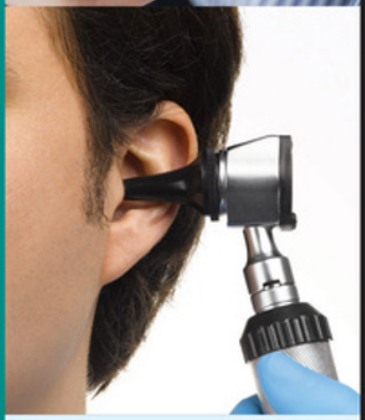
Pocket Guide to Physical Assessment

Edited by
Carol Lynn Cox



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Carol Lynn Cox

PhD, MSc, MA (Theology), MA (Education), PG Dip Education, BSc (Hons), RN, ENB 254, FHEA

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Foreword

Underpinning the appropriate delivery of healthcare is the Physical Assessment. This structured physical examination allows the healthcare professional to obtain a comprehensive assessment of the patient and is critically important in that it leads to clinical decisions that are crucial for the patients' care.

This Pocket Book, *Pocket Guide to Physical Assessment*, provides a clear and easy-to-use reference guide for achieving the Physical Assessment. It is specifically intended for those embarking on a career in healthcare and contains the techniques used by specialist/advanced practitioners.

In this Pocket Guide, the need for a thorough approach to the Physical Assessment is excellently presented by Professor Cox. Professor Cox shows how important it is to develop a rapport with the patient in order to carefully assess their perceptions and how this relationship must be established from the very first meeting when information is exchanged between the healthcare professional and the patient. Fundamental to gaining this perspective is to listen. The importance of guiding the healthcare practitioner to engage in active listening cannot be underestimated and this is reflected in the fact that not being heard is an issue that is often raised as a point of criticism of healthcare professionals by patients and their families.

Careful observation and reports of subjective symptoms are the window through which healthcare professionals gain knowledge of their patients. Following the opening chapters, this Pocket Guide is structured to enable the healthcare professional to learn how to systematically gather information before moving on to an initial diagnosis and further investigations. The tools of inspection,

palpation, percussion, and auscultation are key to this assessment and are excellently laid out in the chapters covering the examination of the different organs of the body.

It is key for healthcare professionals to be able to communicate the outcomes of their Physical Assessment to their professional colleagues. Professor Cox demonstrates her experience and understanding of the world of healthcare when she talks about the importance of this communication between professionals and how the Physical Assessment can bring together the disparate professional views that will underpin the diagnostic process.

In this *Pocket Guide to Physical Assessment*, Professor Cox has created an invaluable guide that will not only support practitioners as they begin a clinical career in healthcare but will also function as an ongoing reference book to support their careers.

Professor Stanton Newman, Pro Vice Chancellor Research,
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Preface

Over the past decade many changes have occurred in relation to medical practice. What has not changed, and should not change, is the view healthcare professionals have in relation to the patient. This view sees the patient as an individual with physical as well as emotional, psychological, intellectual, social, cultural, and spiritual needs. A comprehensive assessment of the patient is the foundation upon which healthcare decisions are made. The best way to develop assessment skills is to learn them systematically. The systematic approach involves taking a full health history, physical examination, and reviewing diagnostic texts/laboratory data. Use of a systematic approach is essential in clinical decision making, which leads to the formulation of a differential diagnosis and final diagnosis.

This Pocket Guide for healthcare professionals is based on Robert Turner's and Roger Blackwood's *Lecture Notes on Clincal Skills* that was written for medical students and Carol Cox's Physical Assessment for Nurses. It is intended to be used as a guide when examining patients in the clinical setting. The Guide includes simple instructions on examination approaches and details of diseases that are relevant to abnormal findings.

Turner and Blackwood's *Lecture Notes on Clinical Skills* has been used in the Oxford Clinical Medical School for over 35 years and is viewed as an essential guide in medicine. Although some doctors may use slightly different techniques in taking a history and physical examination, it is recommended that healthcare practitioners embarking on a career in healthcare use the techniques recommended in this Pocket Guide because they provide a sound approach for developing and employing clinical decision making.

