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CHAPTER ONE
第一章
CLINICAL HISTORY AND RECORDS
临床病史和记录

THE CONVENTIONAL FORM OF A "COMPLETE HISTORY"
(" 完整病史 "的常规格式)

Name(姓名)
Sex(性别)
Age(年龄)
Nationality (民族)
Native place (籍贯)
Occupation(职业)
Marital status(婚否)
Informant (陈诉人)
Reliability(可信性)
Date of admission(入院日期)

Chief complaints (主诉)
Present illness(现病史)
Past history(既往史)including "review of systems" 包括系统回顾)
Personal history (个人史)
Marital history(婚姻史)
Menstrual and child bearing history(月经及生育史)
Family history(家族史)

PHYSICAL EXAMINATION
(体格检查)

General condition(一般情况)
T.P.R.BP(体温、脉搏、呼吸、血压)
Body constitution (体质)
Mentality(意识状态)
Facies and facial expression(面容与表情)
Position(体位)

Posture and gait(姿式与步态)

Development and nutrition (发育与营养)

Examination of different organs (身体各部的检查)

Skin and mucous membrane (皮肤、粘膜)

1. Elasticity(弹性)

2. Temperature and perspiration(体温与出汗)

3. Color(颜色)

4. Edema (水肿)

5. Skin eruption(皮疹)

6. Petechia(淤点)

Lymph nodes(淋巴结) Size, number, consistency, tenderness, mobility (大小,数目,质地,触痛,移动度).

Head organs(头部器官)

1. Skull(头颅) Size, shape, abnormal motion(大小、形状、异常活动).

2. Face(颜面)

3. Eye(眼) Eyelid, eyeball, conjunctiva, sclera, cornea, pupils, ocular motion *etc* (眼睑,眼球,结膜,巩膜,角膜,瞳孔,眼球运动等).

4. Nose(鼻) Size, shape, nostrils, nasal mucosa, septum, nose bleeding and discharges, tenderness of paranasal sinuses *etc* (大小,形状,鼻孔,鼻粘膜,中隔,鼻出血,分泌物,鼻窦压痛等).

5. Oral cavity(口腔) Smell, lips, buccal mucosa, teeth, gums, tongue, throat, tonsils(气味,唇,颊粘膜,牙齿,齿龈,舌,咽,扁桃体).

6. Ear(耳) Shape, external auditory canals and discharge, ear drum, mastoid tenderness(外形,外耳道及分泌物,鼓膜,乳突压痛).

Neck(颈部)

1. Rigidity (强直)

2. Lymph nodes(淋巴结)

3. Thyroid gland(甲状腺)

4. Carotid arterial pulsation(颈动脉搏动)

5. Carotid venous engorgement(颈静脉怒张)

6. Position of the trachea (气管位置)

Chest(胸部)

1. Inspection (望诊) Shape, respiratory movement, breath frequency and rhythm(形状,呼吸运动,频率,节律).

2. Palpation(触诊) Respiratory movement , tactile fremitus(TF) , pleural friction rub (呼吸运动,触颤,胸膜摩擦感).

3. Percussion (叩诊) Lung apex and base, abnormal dullness (肺上下界,异常浊音).

4. Auscultation(听诊) Breath sound(BS), abnormal BS, rales, audible pleural friction rub (呼吸音变化,异常呼吸音,啰音,胸膜摩擦音).

Heart(心脏)

1. Inspection Precordial prominence, apical impulse(心前区隆起,心尖搏动).

2. Palpation Apical impulse, thrill, pericardial friction rub (心尖搏动,震颤,心包摩擦感).

3. Percussion Dullness of the heart(put in figure)(心浊音界"画图表示").

4. Auscultation Frequency, rhythm, cardiac sound, cardiac murmur(心率,心律,心音变化,杂音).

Abdomen(腹部)

1. Inspection Shape, respiratory movement, veins of abdominal wall, peristalsis(形状,呼吸运动,腹壁静脉曲张,肠蠕动波).

2. Palpation Muscular tonicity, tenderness and rebounding pain, mass, fluid thrill, liver, spleen, gall bladder, kidney(肌张力,压痛,反跳痛,包块,震水音,肝、脾、膀胱、肾脏).

