بسم الله الرحمن الرحيم

The general principles of history taking and History Taking. Approach to patients with GI signs and symptoms

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- ***Medicine is learned by the bedside and not in the classroom.***
- ***The gastrointestinal (GI) history should focus on key system-specific symptoms related to the GI tract.***

- A medical history is the first step in making a diagnosis; it will often help direct the physical examination and will usually determine what investigations are appropriate.

*General rules:

- It is an art.
- It is history not story
- Objective not subjective.
- Don’t under-estimate any point bcz it may means a lot of things to an expert.
- don’t repeat your self .. don’t repeat your self.

- You must have the ability to "change" (i.e. change the organization for any reason).
- Take care before entering the room of your patient to protect your self from infections by knowing (if you can) if the pt. has any infectious disease and take the protective instruction for it.

- For male doctors, don't enter to female patient without Chaperon (e.g: nurse).
- Salutatory sentence (e.g. alsalam alaikom).
- Introduce your self.
- let the patient trust you = establish the rapport with the patient.
- Mention the source of the history taking if not from the patient during the presentation of your case.

- More often than not, an accurate history suggests the correct diagnosis, whereas the physical examination and subsequent investigations merely serve to confirm this impression.
- The history is also, of course, the least expensive way of making a diagnosis.

Bedside manner and establishing rapport;

- History taking requires a lot of practice and depends very much on the doctor-patient relationship.
- It is important to try to put the patient at ease immediately, because unless a rapport is established, the history taking is likely to be unrewarding.

- You should aim to leave the patient feeling better for your visit.
- A difficult technique to teach.
- Much has been written about the correct way to interview patients, but each doctor has to develop his or her own method, guided by experience gained from clinical teachers and patients.

Obtaining the history;

- It is useful to make rough notes while questioning the patient.
- Allow the patient to tell the whole story, then ask questions to fill in the gaps.
- Always listen carefully.
- At the end of the history and examination, a detailed record is made.

Personal data:(P.D);

- Name.
- age.
- Nationality.
- Gender.
- Residence.
- Date (not in numbers but by the days ago).
- Route of Admission (OPD, ER …etc).

Presenting (principal) symptom (PS).

- Put it in the patient's own words & list his complaints according to their importance.
- (+ duration).
- Not more than three complaints.

History of presenting illness (HPI); (Analysis of the complaint).

- Each of the presenting problems has to be talked about in detail with the patient.
- Not uncommonly, a patient has many symptoms.
- An attempt must be made to decide which symptom led the patient to present.
- Record each presenting symptom in the patient's own words, avoiding technical terms.

HPI;

- (SOCRATES)
- S = site
- O= onset (acute: Minutes-hour, subacute: hours-days, chronic: for days).
- C= character (stabbing, colicky, sharp, dull, burning, cramping, throbbing) & pattern(continuous, intermittent)
- R= radiation.
- A= associated symptoms
- T= time (duration)
- E= exacerbating & relieving factors (taking drug, position, ….etc)
- S= severity (0-10 scale).

HPI;

- Previous illnesses of the same complain. (what happened in details).
- *don’t forget to ask about the important 3 symptoms:
- - fever
- - weight loss (significant if > 10% of the w. in the past 6 months without diet)
- Appetite

Past history (PH);

- Past medical:
- Any known chronic Illness (DM, HTN, CAD, Asthma, TB,CKD, Hepatitis).
- Any previous admissions in details (date, diagnosis, investigation, procedures, treatments).

PH;

- Past surgical: any surgery in details (date, diagnosis, investigations, drugs, operation type, post operative course).
- Blood transfusion: (Why, How many unit, When, Where, if any reaction occur).
- Immunizations.

Drug History: (D.H);

- Drug scientific name, dose, route, since when & on medical advices ? Compliance?
- Any side effects?
- Usage of Herbal Medicine.
- Usage of OTC.

Allergic History: (A.H)

- Allergy to any substance (DRUG as penicillin or FOOD as eggs or fish, ….etc).

Family history (FH);

- Ask about any history of a similar illness in the family.
- Any chronic Illnesses in the family

(D.M, HTN, Coronary Heart Disease, CKD, Asthma, etc..)

- Inquire about the health and, if relevant, the causes of death and ages of death of the parents and siblings.

Social History;

- Marital status.
- social support/Living conditions.
- Occupation (*Past occupations if relevant*).
- Education.
- Habits/Illicit Drugs.
- Contact (sick/Animal/Sexual).
- Overseas travel
- Immunisation.
- Impact of the disease; DLA/*Marital/Financial/Occupational/Sexual.*

- Systems review (SR).