Carol Lynn Cox

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Special thanks are extended to Robert Turner and Roger Blackwood for granting permission for their text, *Lecture Notes on Clinical Skills*, to be used as a reference for this Pocket Guide. In addition, I am grateful to my students and healthcare practitioners that I have worked with over the years for encouraging me to create this Pocket Guide so that they could have an accessible tool for reference purposes in the clinical setting. This Guide has benefited from their suggestions as well as from medical colleagues with whom I currently practice. I am also grateful to Yogalakshmi Mohanakrishnan, Mitch Fitton, Copy Editor, Tom Marriott, Editorial Assistant, Vincent Rajan, Production Editor and the entire team at Wiley Publishers for their support in completing this Pocket Guide. Any faults or omissions in the text are entirely my own.

1

Interviewing and History Taking

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1.1 General Procedures

1.1.1 Introduction

The patient's history is the major subjective source of data about their health status. It will give you insight into actual and potential problems as well as providing a guide for the physical examination. History taking involves obtaining the patient's chief complaint (quoted in the patient's words), a full review of systems from the patient's perspective, exploration of patient problems associated with the chief complaint, and other (frequently associated) problems that require addressing from the patient's perspective (Ball et al. 2014a, b; Barkauskas et al. 2002; Bickley and Szilagyi 2007, 2013; Cox 2010; Dains et al. 2012, 2015; Epstein et al. 2008; Japp and Robertson 2013; Jarvis 2008, 2015; Seidel et al. 2006, 2010; Swartz 2006; Talley and O'Connor 2006, 2014).

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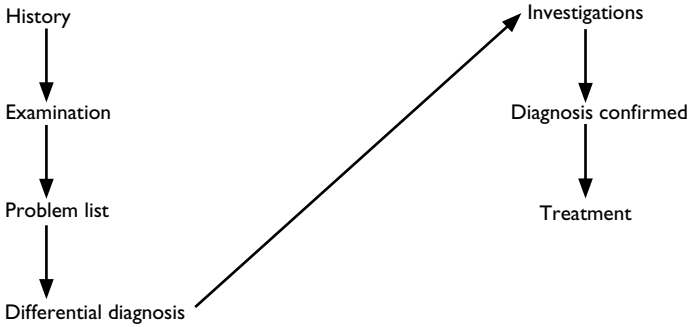

Figure 1.1 Usual sequence of events. Source: Cox 2010. Reproduced with permission from John Wiley and Sons.

1.1.2 Approaching the Patient

- Put the patient at ease by being confident and quietly friendly (Hatton and Blackwood 2003; Jackson and Vessey 2010; Rudolf and Levene 2011; Sawyer 2012).
- Greet the patient: 'Good morning, Mr/Mrs Smith'. (Address the patient formally and use the full name until the patient has given you permission for less formal address.)
- Shake the patient's hand or place your hand on theirs if the patient is ill. (This action begins your physical assessment. It will give you a baseline indication of the patient's physical condition. For example, cold, clammy, diaphoretic, or pyrexial.)
- State your name and title/role.
- Make sure the patient is comfortable.
- Explain that you wish to ask the patient questions to find out what the patient perceives is the problem or has happened.
  Start the history taking by stating something like 'I want to start by asking you some questions about your health'. (Always begin with general questions and then move to more specific questions (Cox 2010)
  Inform the patient how long you are likely to take

and what to expect. For example, after discussing what has happened to the patient, explain that you would like to examine them.

1.1.3 Usual Sequence of Events (Figure 1.1)

1.1.3.1 Importance of the History

- It identifies:
  - what the problem is or has happened
  - the personality of the patient
  - how the illness has affected the patient and family
  - any specific anxieties
  - the physical and social environment.
- It establishes the practitioner–patient relationship.
- It provides the foundation for your differential diagnoses.
- It often gives the diagnosis.
- Find the principal symptoms or symptom. Ask one of the following questions:
  - 'How may I help you?'
  - 'What has the problem been?'
  - 'Tell me, why have you come to the surgery/clinic/hospital today?' or 'Tell me why you came to see me today?'

    Effective history taking involves allowing the patient to talk in an unstructured way whilst you maintain control of the interview. Use language that the patient can understand and avoid the use of medical jargon (Collins-Bride and Saxe 2013; Cox 2010; Sawyer 2012; Tally and O'Connor 2014). Avoid asking questions that can be answered by a simple 'yes' or 'no'. Ask questions that require a graded response. For example, 'Describe how your headache feels'. Avoid using multiple-choice questions that may confuse the patient (Cox 2010; Jackson and Vessey 2010). Ask one question at a time.