3. Percussion Abnormal dullness, shifting dullness, liver, spleen, kidney, urinary bladder(异常浊音,移动性浊音,肝、脾、肾、膀胱).

4. Auscultation Bowel sound, succussion splash, vascular murmur (肠鸣音,溅水声,血管杂音).

External genitalia and anus (外生殖器及肛门)

Spinal column and extremities(脊柱与四肢) Deformity, mobility, tenderness, muscular atrophy, fracture and dislocation(畸形,活动度,触痛,肌萎缩,骨折及脱位).

LABORATORY FINDINGS(实验室检查所见)

FUNCTIONAL AND INSTRUMENTAL EXAMINATIONS(功能及器械检查)

Tentative diagnosis(拟诊):

Signature(签名):

Date(日期):

AN ILLUSTRATION OF CONVENTIONAL FORM OF "COMPLETE HISTORY"

Name Wu × ×	Native place Xinjiang
Sex male	Date of admission Nov. 20, 1997
Age 24	Informant the patient himself
Nationality Hui	Reliability reliable
Occupation a worker	Marital status unmarried

Chief complaints: Rt. middle finger infection followed by rigor, high fever and cough with blood tinged sputum for 10 days.

Present illness: One month ago, a small vesicle (painful) developed at his Rt. middle finger and it was pinned with a needle and pain was relieved. Several days later, it was badly infected with local redness and swelling, and resulted in a small abscess formation which gradually "subsided" after incision and drainage. However, about 10 days later, he experienced sudden onset of rigor and high fever associated with cough, blood tinged sputum and bilateral chest pain which was aggravated by deep breathing during the following days. He went to a local hospital and was diagnosed as "URI". No specific treatment was ever given. There was still high fever with more remarkable cough and bloody pussy sputum, He went to Airforce Hospital and was admitted there with a diagnosis of "pneumonia". After admission there, antimicrobial therapy and corticosteroids were administrated for several days. There was no symptomatic relief and the patient's general condition was progressively worsening. In order to seek further investigation and treatment, he came to our OPD and was admitted to Department of Pulmonology as "cavitary pulmonary tuberculosis" after a chest fluoroscopic examination.

During the period of hospitalization in Department of Pulmonology, antituberculotic therapy was given for one week, however, the patient was further debilitated with high fever, profound weakness, dyspnea, and obvious abdominal distension. At the same time, the patient was subjected to pain, tenderness, swelling and slight redness over the Rt. thigh as well as the lumbo – sacral region, indicating deep abscess formation. Then, incision and drainage were performed on the suspected deep abscess of Rt. thigh and lumbo – sacral region. 40 ml and 20 ml of pus were drained out respectively. Then, the patient was transferred to our Department of Respiratory Medicine for further treatment with diagnosis of "pyemia".

Past history: He had history of "hepatitis" at age of 3 (recovered) and "mumps" at age of 7. No history of chronic cough, hemoptysis nor contact history with open case of tuberculosis. No history of vaccination, operation nor drug allergy.

"Systems review" reveals nothing particular.

Personal history: No habit of drinking or smoking.

Family history: His father died of "esophageal carcinoma" 2 years ago. His mother, brothers and sisters all are living and well.

PHYSICAL EXAMINATION
(At the time of admission to Department of Pulmonology)

T 38.6℃. P 130/min. R 36/min. BP 12/8 kPa.

General condition: The patient is well developed, seriously ill with acute sickly look; slightly dyspneic; mentally clear; active posture.