ROS;

- As well as detailed questioning about the system likely to be diseased, it is essential to ask about important symptoms and disorders in other systems, otherwise important diseases may be missed.
- Remember, if other recent symptoms are unmasked, more details must be sought; relevant information is then added to the history of the presenting illness.

Cardiovascular:

- Chest pain.
- Dyspnea/orthopnea/paroxysmal nocturnal dyspnea(PND).
- Claudication,
- Syncope
- L.L edema,
- Palpitation,
- Cyanosis (central/peripheral).

Respiratory:

- Cough, sputum (color+amount).
- Hemoptysis.
- Wheezing, sneezing.
- Snoring, hoarseness.
- Fever, night sweat.

Gastrointestinal:

- Oral ulcers.
- nausea/vomiting.
- hematemesis.
- dysphagia/odynophagia.
- heartburn/regurgitation.
- abdominal pain/distension.
- diarrhea/constipation.
- bleeding per rectum(color+amount).
- melena/hematochezia.
- Jaundice/Itching.

Endocrine:

- Polyuria/polydipsia.
- loss of appetite/hyperphagia.
- Amenorrhea/galctorrhea.
- Heat/cold intolerance.
- Gain/loss of weight.
- Skin /hair changes.
- Sweating/dryness.

Musculoskeletal:

- Athralgia, myalgias,
- Stiffness, redness, swelling.
- Arthritis.

Hematological:

- easy fatigability,
- easy bleeding,
- bruising,
- yellow skin,
- lymphadenopathy.

Dermatological :

- Rashes.
- skin discolorations.
- nail changes.

Genitourinary:

- Dysuria,
- hematuria,
- Nocturia.
- Frequency.
- Pain (e,g: loin,suprepubic…etc),
- Discharge.

Gynecological & Ob. :

- menarche age.
- menstrual bleeding duration & amount.
- length of the cycle.
- presence of pain &its relation to bleeding.
- the first day of last menstrual bleeding
- contraception.
- dysmenorrhea.
- menopausal age.
- postmenopausal bleeding duration & amount.

-Obstetrics:

- A) In each delivery ask:
- duration of pregnancy (preterm, fullterm, postterm).
- mode of delivery (spontaneous vaginal, by forceps,…).
- the newborn (male or female, alive or dead):
- complication (fetal or maternal)
- B) In each abortion:
- duration of pregnancy
- mode of termination (spontaneous or induced)
- complication in the post abortive period.

- Course in the Hospital;

- Addressing the patient's concerns and expectations.

FINALLY YOU SHOULD ASK THE PATIENT :

- DO YOU HAVE ANY THING ELSE YOU WANT TO TELL ME?

- if you want to learn, always try to present a lot of cases.

- You can change the arrangement of the history scheme upon the case that you have.

Skills in history taking;

- In summary;

- First, establish rapport and understanding.
- Second, ask questions in a logical sequence.
- Start with open-ended questions.
- Listen to the answers and adjust your interview accordingly.
- Third, observe and provide non-verbal clues carefully.

- Fourth, proper interpretation of the history is crucial.
- Your aim should be to obtain information that will help establish the likely anatomical and physiological disturbances present, the aetiology of the presenting symptoms and the impact of the symptoms on the patient's ability to function.

* wash your hand * introduce yourself * get permission * privacy * warm hand and stethoscope...

First impressions

- First impressions of a patient's condition must be deliberately sought.
- First, decide how sick the patient seems to be: that is, does he or she look generally ill or well? The cheerful person sitting up in bed is unlikely to require urgent attention to save his life.
- At the other extreme, the patient on the verge of death may be described as *in extremis* or moribund. The patient in this case may be lying still in bed and seem unaware of the surroundings.
- The face may be sunken and expressionless, respiration may be shallow and laboured; at the end of life, respiration often becomes slow and intermittent, with longer and longer pauses between rattling breaths.
- Apart from gaining a general impression of a patient's state of health, certain general physical signs must be sought

Vital signs

- Certain important measurements must be made during the assessment of the patient. These relate primarily to cardiac and respiratory function and include pulse, blood pressure, temperature and respiratory rate. These vital signs must be assessed at once if a patient appears unwell.
- They provide important basic physiological information.

