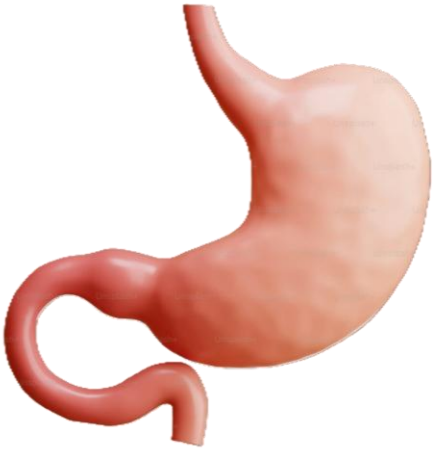
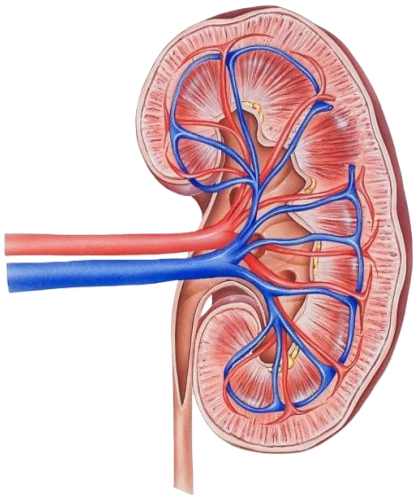
DOPAMINE
SCIENTIFIC TEAM

Final OSCE Checklist

GI & Renal Examination – V1





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COLOR CODE

Black: Comments

Gray: Clarification and Notes

Green: What you ask the patient to do

Blue: Examination Steps

Start-Up:

1. **R**equest a chaperone.
2. **I**ntroduce yourself.
3. Ask for **P**ermission / Ensure **P**rivacy.
4. **E**xplain the examination / Check your **E**quipment.
5. **W**arm and sanitize your hands.
6. Check the **I**nterior (warm, quiet, well-lit room).
7. **P**osition: **Supine (on 15°) with arms parallel to trunk, legs uncrossed, and head resting on 1-2 pillows to relax abdominal muscles.**
8. **E**xposure: **Ideally from Nipple Line to Mid-Thigh (For social reasons: Xiphisternum to Symphysis Pubis).**

General Look:

- Conscious, alert, and oriented to time, place, and person.
- No altered Mental status; Not in pain.
- Not cachectic/malnourished or obese (truncal or general).
- No Jaundice or skin pigmentation.
- No abnormal odors: fetor hepaticus, alcohol, uremia, ketones.
- No late neurological features: spasticity, limb extension, plantar response.

Vital Signs:

- Pulse, BP, RR, Temp, O_2 sat, BMI and waist circumference.

Face:

1. **Eyes:**
   - No Scleral jaundice.
   - No Conjunctival pallor.

2. **Skin**
   - No Parotid swelling (sialadenosis).
   - No Spider nevi.
   - No Rash.
3. **Mouth, throat, and tongue:**
   - No dental carries; No aphthous ulcers.
   - No angular stomatitis; No macroglossia or glossitis.
   - No beefy tongue (folate and vitamin B12 def).
   - No abnormal odors: halitosis, fetor hepaticus, alcohol, uremia, ketones.

Hands:

Inspection:

- No Clubbing, Koilonychia, Leukonychia, or Lindsay's nails.
- No Tar stain.
- No Spider nevi.
- No Muscle wasting.
- No Palmar erythema.
- No Dupuytren's contracture.
- No Needle marks.
- No AV fistula on the arm for dialysis.

Palpation (always maintain eye contact and ask for permission and pain):

- Normal Temperature. Not dry or sweaty.
- No Flapping tremor (hepatic encephalopathy).

Lymph Nodes:

- Examine Left supraclavicular LN (Virchow's node): ***if palpable*** → (+) Troisier's sign in gastric and pancreatic CA; ***otherwise*** → no palpable lymphadenopathy.
- Mention examining axillary, cervical and inguinal LNs.

Anterior Chest:

Examine chest for signs of chronic liver disease, normally:

- No Gynecomastia in men.
- No Breast atrophy in women.
- No Spider nevi.
- No Scratch marks.
- Normal Hair distribution.

Focused Abdominal Examination:

1. Inspection

From the foot of the bed:

- Normal Symmetry; Normal Breathing pattern (abdominothoracic for males).
- Normal contour & shape of the abdomen (flat, scaphoid).
- Umbilicus is inverted, round, and centrally located.
- *Comment on the fullness of the flanks*.

From the right side of the bed (6 S's + 4 V's + 2 others + 2 maneuvers):

- No **S**cars (Mercedes-Benz, Kocher, midline, …).
- No **S**triae.
- No **S**cratch marks.
- No **S**tomata.
- No **S**kin lesions (e.g., hemangiomas, seborrheic/senile warts).
- No **S**pider nevi.
- No **V**isible veins (e.g., caput medusa in portal HTN).
- No **V**isible pulsation.
- No **V**isible peristalsis.
- No **V**isible masses.
- No Bruises (Cullen and Grey turner signs in retroperitoneal bleeding, such as hemorrhagic pancreatitis).
- Normal Hair distribution.

- **Cough impulse:** *Ask the patient to cough* and look for umbilical or inguinal hernias, and Dunphy's sign (sharp pain in RLQ when a patient is asked to cough; in acute appendicitis).
- **Divarication of recti:** *Ask the patient to tilt his head* (يهمّ).

➢ No visible cough impulse; Intact hernial orifices; No Dunphy's sign.
➢ No divarication of recti.

2. Palpation

- Obtain permission, check for pain or tenderness, warm your hands, and maintain eye to eye contact.
- Ask for a chair or kneel down to patient level.