Skin and mucous membrane: Mild cyanosis over the lips and nails; some minute vesicles over the back of trunk; no jaundice, edema nor petechia. Elasticity of the skin fair.

Lymph nodes: No enlargement of the peripheral lymph nodes.

Head organs:

Skull and face: Nothing important.

Eye: No positive finding over eyelid, eyeball, conjunctiva and cornea; pupils round, equal on both sides and reactive to light; ocular motion normal.

Nose: Nasal mucosa slightly congested; no nose bleeding nor discharges; no tenderness over paranasal sinuses.

Oral cavity: No offensive smell; slight cyanosis of the lips; tongue coated with whitish yellow fur; throat clear; tonsils not enlarged.

Ear: No discharges seen in the external auditory canals; no tenderness over the mastoid region.

Neck: Soft, thyroid gland not palpable; no visible distention of carotid arteries; trachea at the median line.

Chest:

Inspection: Normal shape; respiration 36/min, rhythmic.

Palpation: Moderate and slight. diminished TF over right and left lung bases respectively without friction rub felt.

Percussion: Dullness over both lower parts of chest posteriorly, more severe on the Rt. side.

Auscultation: Diminished breath sound over both lung bases, more remarkable on the Rt. side and a few moist rales heard over the Lf. middle part of the chest. No audible pleural friction rub.

Heart:

Inspection: No precordial prominence Apical impulse at the 4th intercostal space within the MCL with tachycardia.

Palpation: Apical impulse is same as inspection; no thrill nor pericardial friction rub palpable.

Percussion: The cardiac dullness is within normal limit(so, "figure" is omitted).

Auscultation: Tachycardia(130/min.), rhythmic, no murmur heard.

Abdomen:

Inspection: There is remarkable distension of the abdomen with limitation of abdominal respiratory movements. No abnormal varicosity of abdomiral wall.

Palpation: No definite tenderness, tense(due to distension)yet no muscular rigidity; no rebounding pain. Liver, spleen and kidney are not palpable.

Percussion: No abnormal dullness, increased tympanic sound over whole abdomen, no percusion pain over kidney area.

Auscultation: Bowel sounds very much diminished over whole abdomen.

Spinal column and extremities: A small area of slight redness and tenderness over the lumbo – sacral region; another more remarkable redness and tenderness associated with swelling over the Rt. upper thigh. The vertebral column itself and joints are nothing abnormal. Knee jerk active.

External genitalia and anus: Normal appearence.

LABORATORY DATA

Blood routine: WBC 13.43×10^9/L, N 92%, L 7%, M 1%, Hb 125 g/L. sputum TB(–). Urine routine: WBC 6 – 8/HP. Protein(+). Blood culture reveals growth(3 times)of *Staphylococcus aureus* with positive coagulase test. Liver and renal functional tests normal. ECG shows sinus tachycardia. Blood gas analysis: Moderate hypoxemia and mild hypocapnia with respiratory alkalosis, partially compensated.

Chest film taken just before admission(Dec. 14, 1997) reveals bilateral multiple irregular round hazy shadows of 1 – 2 cm in diameter, mainly in the middle lower and outer zones of both lung fields; some of them show central rarefaction, indicating small cavitation. Both costal phrenic angles are blunt, more remarkable on the Rt. side, suggesting small to moderate amount of pleural effusion. Trachea at medican line. The heart shadow is normal.

DIAGNOSIS: Staphylococcal pyemia

1. Hematogenous(multiple)lung abscess
2. Bilateral pleural effusion(or empyema?)
3. Deep abscess of the Rt. thigh and lumbo – sacral region.

Dr. × × ×

Dec. 20, 1997.

