

YLL SENIORS TEACHING INITIATIVE 2014/2015

M3 Lecture 6: An approach to Physical Diagnosis & the OSCE exam

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PART A. It is your M3 OSCE exam. You have been waiting anxiously in the freezing LT since 12pm. It is now 4.30 pm and finally it is your turn.

1. With much trepidation you open the door for station 1. A young Chinese lady chirps "Good morning!" – she looks a little too happy. The examiner, who looks especially post-call, grunts "please examine her thyroid". You smile broadly because you are so familiar with the standard template for thyroid exam. What signs do you look for and how do you put the signs together?

Please examine thyroid. > Surg
 Please examine thyroid system > Med.

Tremor
 HR
 Reflex
 Eye
 Pretibial myxedema

THYROID	FUNCTION		
	Hypo	Eu	Hyper
N.I. goitre	Thyroiditis Post-12 or op	(n)	Thyroiditis.
Diffuse goitre	Hashimoto ←	12 deficiency Hashimoto ←	Graves Hashimoto
MNG		MNG	MNG.
Solitary nodule.		CA Adenoma Cyst MNG dominant nodule.	MNG toxic nodule.

STRUCTURE
 nodule.
 swallowing
 fixation
 hoarseness
 SOB

2. A well-known NUH paed's prof greets you at station 2. She points to a squirmy 10-year-old boy sitting in his wheelchair – "This boy has difficulty walking, please examine." What are you thinking of and what do you want to examine?

Obscure part:

Difficulty Walking

NEURO

MSK

OTHERS

syndromic?
dev't delay?

not syndromic

eg trauma
septic jt
rheum

eg sepsis
CCF

CENTRAL
eg. Down's.

weak

not weak but uncoordinated.

PYRAMIDAL

EXTRAPYRAMIDAL

↑ tone
↑ reflex
↑ clonus
Babinski

↓ tone
↓ reflex
fasciculate.

Ataxic
Central
↓
Cerebellar
Peripheral
↓
DCML
↳ CP.

Movement disorders
↳ CP

UMN

LMN

Unilateral

Bilateral

Where is lesion?
+ Cortical signs → Cortex
+ CN Δ Ataxia → Brainstem
+ nothing → Subcortex

① Para-sagittal lesion
Spinal cord.
② First level
Tuft of hair
lobifolia.
Cervical myelop.

What is the lesion?

- > CP
 - > Stroke
 - > Infection
 - > Neoplastic
 - > Others
- look for
- shunt,
- big head.
- scars

[Where is the lesion]

	AHC	Radicle	Plexus	Nerve	Polyn	NMJ	Muscl
Weakness	Myotomal		Specific		Distal	Proximal	
Symmetry	Asymmetric		Specific	Symmetric			
Sensory	n	±			↓		n
Additional features	Fasciculate	Pain			Glove + stocking	Fatigue	Pseudo hypertrophy
Causes - paed's	SMA		Erb Klumpke		CMT GBS	MG	DMD Myositis
Causes - adult also	MND Polio	Disk prolapse		Capel tunnel	DM Toxins		rash? myotoni facies pain!

[What is the lesion].

3. You go on to Station 3. A elderly Malay man lies uncomfortably on the examining couch, almost falling off. A glum-looking examiner points to the patient's distended abdomen, and says, "This patient complains of a swollen tummy. Please examine and tell me your diagnosis". You notice that the patient is having difficulty catching his breath. How would you proceed?



Why is it pelvic

Why is it a kidney?