GI Symptoms

- There are a plethora of GI symptoms and some can be specific to the upper GI tract, some specific to the lower GI tract and others to the hepatobiliary system. Explore these symptoms in more detail.
- The key symptoms to determine in the GI history include:
- Abdominal pain
- Dysphagia: difficulty swallowing
- Heartburn: reflux symptoms
- Dyspepsia: indigestion
- Nausea & vomiting
- Change in bowel habit: constipation, diarrhoea
- Bleeding: haematemesis, melaena (Jet black tarry offensive stool), PR bleeding
- Jaundice
- Weight loss

Clinically important weight loss

- Clinically important weight loss is generally defined as loss of more than 5 percent of usual body weight over 6 to 12 months.
- Patients who are overweight or obese may intentionally lose weight to improve their health. However, progressive unintentional (involuntary) weight loss often indicates a serious medical or psychiatric illness.

Temporal wasting

Apthous ulcers.

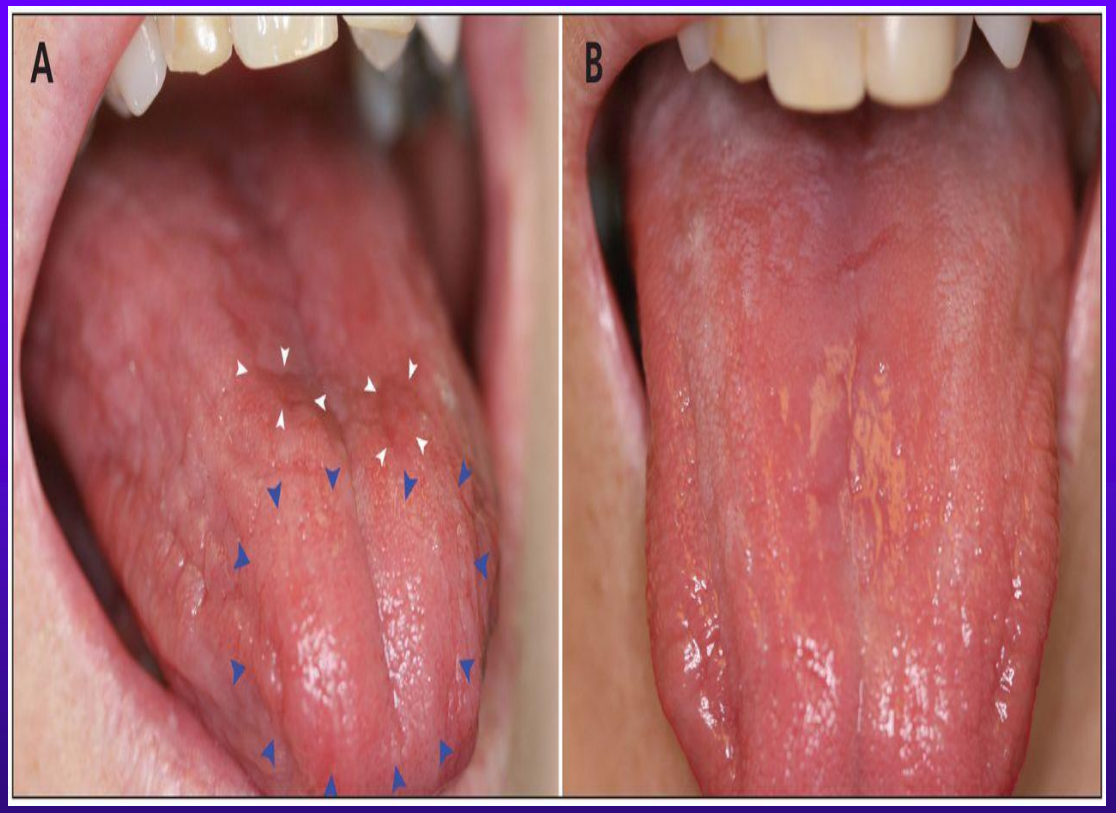
Palatal petechia

Fetor hepaticus

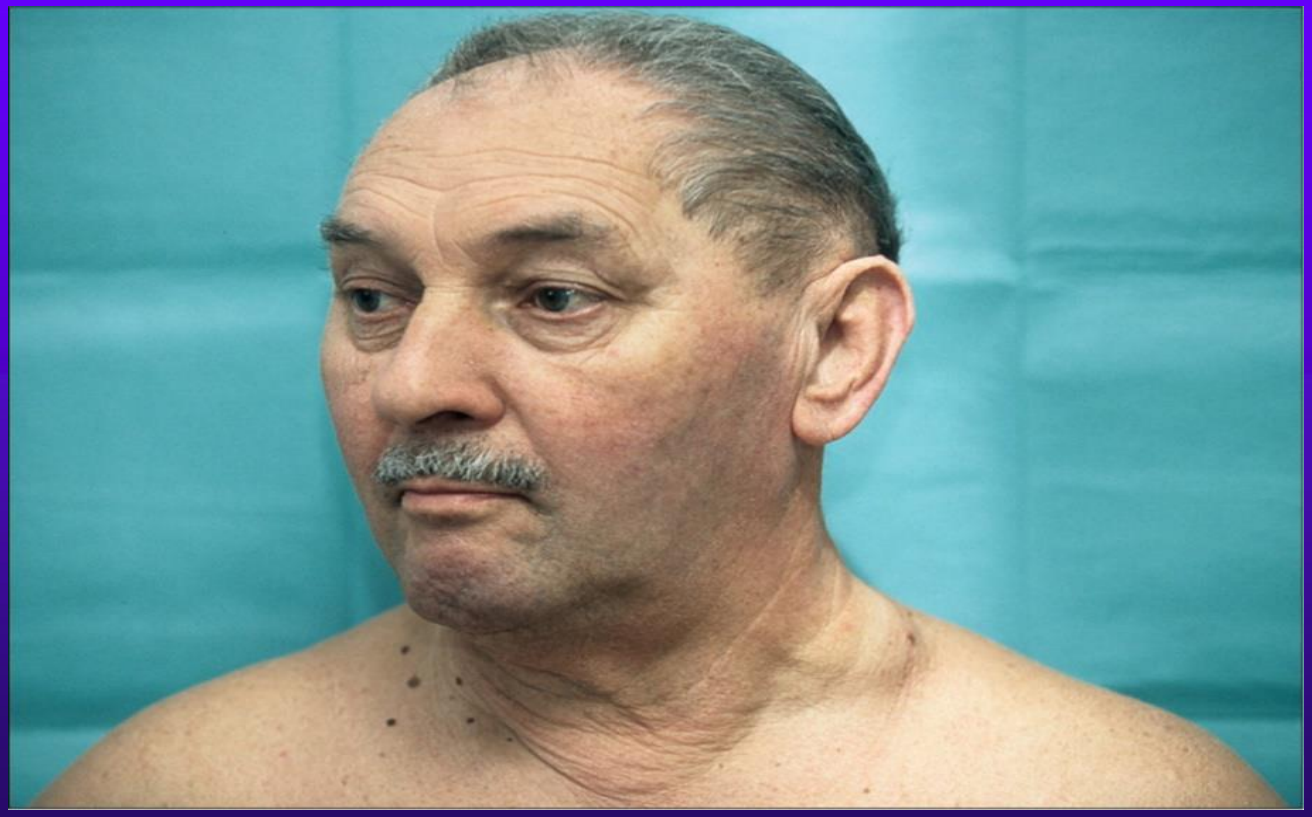
- Known as breath of the dead or hepatic foetor, is a condition seen in portal hypertension where portosystemic shunting allows thiols to pass directly into the lungs. It is a late sign in liver failure and is one of the clinical features of hepatic encephalopathy.
- The breath has a sweet, fecal smell.

Jaundice

Glossitis



Virchow's node



Angular Cheilitis

- Also known as angular stomatitis.
- Tthe nutritional deficiencies, particularly those of riboflavin (B2), niacin (B3), pyridoxine (B6), folate (B9), iron, and general protein malnutrition, may produce smooth, shiny, red lips associated with angular stomatitis, collectively known as cheilosis.

Angular stomatitis.