《完整病史》格式与举例

姓名	吴××	籍贯	新疆
性别	男	婚否	未婚
年龄	24	入院日期	1997.11.20
民族	回	陈诉人	患者本人
职业	工人	可信性	可信

主诉 右手中指感染后,继而寒战、高热,咳嗽带血痰 10 d。

现病史：一个月前,病人右手中指起一“小泡”(疼痛),用针头刺破后,疼痛缓解,几天后局部被感染，出现红肿并形成一小脓肿，经切开引流后，局部好转。但约 10 d 后,突发寒战、高热,随后数日,出现咳嗽、血痰及两侧胸痛,随深呼吸而加重。病人就诊于某基层医院,拟诊“上呼吸道感染”,给予一般的感冒药物。高热仍不减,咳嗽加重,并咯出少量脓血痰。此时,病人至本市空军医院就诊,拟诊“肺炎”而收住院。入该院后经抗生素(药名不详)治疗数日,兼用过静滴糖皮质激素,但症状未见好转,高热持续,一般情况恶化。为寻求进一步诊疗,病人来我院就诊，门诊胸透，报告为“空洞性肺结核”而收入肺科住院。入院后曾试用抗结核药物治疗一周,未见疗效。高热持续,显著衰弱,气促,明显腹胀。同时,病人还觉右腿部及腰骶部疼痛。查体局部有红肿及叩击痛，提示深部脓肿，经该两处切开引流，分别排出脓液 40 ml 及 20 ml。因而,以“脓毒血症”转入呼吸内科作进一步诊疗。

既往史：病人称 3 岁时曾患“肝炎”(以后肝功恢复),7 岁时曾患“腮腺炎”。无慢性咳嗽、咯血史，无结核病接触史。无预防接种史、手术史或药物过敏史。

“系统回顾”无重要发现。

个人史：无烟、酒嗜好。

家族史：病人父亲两年前死于“食管癌”，母亲兄妹均健康。

体 格 检 查

(住入本科时体征)

