FOUNDATION COURSE (Week 2)

THE GENERAL EXAMINATION

These notes are mainly for guidance, they are not meant to be prescriptive.

INTRODUCTION

This element has traditionally included all material that does not fit conveniently into any other system. Students have been encouraged as a routine to look for signs that are of little value in modern medicine, such as koilonychia or Dupuytren's contractures. Students look diligently for splinter haemorrhages and Osler's nodes, despite the extreme rarity of subacute bacterial endocarditis. This approach is largely a waste of time and should not be part of the *basic* general examination but reserved for diagnostic situations that demand it. The general examination should follow the same three principles as any other element of the diagnostic process:

1 To establish or refute diagnostic hypotheses generated by the history.
2 To screen for important abnormalities.
3 To satisfy patient requests for reassurance.

The general examination refers not so much to a process, since it is not a discrete process, but to a style of recording data. Many items in it may more usefully be recorded under other system headings if the patient has other signs in those systems.

AIMS OF THIS SESSION

1 Show students a ***basic*** standard approach to the general examination.
2 Demonstrate generic components of examination
   - deciding what signs you need to look for (hypotheses from history)
   - explaining what you are going to do
   - avoiding pain
   - interpreting findings as you go along
   - ensuring adequate patient exposure
   - maintaining patient comfort and coverage
   - adequate lighting
3 Illustrate reasons why signs are sought. Why, for example, examination of the hands may reveal distant pathology.
4 Model professional attitude to patients in approach to student volunteer.
5 Allow students to 'have a go' under supervision. Remind them that this is only a taster and that they will go over everything again in detail in their skills firms. For this session the technique is the important thing, not the findings.

Please **do not** use this session to discuss all the abnormalities you might find. Those mentioned below are for the purposes of illustration only, they do not all have to be mentioned to the students.

PROCEDURE

Introduce yourself and explain the procedure. Ensure the patient is comfortable and maintain the patient's dignity.

Look at the patient from the end of the bed:

- Does the patient prefer a fixed position (knees up, bending forward etc)? Introduce these as localising signs and concept of pain being enhanced by tissue tension.
- Patient lying rigid or restless?
- Non-specific signs of 'illness', interest and interaction with surroundings.
- (Eyes closed sign)

The **general examination** should contain the following elements:

1 Signs of illness
1 weight loss
    - sodium and water depletion (dehydration)
    - minor involuntary movements
    - level of consciousness and responsiveness to the examiner
    - fever
    - lack of spontaneous behaviour
2 General mood
3 Signs of weight loss
4 Skin
5 Hair
6 Examination of the hands and nails for clubbing, etc
7 Facial appearance
8 Mouth and fauces
    - teeth
    - tongue
    - buccal mucosa
9 Eyes
1 pallor of conjunctivae
    - jaundice
10 Oedema, distinguish pitting oedema from lymphoedema
11 Breasts (not part of foundation course)
12 Lymphadenopathy - show students how to check cervical and axillary lymphadenopathy