Avoid asking questions like: 'What's wrong?' or 'What brought you here?' Use clarification to confirm your understanding of the patient's problem. Avoid forming premature conclusions about the patient's problem and above all remain nonjudgemental in your demeanour. Avoid making judgemental statements.

- Let the patient tell their story in their own words as much as possible.

  At first listen and then take discreet notes as the patient talks.

  When learning to take a history there can be a tendency to ask too many questions in the first two minutes. After asking the first question you should normally allow the patient to talk uninterrupted for up to two minutes.

  Do not worry if the story is not entirely clear or if you do not think the information being given is of diagnostic significance. If you interrupt too early, you run the risk of overlooking an important symptom or anxiety.

  You will be learning about what the patient thinks is important. You have the opportunity to judge how you are going to proceed. Different patients give histories in very different ways. Some patients will need to be encouraged to enlarge on their answers to your questions; with other patients, you may need to ask specific questions and to interrupt in order to prevent too rambling a history. Think consciously about the approach you will adopt. If you need to interrupt the patient, do so clearly and decisively. Most important, do not give the impression you are in a hurry to conclude the discussion as this impression may cause the patient to withhold valuable information you need before commencing your physical examination.

- Try, if feasible, to conduct a conversation rather than an interrogation, following the patient's train of thought.
  You will usually need to ask follow-up questions on the main symptoms to obtain a full understanding of what they were and of the chain of events.
- Obtain a full description of the patient's principal complaints.
- Enquire about the sequence of symptoms and events.
  Beware pseudomedical terms, e.g. 'gastric flu' – enquire what happened. Clarify by asking what the patient means.
- Do not ask leading questions.
  A central aim in taking the history is to understand patients' symptoms from their own point of view. It is important not to tarnish the patient's history by your own expectations. For example, do not ask a patient whom you suspect might be thyrotoxic: 'Do you find hot weather uncomfortable?' This invites the answer 'yes' and then a positive answer becomes of little diagnostic value. Ask the open question: 'Do you particularly dislike either hot or cold weather?' (Ball et al. 2014a, b; Bickley and Szilagyi 2013; Coulehan 2006).
- Be sensitive to a patient's mood and nonverbal responses.
  For example, hesitancy in revealing emotional content. Use reflection so that the patient will expand on their discussion.
- Be understanding, receptive, and matter of fact without being sympathetic. Display and express empathy rather than sympathy.
- Avoid showing surprise or reproach.
- Clarify symptoms and obtain a problem list.
- When the patient has finished describing the symptom or symptoms:

- briefly summarise the symptoms
- ask whether there are any other main problems (Coulehan 2006).
  For example, say, 'You have mentioned two problems: pain on the left side of your tummy, and loose motions over the last six weeks. Before we talk about those in more detail, are there any other problems I should know about?'

1.1.4 Usual Sequence of History

- nature of principal complaints, e.g. chest pain, poor home circumstances
- history of present complaint
- details of current illness
- enquiry of other symptoms (see Functional Enquiry)
- past history
- family history
- personal and social history

- If one's initial enquiries make it apparent that one section is of more importance than usual (e.g. previous relevant illnesses or operation), then relevant enquiries can be brought forward to an earlier stage in the history (e.g. past history after finding principal complaints).

1.1.5 History of Present Illness

- Start your written history with a single sentence summing up what your patient's complaint is. It should be like the banner headline of a newspaper. For example: c/o chest pain for six months.
  (It is best to state in quotation marks the patient's chief complaint in the patient's own words when documenting.)

- Determine the chronology of the illness by asking:
  - 'How and when did your illness begin?' or
  - 'When did you first notice anything wrong?' or
  - 'When did you last feel completely well?'
- Begin by stating when the patient was last perfectly well. Describe symptoms in chronological order of onset.
  Both the date of onset and the length of time prior to being seen by you should be recorded. Symptoms should never be dated by the day of the week as this later becomes meaningless (Bickley and Szilagyi 2007, 2013; Cox 2010).
- Obtain a detailed description of each symptom by asking:
  - 'Tell me what the pain was like', for example. Make sure you ask about all symptoms, whether they seem relevant or not.
- With all symptoms obtain the following details:
  - duration
  - onset – sudden or gradual
  - what has happened since:
    - constant or periodic
    - frequency
    - getting worse or better
  - precipitating or relieving factors
  - associated symptoms.
- If pain is a symptom also determine the following:
  - site
  - radiation
  - character, e.g. ache, pressure, shooting, stabbing, dull
  - severity, e.g. 'Did it interfere with what you were doing?' 'Does it keep you awake?' 'Have you ever had this type of pain before?' 'Does the pain make you sweat or feel sick to your stomach?'