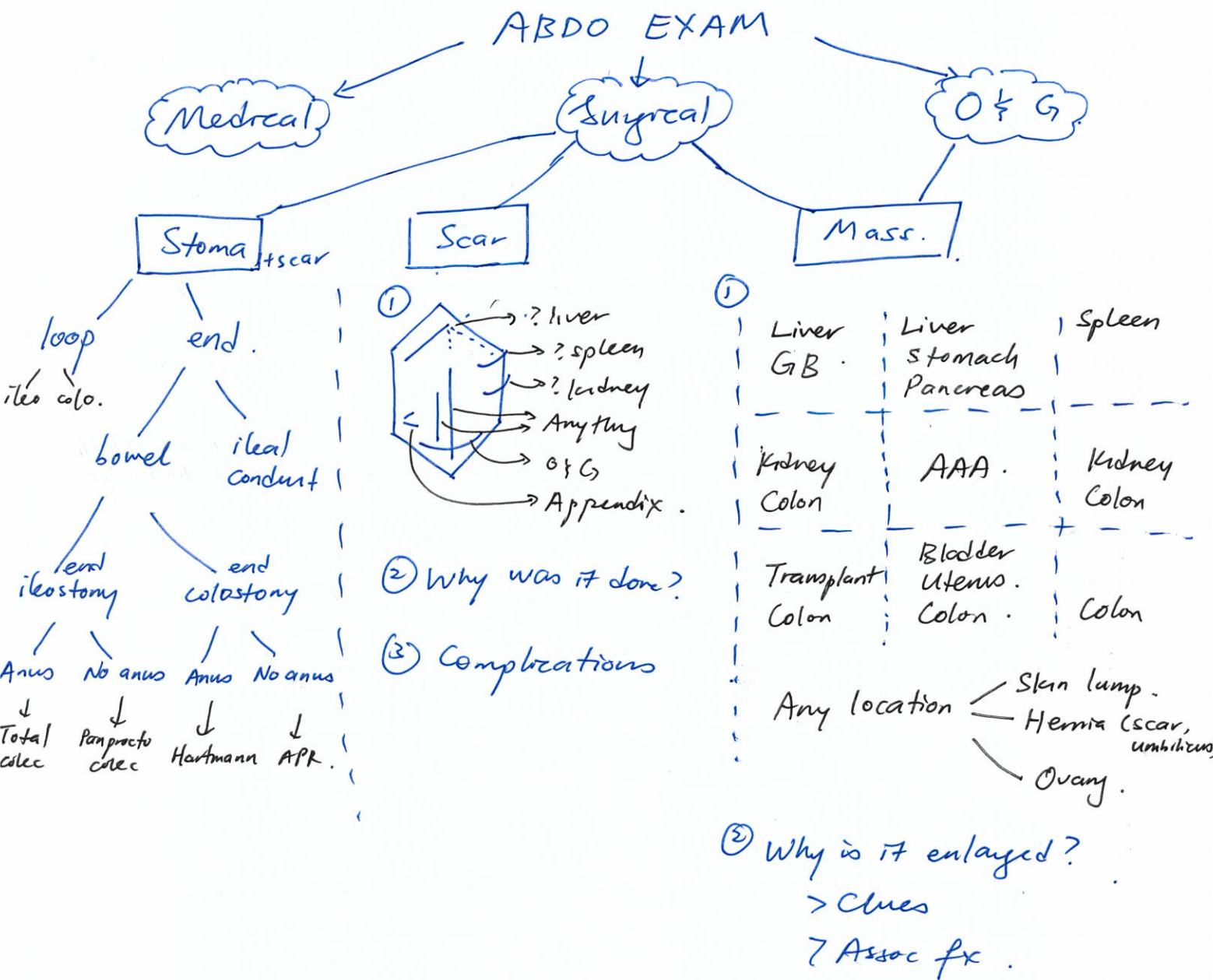
Why is it a liver?
Why is it a spleen?

This case : ascites .

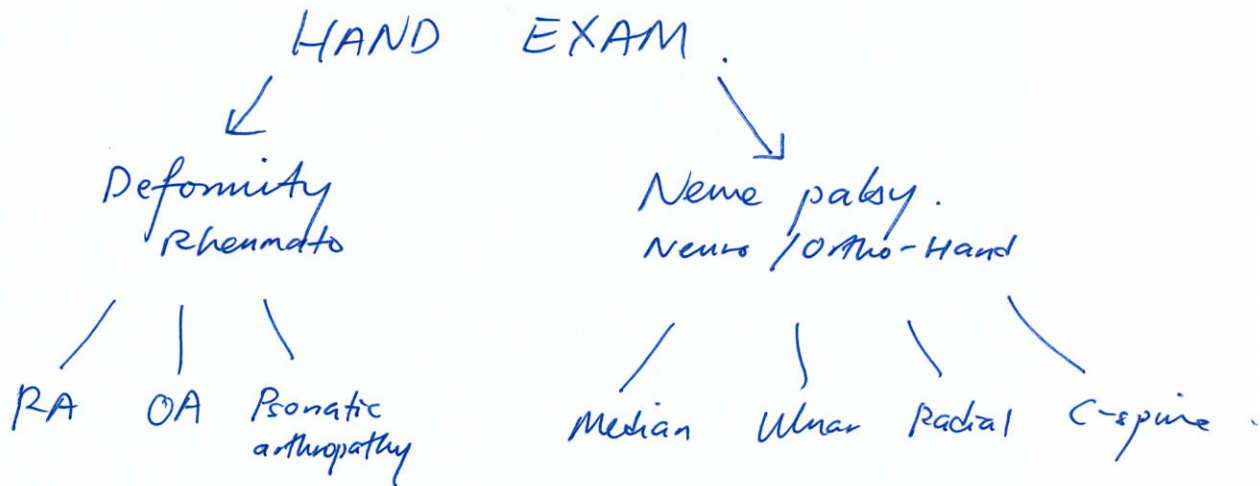
- Cardiac failure
- Renal failure
- Cirrhosis (or Budd-Chiari)
- CA (or TB)