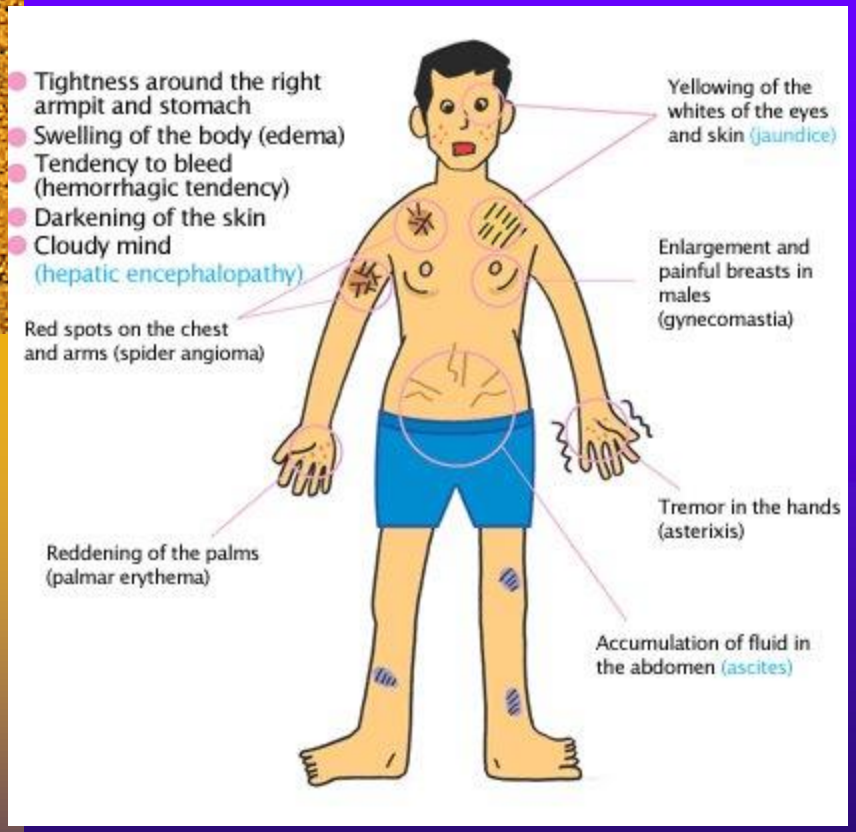
Spider naevus

- is dilation of preexisting central arterioles from which numerous thin-walled capillary branches radiate like spider legs, carrying away freely flowing blood.

Spider naevus

Gynecomastia

- Gynecomastia is the benign enlargement of male breast glandular tissue and is the most common breast condition in males.


Tightness around the right armpit and stomach
Swelling of the body (edema)
Tendency to bleed (hemorrhagic tendency)
Darkening of the skin
Cloudy mind (hepatic encephalopathy)
Red spots on the chest and arms (spider angioma)
Reddening of the palms (palmar erythema)
Yellowing of the whites of the eyes and skin (jaundice)
Enlargement and painful breasts in males (gynecomastia)
Tremor in the hands (asterixis)
Accumulation of fluid in the abdomen (ascites)

Acanthosis nigricans

- is a skin condition characterised by a velvety papillomatous overgrowth of the epidermis. Darkening and thickening (hyperkeratosis) of the skin occurs mainly in the flexural areas, particularly the axillae, groins, inframammary regions, and the neck.
- Acanthosis nigricans is usually a sign of an underlying condition or disease, such as obesity or diabetes (benign).

  Its presence as a sign of internal malignancy is rare.

Ascites

- is the pathologic accumulation of fluid within the peritoneal cavity. It is the most common complication of cirrhosis and occurs in about 50% of patient with decompensated cirrhosis in 10 years.

Caput medusae

- The term caput medusae is Latin for “head of Medusa. Medusa was a character in mythology who had snakes for hair. The swollen veins can look like snakes extending from a knot in the middle that loosely resembles a head.
- Caput medusae is the appearance of distended and engorged superficial veins, which are seen radiating from the umbilicus across the abdomen.

Leukonychia

- Leukonychia (or leuconychia), is a medical term for white discoloration appearing on nails.
- Arsenic poisoning, Lead poisoning, Pneumonia
- Heart disease, Kidney failure
- Ill health, Hypoalbuminemia
- Vitamin deficiency, Ulcerative colitis
- Liver cirrhosis, Psychogenic stresses
- Onychophagia, Trauma injury
- Occupational trauma, Zinc deficiency
- Protein deficiency, Psoriasis[
- Iron deficiency

Koilonychia

- also known as spoon nails, is a nail disease that can be a sign of hypochromic anemia, especially iron-deficiency anemia. It refers to abnormally thin nails (usually of the hand) which have lost their convexity, becoming flat or even concave in shape. In a sense, koilonychia is the opposite of nail clubbing.

Koilonychia

Clubbing

- Clubbing is a bulbous uniform swelling of the soft tissue of the terminal phalanx of a digit with subsequent loss of the normal angle between the nail and nail bed. Clubbing is usually acquired and is associated with certain cardiopulmonary and gastrointestinal disorders, but may occur in congenital or familial forms.

Clubbing

Facies

- A specific diagnosis can sometimes be made by inspecting the face, its appearance giving a clue to the likely diagnosis.
- Some facial characteristics are so typical of certain diseases that they immediately suggest the diagnosis and are called the diagnostic facies.
- Apart from these, there are several other important abnormalities that must be looked for in the face.