Avoid technical language when describing a patient's history. Do not say 'the patient complained of melaena', rather: 'the patient complained of passing loose, black, tarry motions'.

1.1.6 Supplementary History

When patients are unable to give an adequate or reliable history, the necessary information must be obtained from friends or relations. A history from a person who has witnessed a sudden event is often helpful.

When the patient does not speak English, arrange for an interpreter to translate for the patient. Bear in mind that numerous authors (Barkauskas et al. 2002; Ball et al. 2014a; Bickley and Szilagyi 2013; Cox 2010; Jarvis 2015; Rhoads and Paterson 2013) indicate that, if possible, family members and patients' young children should not be used as interpreters. Family members will frequently tell you what they think the patient's problem is rather than what the patient thinks the problem is. Because some questions that you may ask the patient are sensitive in nature, children should not be asked to interpret for their parents (Cox 2010; Lack 2012).

1.2 Functional Enquiry

This is a checklist of symptoms not already discovered.

Do not ask questions already covered in establishing the principal symptoms. This list may detect other symptoms.

- Modify your questioning according to the nature of the suspected disease, available time, and circumstances (Lack 2012).
  If during the functional enquiry a positive answer is obtained, full details must be elicited. **Asterisks (*) denote questions that must nearly always be asked.**

1.2.1 General Questions (These May Be Considered as Part of your Review of Systems)

- Ask about the following points:
  - *appetite: 'What is your appetite like? Do you feel like eating?'
  - *weight: 'Have you lost or gained weight recently?'
  - *general well-being: 'Do you feel well in yourself?'
  - *feelings of sadness or depression (to rule out feelings of suicide): 'Do you feel sad or depressed?'
  - fatigue: 'Are you more or less tired than you used to be?'
  - fever or chills: 'Have you felt hot or cold? Have you shivered?'
  - night sweats: 'Have you noticed any sweating at night or any other time?'
  - aches or pains
  - rash: 'Have you had any rash recently? Does it itch?'
  - lumps and bumps.

1.2.2 Cardiovascular and Respiratory System

- Ask about the following points:
  - *chest pain: 'Have you recently had any pain or discomfort in the chest?'

The most common causes of chest pain are:

- *ischaemic heart disease*: severe constricting, central chest pain radiating to the neck, jaw, and left arm; *angina*: pain frequently precipitated by exercise or

emotion and relieved by rest; *myocardial infarction*; the pain may come on at rest, be more severe, and last hours
- *pleuritic pain*: sharp, localised pain, usually lateral; worse on inspiration or cough
- *anxiety or panic attacks*: a very common cause of chest pain. Enquire about circumstances that bring on an attack.
- *shortness of breath: 'Are you breathless at any time?'

Breathlessness (dyspnoea) and chest pain must be accurately described. The degree of exercise that brings on the symptoms must be noted (e.g. climbing one flight of stairs, after 0.5 km [1/4 mi] walk).

- shortness of breath on lying flat (*orthopnoea*): 'Do you get breathless in bed? What do you do then? Does it get worse or better on sitting up? How many pillows do you use? Can you sleep without them?'
- waking up breathless: 'Do you wake at night with any symptoms? Do you gasp for breath? What do you do then?'

Orthopnoea (breathless when lying flat) and *paroxysmal nocturnal dyspnoea* (waking up breathless, relieved on sitting up) are features of *left heart failure*.

- *ankle swelling

Common in *congestive cardiac failure* (*right heart failure*).

- palpitations: 'Are you aware of your heart beating?'

Palpitations may be:

- single thumps (*ectopics*)
- slow or fast
- regular or irregular

Ask the patient to tap them out.

Paroxysmal tachycardia (sudden attacks of palpitations) usually starts and finishes abruptly.

- *cough: 'Do you have a cough? Is it a dry cough or do you cough up sputum? When do you cough?'
- sputum: 'What colour is your sputum? How much do you cough up?'

Green sputum usually indicates an *acute chest infection*. Clear sputum daily during winter months suggests *chronic bronchitis*. Frothy sputum suggests *left heart failure*.