[Pdx : by SAAG]

4. At station 4, you are invited to examine another abdomen. Patient is an young Indian gentleman. You lift up the shirt and see a large midline scar with a stoma bag on the abdomen. How would you proceed?



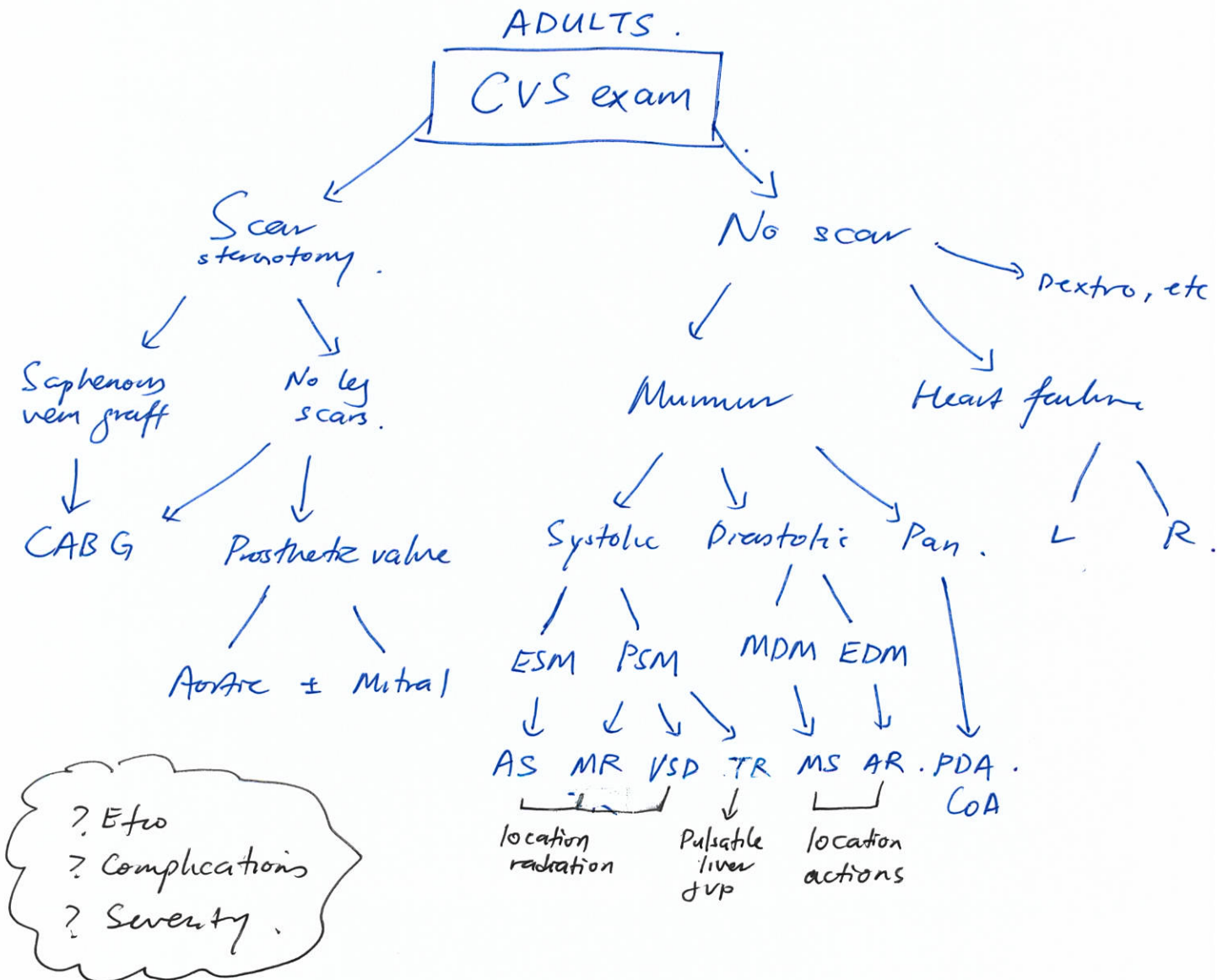
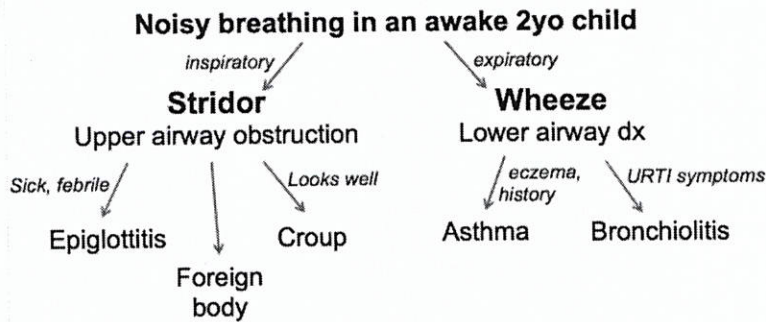
5. Station 5. An elderly Chinese lady smiles at you from her seat. "This lady has difficulty picking up coins. Can you look at her hands and tell me why?"