Jaundice

- When the serum bilirubin level rises to about twice the upper limit of normal, bilirubin is deposited in the tissues of the body. It then causes yellow discoloration of the skin (*jaundice*) and more dramatically, the apparent discoloration of the sclerae. The usual term *scleral icterus* is misleading, since the bilirubin is actually deposited in the vascular conjunctiva rather than the avascular sclerae. The sclerae (conjunctivae) are rarely affected by other pigment changes. In fact, jaundice is the only condition causing yellow sclerae. Other causes of yellow discoloration of the skin, but where the sclerae remain normal, are carotenaemia.

Cyanosis

- This refers to a blue discoloration of the skin and mucous membranes; it is due to the presence of deoxygenated haemoglobin in superficial blood vessels. The haemoglobin molecule changes colour from blue to red when oxygen is added to it in the lungs. If more than about 50 g/L of deoxygenated haemoglobin is present in the capillary blood, the skin will have a bluish tinge.
- Cyanosis does *not* occur in anaemic hypoxia because the total haemoglobin content is low.
- Cyanosis is more easily detected in fluorescent light than in daylight .

Pallor

- *Anaemia* can produce pallor of the skin and should be noticeable, especially in the mucous membranes of the sclerae if the anaemia is severe (less than 70 g/L of haemoglobin).
- Pull the lower eyelid down and compare the colour of the anterior part of the palpebral conjunctiva (attached to the inner surface of the eyelid) with the posterior part where it reflects off the sclera. There is usually a marked difference between the red anterior and creamy posterior parts.

Hair

- Bearded or bald women and hairless men not uncommonly present to doctors.
- These conditions may be a result of more than the rich normal variations of life, and occasionally are due to endocrine disease.

Weight, body habitus and posture

- Look specifically for obesity. This is most objectively assessed by calculation of the body mass index (BMI), where the weight in kilograms is divided by the height in metres squared. Normal is less than 25 kg/m2. A BMI of ≥30 indicates frank obesity. *Morbid* obesity is a weight of more than twice the ideal (BMI >45-50).

The hands and nails

- Changes occur in the hands in many different diseases. It is useful as an introduction to shake a patient's hand when meeting him or her. Apart from being polite, this may help make the diagnosis of dystrophia myotonica, a rare muscle disease in which the patient may be unable to let go. Shaking hands is also an acceptable and gentle way of introducing the physical examination.

The hands and nails

- There is probably no subspecialty of internal medicine in which examination of the hands is not rewarding. The shape of the nails may change in some cardiac and respiratory diseases, the whole size of the hand may increase in acromegaly, gross distortion of the hands' architecture occurs in some forms of arthritis, tremor or muscle wasting may represent neurological disease, and pallor of the palmar creases may indicate anaemia.

Nail signs in systemic disease

- Blue nails: Cyanosis, Wilson's disease, ochronosis.
- Red nails: Polycythaemia (reddish-blue), carbon monoxide poisoning (cherry-red).
- Clubbing; Lung cancer, chronic pulmonary suppuration, infective endocarditis, cyanotic heart disease, congenital, HIV infection, chronic inflammatory bowel disease.
- Koilonychia (spoon-shaped nails); Iron deficiency, fungal infection, Raynaud's disease.

Smell

- Certain medical conditions are associated with a characteristic odour.
- These include the sweet smell of the breath in patients with liver failure, the ammoniacal fish breath ('uraemic fetor') of kidney failure and, of course, the stale cigarette smell of the patient who smokes.

Preparing the patient for examination

- An accurate physical examination is best performed when the examining conditions are ideal. This means that, if possible, the patient should be in a well-lit room (preferably daylight) from which distracting noises and interruptions have been excluded (rarely possible in busy hospital wards).
- The patient must be undressed so that the parts to be examined are accessible.
- Modesty requires that a woman's breasts be covered temporarily with a towel or sheet while other parts of the body are being examined. Male doctors and students should be accompanied by a female *chaperone* when they examine a woman.
- Both men and women should have the groin covered-for example, during the examination of the legs.
- Outpatients should be provided with a gown to wear. However, important physical signs will be missed in some patients if excessive attention is paid to modesty. The position of the patient in bed or elsewhere should depend on what system is to be examined.
- For example, a patient's abdomen is best examined if he or she lies flat with one pillow so that the abdominal muscles are relaxed.