T 38.6℃ P 130/min R 36/min BP 12/8 kPa

一般情况：病人发育良好,急性重病容,唇、甲床轻度发绀,自动体位,意识清楚。

皮肤、粘膜：唇部及甲床可见轻度发绀,背部有散在小汗疹；皮肤弹性尚可,未见黄疸、水肿及出血点。

淋巴结：无表浅淋巴结肿大。

头部器官：

头颅与颜面：无重要发现。

眼 眼睑、眼球、结膜及角膜无阳性体征 瞳孔双侧等圆等大，对光反射灵敏 眼球运动正常。

鼻 鼻腔粘膜略充血，无鼻出血或分泌物，鼻窦区无压痛。

口腔 呼气无恶臭味，唇部轻度发绀，舌略带黄腻舌苔，咽部未见充血，扁桃体未见肿大。

耳：外耳道未见分泌物，乳突区无叩击痛。

颈部 颈软，甲状腺不大，未见颈动脉搏动征，气管居中。

胸 部：

望诊：胸廓形态正常，呼吸快（36次/min），律整。

触诊 两肺底部触颤轻（左）至中度（右）减弱，未触及胸膜摩擦感。

叩诊 两肺底（背部）轻度叩浊，右侧稍重。

听诊 左肺中部听到少许水泡音，两肺底呼吸音减弱，右侧略明显，未听到胸膜摩擦音。

心 脏：

望诊：无心前区隆起，心尖搏动位于锁骨中线内第 4肋间区。

触诊：心尖搏动同望诊所见，未触及震颤及心包摩擦感。

叩诊 心浊音界在正常范围内（画图从略）。

听诊：心率快（130 次/min），心律齐，各瓣膜区未闻及杂音。

腹 部：

望诊 腹部胀满，腹式呼吸运动减弱，未见异常腹壁静脉曲张。

触诊 腹壁张力较高（胀气），但无肌紧张，无明显压痛，无反跳痛。肝、脾、肾脏未触及。

叩诊：无异常浊音，全腹鼓音显著增强；肾区无叩击痛。

听诊：全腹肠鸣音显著减弱。

脊椎与四肢：

腰骶部有小局限性发红和叩痛区，右腿上部也有一明显的红晕区，肿胀、压痛较明显。脊椎、关节未见异常，膝反射活跃。

外生殖器与肛门：无异常发现。

实 验 室 检 查

血常规 白细胞 13.42×10^{9}/L，N 92%，L 7%，M 1%，血红蛋白 125 g/L。痰 TB（－）。尿常规 白细胞 6－8/Hp，蛋白（＋），血培养有金黄色葡萄球菌生长（3 次），凝固酶试验阳性。肝、肾功能测验，结果正常。心电图显示窦性心动过速。血气分析：中度低氧血症，轻度低碳酸血症，呈代偿性呼吸性碱中毒。

入院前数日（1997.12.14）胸片，显示双侧肺野有多发性、不规则圆形模糊阴影，约 1～2 cm 大小，遍布于两中下肺野及外缘，有的圆形阴影中心有疏松透明区，提示多发性小空洞形成。双侧肋膈角变钝、消逝，右侧较明显，提示有小至中量胸膜腔积液。气管居中，心脏大小正常。

诊断 葡萄球菌性脓毒血症

1. 血原性肺脓肿（多发性）

2.双侧胸膜腔积液（不能除外脓胸）
3.右腿及腰骶部深部脓肿

签名：×××医师
日期：1997.12.20

RECOMMENDATION OF SOME REMARKS IN WRITING AN "ADMISSION NOTE"

(介绍'住院病史'书写中的若干注意事项)

1. THE GENERAL DATA Such as name, age, sex, nationality, occupation, *etc* are essentially the same as "complete history".

(一般项目 如姓名、年龄、性别、民族及职业等与'完整病史'基本相同)。

2. CHIEF COMPLAINTS and PRESENT ILLNESS Both are also the main constitutions of the "admission note" which should also be described in details in order to offer sufficient diagnostic information of the disease, nevertheless, they could be more simple and concise than those of the "complete history".

(主诉及现病史:两者同样是住院病史的主要内容,须详细加以记录,以提供足够的诊断信息,不过,它较'完整病史'可简明扼要些)。

3. PAST HISTORY Mainly the positive findings of the diseases that related to the "present illness" are mentioned。"System review" can be omitted.

(既往史 主要描述与'现病史'有关的既往疾病史;'系统回顾'可省略)。

4. PERSONAL HISTORY and FAMILY HISTORY Only the important findings are recorded.

(个人史及家族史 记录其主要内容)。

5. PHYSICAL EXAMINATION(P.E.) Physical examination should be performed in details systematically, and and the main positive physical findings are recorded comprehensively.

(体格检查 须进行系统和详细的检查,采取综合性叙述方式,记录主要阳性体征)。

6. LABORATORY FINDINGS, FUNCTIONAL and INSTRUMENTAL EXAMINATIONS The significant data are recorded in details respectively.

(实验室检查,功能及器械检查 分别记录其主要结果)。

7. Finally, put "IMPRESSION" or "DIAGNOSIS"(if it is definite)

最后,提出'拟诊'或'诊断'(如果肯定)。

8. "SIGNATURE" and "DATE" (医师签名及日期)。

ILLUSTRATION OF AN "ADMISSION NOTE" (respiratory disease)

SUN × ×, a female patient of Han nationality, aged 48, a worker, married, was admitted on Apr. 17, 1994, because of chronic cough, expectoration for 10 years, and chill, high fever with worsening of cough and chest pain for 3 days.

Ten years ago, she began to have cough with a little mucoid sputum which usually occurred in the cold weather, while in the summer days, she felt comparatively better. However, cough and expectoration worsened gradually year by year, and was associated with shortness of breath and palpitation on exertion in recent 2 years, but there was no edema ever noticed over the lower extremities.