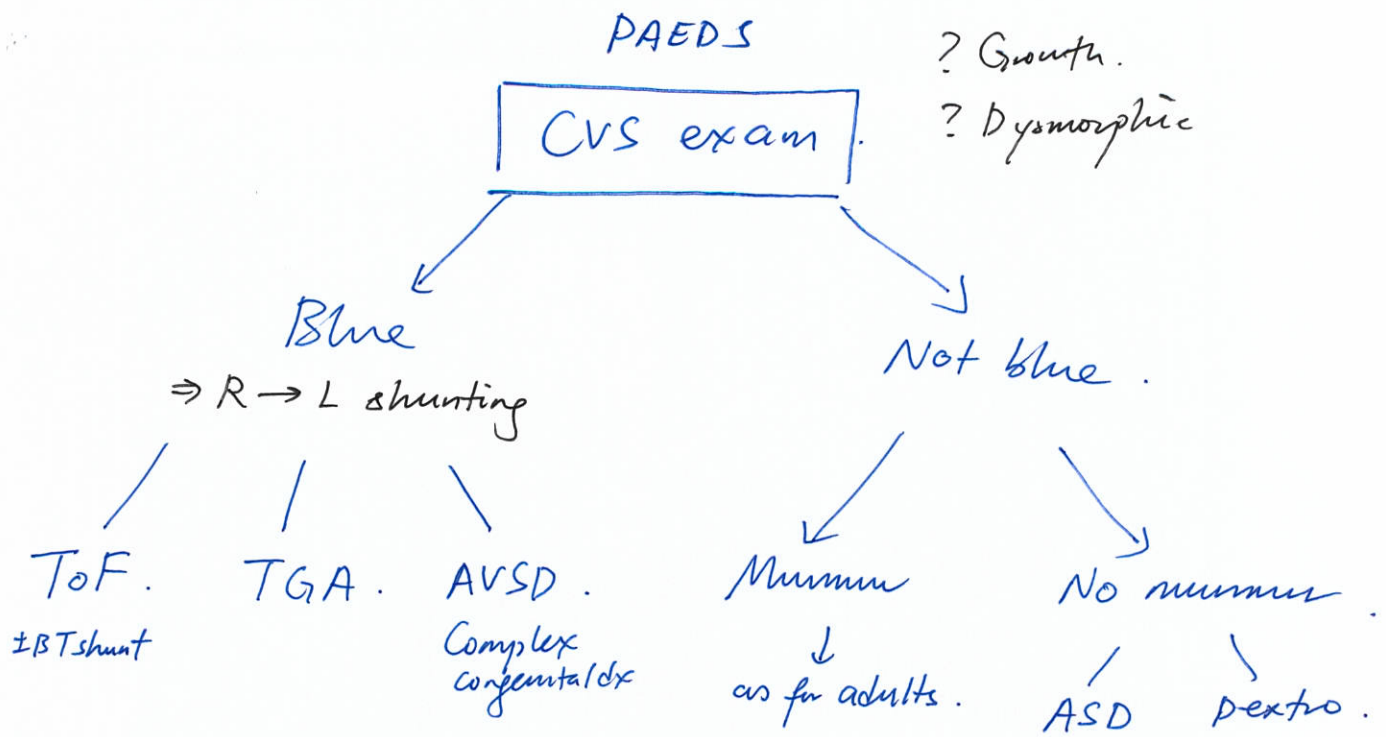


PART B. Many students go through the steps of the physical exam with brain turned off, eliciting some signs and being unsure about others. When asked to present their findings and suggest a diagnosis, they inevitably blank out.