- *blood in sputum (*haemoptysis*): 'Have you coughed up blood?'

Haemoptysis must be taken very seriously. Causes include:

- carcinoma of bronchus
- pulmonary embolism
- mitral stenosis
- tuberculosis
- bronchiectasis
- blackouts (*syncope*): 'Have you had any blackouts or faints? Did you feel light-headed or did the room go round? Did you lose consciousness? Did you have any warning? Can you remember what happened?'
- *smoking: 'Do you smoke? How many cigarettes do you smoke each day?'

1.2.3 Gastrointestinal System

- Ask about the following points:
  - nausea: 'Are there times when you feel sick?'
  - vomiting: 'Do you vomit? What is it like?'

'Coffee grounds' vomit suggests 'altered' blood such as with a bleeding ulcer.

Old food suggests *pyloric stenosis*.

If blood, what colour is it – dark or bright red?

- difficulty in swallowing (*dysphagia*): 'Do you have difficulty swallowing? Where does it stick?'

For solids: often organic obstruction.

For fluids: often neurological or psychological.

- indigestion: 'Do you have any discomfort in your stomach after eating?'
- abdominal pain: 'Where is the pain? How is it connected to meals or opening your bowels? What relieves the pain?'
- *bowel habit: 'How often do you open your bowels?' or 'How many times do you open your bowels per day?' 'Do you have to open your bowels at night?' (often a sign of true pathology)

If *diarrhoea* is suggested, the number of motions per day and their nature (blood? pus? mucus?) must be established. Frothy, frequent diarrhoea may be suggestive of coeliac disease.

'What are your motions like?' The stools may be pale, bulky, and float (fat in stool – *steatorrhoea*) or tarry from digested blood (*melaena* – usually from upper gastrointestinal tract).

Bright blood on the surface of a motion may be from *haemorrhoids*, whereas blood in a stool may signify *cancer* or *inflammatory bowel disease*.

Question what the patient has eaten. Red stool may indicate the patient has been eating beets, for example.

- jaundice: 'Is your urine dark? Are your stools pale? What tablets have you been taking recently? Have you had any recent injections or transfusions? Have you been abroad recently? How much alcohol do you drink?'

Jaundice may be:

- obstructive (dark urine, pale stools) from:
  - carcinoma of the head of the pancreas
  - gallstones
- hepatocellular (dark urine, pale stools may develop) from:
  - *ethanol* (cirrhosis)
  - drugs or transfusions (viral hepatitis)
  - drug reactions or infections (travel abroad, viral hepatitis, or amoebae)
- haemolytic (unconjugated bilirubin is bound to albumin and is not secreted in the urine).

1.2.4 Genitourinary System

- Ask about the following points:
  - dysuria: pain on urination – usually burning (often a sign of infection/cystitis)
  - loin pain: 'Any pain in your back?'

Pain in the loins suggests pyelonephritis.

- *urine: 'Are your waterworks all right? Do you pass a lot of water at night? Do you have any difficulty passing water? Is there blood in your water?' (suggests haematuria)

Polyuria and *nocturia* occur in *diabetes.*

Prostatism results in slow onset of urination, a poor stream, and terminal dribbling.

- sex: 'Any problems with intercourse or making love?'
- *menstruation: 'Any problems with your periods? Do you bleed heavily? Do you bleed between periods?'

Vaginal bleeding between periods or after the menopause raises the possibility of *cervical* or *uterine cancer.*

Menstrual cycle: Last menstrual period (**LMP**) and length of bleeding. (Normal cycle is 21–35 days. Normal period is between 5 and 8 days with between 70 and 200 ml of blood loss.) If indicated, ask about intermenstrual bleeding, postmenopausal bleeding or postcoital bleeding.

- vaginal discharge (if present, ask about colour, consistency, and odour; does it cause itching?)
- pain on intercourse (*dyspareunia*).

1.2.5 Nervous System

- Ask about the following points:
  - *headache: 'Do you ever have any headaches? Where are they?' (location) 'When do you get headaches?' 'What are they like?' (quality/intensity)

Headaches often originate from tension and can be either frontal or occipital. Occipital headache on waking in the early morning may be due to *raised intracranial pressure* (e.g. from a *tumour* or *malignant hypertension*). Ask if the headache is associated with flashing lights (*amaurosis fugax*) (Bickley and Szilagyi 2013; Cox 2010).