Three days before admission, she abruptly felt chill soon followed by high fever and worsening of cough and expectoration than before. On the next day, she developed pleuritic pain over both sides of the chest, associated with some shortness of breath at the same time. Cough turned to be more remarkable with moderate amount of grayish mucoid sputum. There was no rusty or bloody sputum. No edema ever noticed over the lower extremities. Fever was still running high with profound weakness. Then, she came to our outpatient department (OPD) for medical help. A leucocytic count was taken and found to be 13.0×10^9/L with 82% of PMN; chest radiography showed patchy haziness over both lower lung fields, more marked on the left side, and the right costal phrenic angle was obliterated. The patient was admitted for further investigation.

Past history revealed history of "chronic hepatitis" in 1973, and "viral encephalitis" in 1974. Otherwise, nothing particular.

Personal history and family history reveal no significant finding.

PHYSICAL EXAMINATION

T 38.5℃, P 108/min, R 22/min, BP 15/9 kPa

The patient is well developed, thin, dyspneic and acutely ill. No noticeable cyanosis, nor edema; mentally clear; active posture. No peripheral lymph node enlargement. The throat is congested. The other head organs essentially negative. Neck soft, without visible venous distention. Trachea is at the median line. The chest is symmetrical, barrel shaped with diminished breath sounds and a lot of moist rales audible over both lung bases posteriorly, more marked on the right side. The cardiac dullness is found to be comparatively diminished. The heart rhythm with tachycardia (108/min) is regular; no murmur audible; $P_2 > A_2$; apical S_1 is less loud than that of epigastric region. Abdomen soft; no abnormal dullness; liver and spleen not palpable. Vertebrae, extremities and joints reveal NO important finding. No edema over the lower extremities.

LABORATORY DATA

Hb 125 g/L, WBC 12.4×10^9/L, N 83%, L 17%. Urine routine normal; ESR 19 mm/h. Sputum culture: growth of pneumococcus. ECG: signs of right ventricular hypertrophy (RVH) and a few ventricular extrasystols; Blood gas analysis: pH 7.47, PaO_2 60.7 mmHg, BE + 3.

Chest film taken on admission (Apr. 18, 1994) shows increased markings with small patches of hazy peribronchial infiltrations over both lower lung fields, more marked on the left side, and some pleural reaction on the right side. The pulmonary cornus is prominent (greater than 3 mm) and the contour of the cardiac apex appears to be rounded and upward, indicating RVH.

DIAGNOSIS: 1. Pneumococcal bronchopneumonia
2. COPD complicated with cor pulmonale,
cardio-pulmonary function compensated

Dr. × × ×
Apr. 18, 1994.

《住院病史》举例(呼吸疾病)

孙××,女,汉族,48岁,已婚,工人,于1994年4月17日收住院。主诉:慢性咳嗽、咳痰10年,发冷、高热,咳嗽加重兼胸痛3 d而入院。

病人10年前开始咳嗽,咯少许粘液性痰,咳嗽、咳痰每逢寒冷季节加重,夏天则好转。呼吸道症状逐年加重,近两年来兼有活动后心慌、气短,尚未发现下肢水肿。

入院前3 d,病人突感发冷,继而高热,咳嗽、咳痰较以往加重,并于次日感双侧胸痛且同时感气促;咳嗽加重后,咯中量灰色粘液性痰。无铁锈色痰或血痰,无下肢水肿。高热持续不退,病人感显著软弱,乃来我院门诊就诊。当时查血常规,白细胞计数为13.0×10^9/L,中性粒细胞占82%,胸部X线检查显示两下肺野有小片状模糊阴影,左侧较明显,同时,右侧肋膈角消失。病人乃收入院作进一步诊察。