- Attempt to create a logical schema (thought process) for the Cardiovascular Exam in adults and in children.
 - What are the key differential diagnoses (for both adults and for children)?
 - What are the key findings that distinguish between these diagnoses?
 - Hence, as you go through each step of the exam, what are the key branch points that will make you think of one group of diagnoses over others?

A sample schema is provided below (refer to Lecture 2: Clinical Reasoning)





How to develop an approach?

1. Have a feel for each case. What are the most salient / notable features? Are these features reliable? Or will you get caught out
- ↓
2. Identify key differentiators as branch points in your schema.
- ↓
3. Prioritize these differentiators — what do you look for first? What later?
- ↓
4. Practice! Try out your schema on real patients

Gain more clinical experience
↓
Refine your thought process
↓
Edit approach.

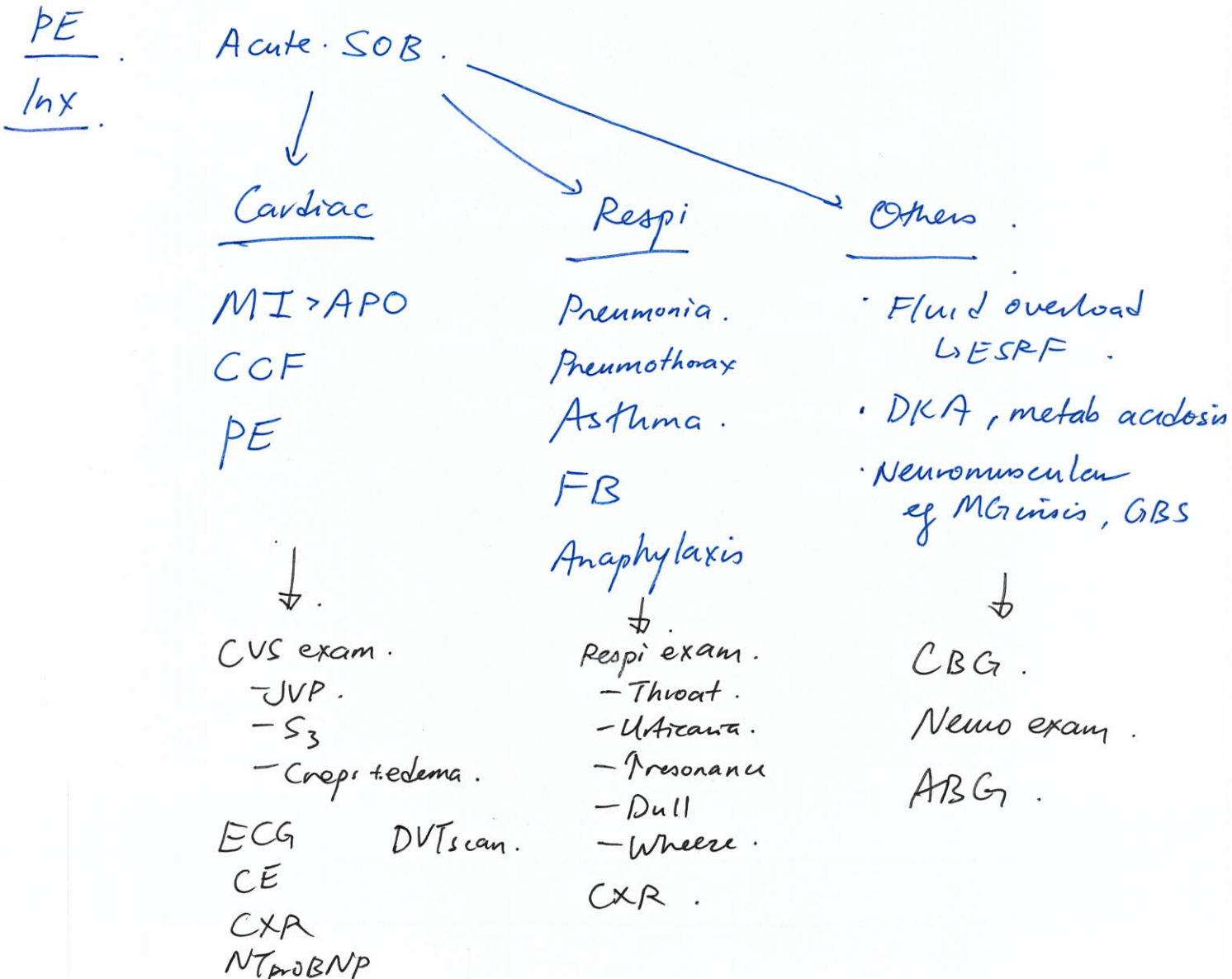
Also see lecture 2: approach to clinical reasoning.
(more details on use of schemata)

