you will need information about the mother's pregnancy. Did she take any drugs during pregnancy? What was the patient's birth weight? Were there any difficulties during delivery? What was the rate of physical and mental development in early life?

9 Social history

Record the marital status and the type and place of dwelling. Ask about the patient's occupation, paying special regard to contact with hazards such as dusts and chemicals. What are the patient's leisure activities? Has the patient travelled abroad? List the countries he has visited and the dates of the visits.

10 Habits

Does the patient smoke? Cigarettes, cigar or pipe? Record the frequency, quantity and duration of smoking. Does the patient drink alcohol? Record the type and quantity consumed and the duration of the habit. Does the patient have any unusual eating habits?

Special Histories

The history of pain

We have all experienced pain. It is one of nature's ways of warning us that something is going wrong in our body. It is an unpleasant sensation of varying intensity. Pain can come from any of the body's systems but there are certain features common to all pains that should always be recorded.

Be careful of your use of the word 'tenderness'. Tenderness is pain which occurs in response to a stimulus, usually from the doctor, such as pressure by his hand, or forced movement. It is possible for a patient to be lying still without pain and yet have an area of tenderness. **The patient feels pain — the doctor elicits tenderness.** But although patients usually complain of pain, they may also have observed tenderness if they happen to have palpated a painful area or discovered a tender spot by accident. Thus tenderness can be both a symptom and a physical sign.

The history of a pain frequently betrays the diagnosis, so you must question the patient closely about each of the following features, some of which are depicted graphically in Figure 1.1.

1 Site

Many factors may indicate the source of the pain but the most valuable indicator is its site.

It is of no value to describe a pain as 'abdominal pain', you must be more specific. Although the patient will not describe the site of his pain in anatomical terms, he can always point to the site of

maximum intensity which you can convert into an exact description. If the pain is indistinct in nature and spread diffusely over a large area, you must describe the area in which the pain is felt and the point (indicated by the patient) of maximum discomfort.

It is also worthwhile asking about the **depth** of the pain. Patients can often tell you whether the pain is near to the skin or deep inside.

2 Time and mode of onset

It may be possible to pinpoint the onset of the pain to the minute, but if this cannot be done record the part of the day or night when the pain began.

To make your notes exact you must record the calendar dates on which events occurred, but it is also very useful to add in brackets the time interval between each event and the current examination, because it is these intervals, not the actual dates, which are more relevant to the problems of diagnosis. For example, 'Sudden onset of severe epigastric pain on 16th September, 1973, at 11.00 a.m. (3 days ago)', but remember that such comments are useless if you forget to record the date of the examination.

Whenever you write a note about a patient, whether it be a short progress note or his full history, make certain that you start by writing down the date.

Ask if the pain began insidiously or suddenly.

3 Severity

Individuals react differently to pain. A severe pain to one person might be described as a dull ache by another. Consequently you must be wary of the adjectives used by the patient to describe the severity of his pain. A far better indication of severity is the effect of the pain on the patient's life. Did it stop him going to work? Did it make him go to bed? Did he have to call his doctor or try proprietary analgesics? Did it wake him up at night, or stop him going to sleep? Did it force him to lie still or roll around?

The answers to these questions will give you a far better indication of the severity of a pain than words such as mild, severe, agonizing or terrible.

Your assessment of the way the patient responds to his pain, formed while you are taking the history, may profoundly affect your treatment.

4 Nature of the pain

Patients find it very difficult to describe the nature of their pain but some of the adjectives which are commonly used, such as aching, stabbing, burning, throbbing, constricting, distending, gripping and colic, have a similar meaning to the majority of people.

Burning and throbbing sensations are within everyone's experience. We have all experienced a burning sensation from our skin due to contact with intense heat, so when a patient spontaneously states that his pain is 'burning' in nature, it is likely to be so. We have all experienced a throbbing sensation at some time in our life so this description is also usually accurate.

Revision Panel 1.2
The features of a pain that must be elicited

1. *Site*
   Record the *exact* site.
2. *Time and mode of onset*
   Record the time and date of onset and the way the pain began.
3. *Severity*
   Assess severity by its effect on the patient.
4. *Nature*
   Aching, burning, stabbing, constricting, throbbing, distending, colic.
5. *Progression of the pain*
   Describe the progression of the pain.
6. *The end of the pain*
   Describe how the pain ended. Was the end spontaneous or brought about by some action by the patient or doctor.
7. *Duration*
   Record the length of the pain.
8. *Relieving factors*
9. *Exacerbating factors*
10. *Radiation*
    Record the time and direction of any radiation of the pain. Remember to ask if the nature of the pain changed at the time of movement.
11. *Cause*
    Make a note of the patient's opinion of the cause of the pain.