既往史:自称1973年曾患"慢性肝炎";1974年曾患"病毒性脑炎"。其他无特殊。

个人史及家族史无重要情况。

体格检查

T 38.5℃, P 108/min, R 22/min, BP 15/9 kPa

病人发育良好,单瘦,气促及急性病容。无肉眼可见发绀及水肿,自动体位,意识清楚。表浅淋巴结不肿大,咽部略充血,其他头部器官无重要发现。颈软,未见颈静脉充盈,气管位置居中。胸廓对称,呈桶状,双侧呼吸音减弱,两肺底听到较多水泡音,右侧更为明显。心浊音界相对缩小,心率快(108次/min),心律齐,未闻杂音,$P_2>A_2$,剑突下第一心音较心尖区为响。腹部平软,无异常浊音,肝、脾未触及。脊椎、四肢及关节无重要发现,下肢无水肿。

实验室检查

Hb 125 g/L, WBC 12.4×10^9/L, N 83%, L 17%。尿常规正常;ESR 19 mm/h;痰培养肺炎链球菌(肺炎双球菌)呈阳性;心电图:有右心室肥大征及少数室性早搏;血气分析:pH 7.47, PaO_2 60.7 mmHg, BE+3。

入院后胸片(1994.4.18)显示两侧肺纹理增加,两下肺野小片状模糊阴影,呈支气管周围浸润,左侧较明显,右侧有胸膜反应征象。肺动脉圆椎突隆(>3 mm高度),兼心脏的外形圆钝上翘,提示右心室肥大征。

诊断:1.肺炎链球菌性支气管肺炎

2.慢阻肺合并肺心病,心肺功能代偿

医师签名：× ××

日期：1994.4.18

ILLUSTRATION OF AN "ADMISSION NOTE"
(cardio-vascular disease)

Chu × ×, a 22 years old female patient of Han nationality, unmarried, a worker, was admitted on Dec. 24, 1998, with chief complaints of polyarthritis followed by exertional palpitation and dyspnea off and on for 8 years, which were exacerbated in recent 2 weeks and accompanied by edema and paroxysmal noctural dyspnea.

The patient recalls that she had multiple joint pain associated with redness and swelling in the winter of 1992, yet no fever, no erythema circinatum nor subcutaneous nodules were ever noticed. It subsided after a period of medication. She was asymptomatic until two years ago, she began to experience palpitation associated with exertional dyspnea and remarkable fatigue as well as mild edema over both lower extremities at times. She went to a local hospital for medical help and was discovered to have "rheumatic heart disease". Conventional medications were given to the patient, however, no obvious symptomatic relief was obtained, but her general condition gradually deteriorated, dyspnea and palpitation (even at rest) worsened and edema (at times) occurred over the lower extremities. In recent 2 weeks before admission, symptoms worsened further with paroxysmal noctural dyspnea, frank edema over the lower extremities, anorexia and uropenia. There was no fever nor joint pain during the symptomatic period.

Past history, personal history and family history reveal nothing important.

PHYSICAL EXAMINATION

P 37.2℃, P 100/min. R 26/min. BP 14/8 kPa

The patient is well developed, very ill, dyspneic and cyanotic over the lips, with pale facial appearance, in orthopneic position, without edematous looking. Mentally clear. Peripheral lymph nodes are not palpable. No eruption, no jaundice or petechia over the skin and mucous membrane. The head organs reveal no important finding; throat no congestion, tonsils no enlargement. Neck soft; the jugular veins are distended with positive sign of hepatojugular reflux; no visible carotid arterial pulsation. Respiration is dyspneic (26/min); no dullness over the lung fields. Breath sounds are a little bit rough with fine moist rales over both lung bases. The heart borders are remarkably enlarged to both sides with a diffuse apical impulse in the 6th intercostal space between the midclavicular line and the anterior axillary line. No thrill palpable. Cardiac rhythm is regular with cardiac rate of 100 per minute. The 1st heart sound is diminished in intensity. A grade Ⅲ blowing pansystolic murmur that radiates toward the axilla and a low pitched rumbling diastolic murmur are audible at the mitral area. No gallop sounds are audible and mitral opening snap is not heard. Another diastolic murmur is audible in the 2nd and 3rd intercostal spaces