Cases 7-9 are more for discussion. You will encounter in my

PART C. You are the A&E MO. The following patients come in while you are on shift. Unfortunately you are unable to talk to them. Can you still come to a diagnosis?

7. It is 4am. An elderly Indian lady is brought in by her husband, who was woken up by her heavy breathing. Indeed she appears to be in respiratory distress, and is only able to speak in words. You attempt to obtain a history but she is too breathless to talk much. You can only gather that she has had previous episodes of shortness of breath, and her husband is unable to offer anything additional. You look up the computer and find a long list of cardiac, respi, endocrine, general surgery, and orthopaedic visits – but clinic notes (written on paper) are not available immediately. What do you do now?

Resus. Paras., ABC.
 PI, O₂.
 ? Dup – no! ⇒ 1/0.

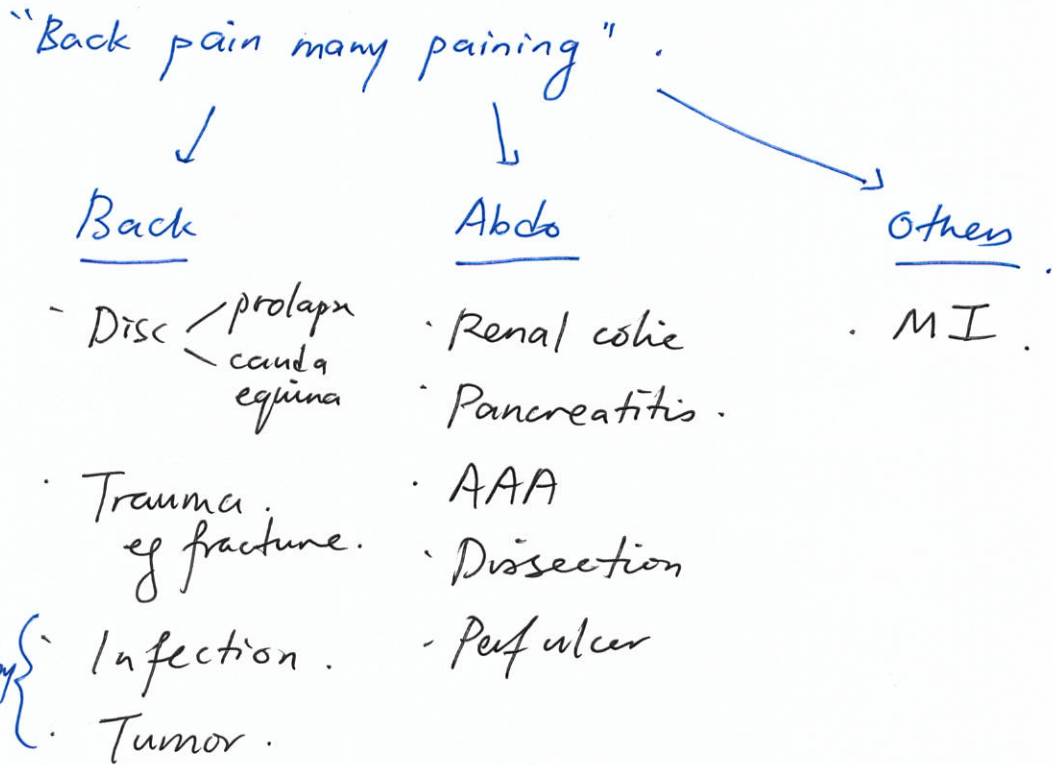


8. The nurses thrust you a case file, "Dr can you please see this gentleman first? He doesn't look well". Walking over to the trolley, you see a bangaladeshi foreign worker writhing in pain. He thumps on his back, around the lumbar region, and says, "Many many paining! Many many!". He denies any trauma, but unfortunately he speaks no other English. There are no available translators for the next 20 min. You look up the computer and find no past medical history. What do you do now?