Superficial Palpation:

- Palpate all 9 regions; move row by row.

➢ No tenderness, no superficial masses, soft lax abdomen, no guarding, no rigidity.

Deep Palpation:

- Same locations as superficial but press deeper.
- Check for Sister Mary Joseph's nodules (hard umbilical nodules in metastasis).

➢ No deep masses; No deep tenderness.
(If there is a mass; use SPACESPIT. To differentiate between intraabdominal and abdominal wall masses, *ask the patient to raise their head to tense their abdominal muscles;* intraabdominal masses will disappear, unlike wall masses).

Specific Signs (usually mention only, except for Murphy's sign):

- **Murphy's sign:** *Ask the patient to take a deep breath in*, then gently palpate starting from the RIF moving upward with each breath (see liver palpation technique), evoking pain with the arrest of inspiration (RUQ; acute cholecystitis).
- **Rebound tenderness:** pain when pressure on abdomen is <u>suddenly</u> released (peritonitis; usually mentioned in context of acute appendicitis in RIF).
- **Rovsing's sign:** palpation in LIF produces pain in RIF (acute appendicitis).
- **Obturator sign:** flex the knee and the thigh and internally rotate the thigh (painful response = inflamed pelvic appendix).
- **Iliopsoas sign:** *Ask the patient to flex their thigh against the resistance of your hand*. Alternatively, extend the hip while the patient is lying on their side. (Painful response = inflamed retrocecal appendix.)

3. Percussion

- Percuss over the 9 regions of the abdomen.

➢ Normal tympanic percussion all over the abdomen.

4. Special Organ Tests

Liver:

- **Palpation:** Place the edge of your hand flat on RIF. *Ask the patient to take deep breath from the mouth*. Move your hand up the abdomen (move during expiration; palpate during inspiration) until you reach the costal margin or detect the liver edge. (If liver edge is palpable, describe size, surface, consistency, edge, pulsation, tenderness).
- **Percussion (Liver Span):** *Ask the patient to hold their breath in full expiration*, percuss downwards from the right 2nd ICS to 5th ICS in the MCL, listening for dullness indicating the upper border. Measure the distance from the upper border to the palpable liver edge (normally 8-12 cm). (If the liver edge is not palpable, then percuss starting from the RIF upwards until it becomes dullness).

➢ Liver edge not palpable. Liver span is normal (8-12 cm). No hepatomegaly.

➢ No tenderness and <u>No Murphy's sign.</u>

Spleen:

- **Palpation:** *Ask the patient to take a deep breath*, start from RIF and move diagonally upwards towards left hypochondrium. (If you cannot feel the splenic edge, *ask the patient to roll on their right side* and repeat. Palpate with your right hand, placing your left hand behind the patient's left lower ribs, pulling the ribcage forward).
- **Percussion:** Percuss over the lateral chest wall posterior to the left midaxillary line beneath (9^{th}, 10^{th}, 11^{th} ribs).

➢ Spleen is impalpable, no splenomegaly, no tenderness. Spleen is dull to percussion.

Kidneys:

- **Bimanual exam:** Place your right hand above and the left hand below. *Ask the patient to take a deep breath,* and feel for a palpable kidney on both sides.

- **Balloting technique:** Place your left hand under the patient's back, with your right hand pushing firmly on anterior abdominal wall. Flex your left-hand fingers and check for any "jumping" mass with you right hand, also on both sides.
- **Costovertebral angle:** *Ask the patient to sit up*. With a closed fist (ulnar side), strike gently between the spine and 12th rib, bilaterally. Note any discomfort/pain.

➢ Kidneys are impalpable by bimanual exam but ballotable.

➢ No costovertebral angle tenderness.

Bladder:

- **Percussion:** Percuss over a tympanic area in the upper midline area of the abdomen and then down towards the symphysis pubis. (A change to a dull percussion indicates the upper border of the bladder).

➢ Normal suprapubic dullness (if bladder is empty → tympanic percussion).

Ascites Tests:

- **Shifting dullness (for minor to moderate ascites):** Percuss from the midline (tympanic area) laterally to the flank (dull area). Keep your finger on the site of dullness and *ask the patient to turn on to their opposite side*. Wait for 10-15 seconds, then percuss again (If tympanic, shifting dullness is present).
- **Fluid thrill (for massive ascites):** *Ask the patient to place their hand on the midline of the abdomen*. Place the palm of your left hand flat against the left side and flick a finger of your right hand against the right side. (If you feel a ripple against your left hand, a fluid thrill is present).

➢ Negative shifting dullness; No transmitted thrills.
➢ Mention examining for succussion splash.

5. Auscultation

- Auscultate the following areas using the diaphragm:
    1. **Bowel sounds:** RIF (ileocecal valve), up to 2 mins.
    2. **Aorta bruits:** just above the umbilicus.
    3. **Renal artery bruits:** 2-3 cm (above + lateral) to the umbilicus, bilaterally.
    4. **Liver bruits and friction rubs:** over the liver area.
    5. **Spleen bruits and friction rubs:** over the spleen area.

➢ Normal gurgling bowel sounds every 5-10 seconds, no bruits, no friction rub.

6. Complete the Examination (Just Mention):

Memorize them anatomically, top-to-bottom:

1. JVP.
2. Heart sounds.
3. Lungs for pulmonary edema.
4. Genitalia in males for testicular atrophy.
5. Per rectal exam.
6. Inguinal lymph nodes for hernia.
7. Femoral bruits.
8. Sacral edema.
9. Lower limb for edema, hair loss, and pyoderma gangrenosum.

Changes from Version 0 → Version 1:

1. Abdominal inspection (foot of the bed): added comment for fullness of the flanks
2. Kidney exam: comment “not ballotable” → “ballotable”