?? onset

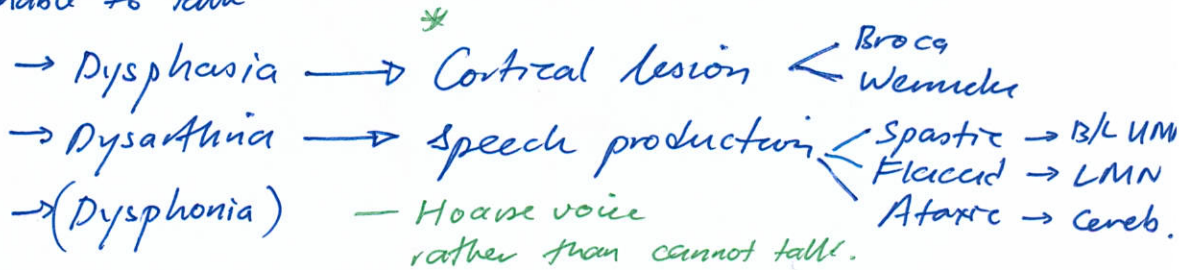
Resus.

PE

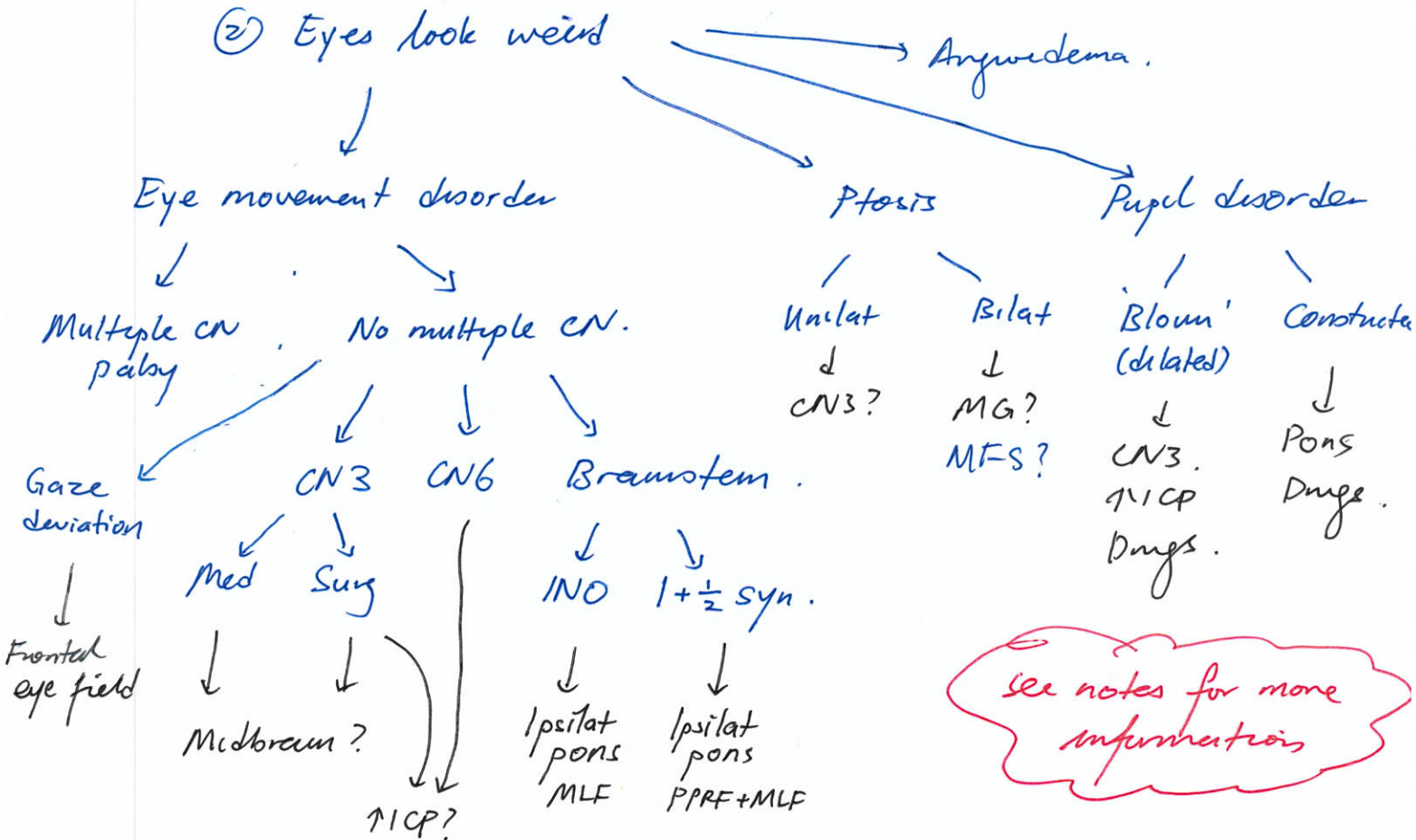


9. An elderly Malay gentleman is brought in by the paramedics. His wife says that he was unable to get out of the bed this morning, and suddenly became unable to talk. The nurse reports that his eyes 'look weird'. What do you do now?

① Unable to talk



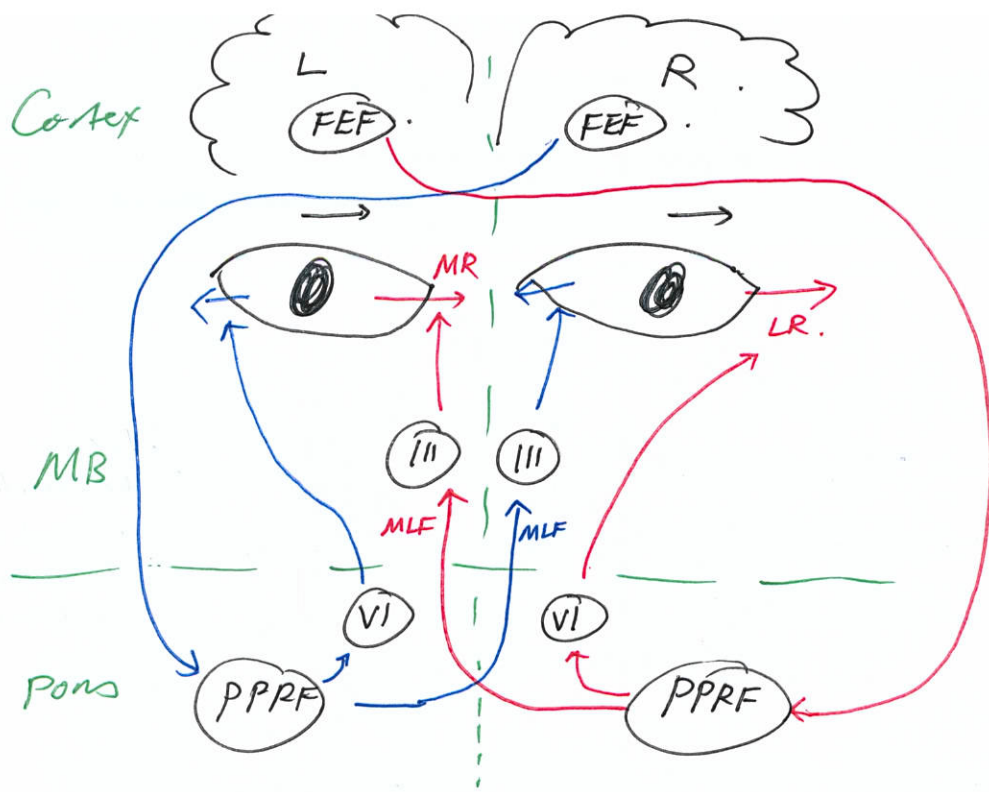
② Eyes look weird



Management

Resuscitate.
 Is this acute stroke?
 Is there ↑ICP?
 Can I thrombolysc?

*Examine!



INO: lesion in ipsilateral MLF — cannot adduct
 — contralateral abduct with nystagmus

$\frac{1}{2}$: lesion MLF + PPRF — no ipsilateral PPRF → cannot look ipsilateral (both eyes)
 — no ipsilateral MLF → cannot adduct to contralateral (the eye)
 ∴ all horizontal eye movements unpaired except contralateral abduction

PART D. Reflection

10. Right now, what goes through your mind when you do a physical exam?

- How has that changed since CSFP?
- Is what you are doing now adequate?
- How do you get to the next level?

All cases . Don't stop at diagnosis .

- > Diagnosis & ddx .
- > Etiology
- > Complications & function
- > Existing management



LEARN HOW TO PRESENT !

- > No use getting everything right if you can't communicate that to the examiner .
- > Only way is to practice examining + presenting without knowing the diagnosis beforehand .
- > Hope this session gives you a jumpstart . My suggestions are not perfect → improve on it & adapt for yourself !

Nyck.
2014. 