

Introduction: RIPE, WIPE

- *Introduce your self & Ask about the patient Name
- *Take a permission
- *Explain to the patient what you will do
- *Chaperone
- *Check the Room Temperature and light ,Ensure privacy
- *Hand hygiene

* Exposure

*Position

General:

- ! Alert, Conscious, Oriented to time, place, & person.
- ! Sitting/lying comfortably , not in distress
- ! Normal posture & gait.
- ! Appropriate body habitus.
- ! Clothing clean and appropriate.
- ! Facial expression calm and appropriate.
- ! Normal breathing ,not tachypneic.
- ! No respiratory distress.
- ! No increased work of breathing.
- ! No abnormal sounds(wheeze,stridor.)
- ! No medical equipment attached.
- ☐ Speech clear.
- ☐ No hoarseness.
- ☐ No abnormal body odor.

Vital Signs:

2 RS: RR & O₂ Sat

2 CVS: HR & BP

Temp, Painscore, BMI

Head examination:

→ Hair:

Normal hairline.

Normal hair distribution.

→ Eyebrows:

Eyebrows are full with no lateral thinning.

→ Eyes:

- No conjunctival pallor.
- No scleral jaundice.
- No exophthalmos.
- No periorbital edema.

→ Mouth:

- Normal palate.
- No cyanosis.
- No mucosal jaundice.

Mouth Odor

- Normal breath odor.

Tongue

- Normal color ,size , no deviation ,no fasciculations , no masses.

→ Face:

- Facial symmetry.
- No facial swelling.
- No plethora.
- No hyperpigmentation.
- No hypopigmentation.
- No facial deformities.

Hand Examination:

Inspection:

Skin

- No hyperpigmentation, No hypopigmentation. ,No tobacco staining.

Tremor & Deviation

- No deviation ,No essential tremor ,No flapping tremor.

Muscle Wasting

- No muscle wasting.
- No thenar, hypothenar wasting.
- No interosseous wasting.

Hand Color

- No pallor.
- No peripheral cyanosis.

Skin Changes

- No coarse skin.
- No tight skin.

Hand Deformities

- No deformities.

Nails

- No nail changes.

palpation:

- Ask permission.
- Ask about pain.
- Assess temperature.
- Assess tenderness.
- Assess capillary refill (<3 sec).

Clubbing

- Schamroth window present.
- Normal hyponychial angle.
- Normal phalangeal depth ratio.
- Assess nail fluctuation.

Neck Examination:

- No scars.
- No neck masses.
- No visible veins.
- Assess JVP, thyroid gland, carotid

Skin Examination:

No jaundice , No hyperpigmentation ,No hypopigmentation, No peripheral cyanosis ,No ulcers ,No visible lumps or masses.

If a Lump is Present (SPACESPIT)

- Size
- Position
- Attachment
- Consistency
- Edge
- Surface & Shape
- Pulsation/Thrills/Bruits
- Inflammation
- Transillumination

Hydration:

No signs of dehydration.

- Moist oral mucous membranes.
- Normal skin turgor.
- No decreased urine output.

Lymph Node Examination:

*Preparation:

Explain examination.

Ask permission.

Ask about pain.

Compare both sides systematically.

Head and Neck lymph nodes:

Anterior group:

- Submental lymph nodes
- Submandibular lymph nodes
- Tonsillar (jugulodigastric) lymph nodes
- Pre-auricular (parotid) lymph nodes
- Deep cervical lymph nodes (upper, middle, and lower)
- Supraclavicular lymph nodes
- Scalene lymph nodes

Posterior group:

- Occipital lymph nodes
- Posterior auricular (mastoid) lymph nodes
- Posterior cervical lymph nodes (upper and lower)

Other lymph node groups examined:

- Axillary lymph nodes → Rt. axillary → with left hand
- Epitrochlear lymph nodes → Rt. epi → with Rt thumb

*Inspection: no mass, no scars, no swelling, no redness, no dilated Vein.
*palpation: No mass, no tenderness, no lymphadenopathy.
Symmetrical bilateral palpation of lymph nodes of head & neck, axillary, epitrochlear regions

General RS physical examination:

introduction & Preparation:

Introduce yourself

patient identity

Ask for permission

Explain the examination

Request a chaperone if needed

Wash your hands or ensure hand hygiene

Ensure privacy, adequate lighting, appropriate temperature

Prepare tools

Position the patient (semi-sitting at 45°)

Ensure appropriate exposure (from umbilicus to neck)

General

- Ensure the patient is alert, conscious, and oriented to time, place, and person
- Observe the patient's posture and general appearance then comment:
Patient is sitting comfortably, not using pursed lips breathing, and not in a tripod position
- Check for any respiratory support or devices then comment there is no:
nebulizers, inhalers, oxygen mask, sputum pot
- Ask the patient to take a deep breath and then exhale then comment:
No audible wheeze or stridor
- Assess the vital signs:
2CVS: (Heart rate, Blood pressure)
2RS: (Respiratory rate, Oxygen saturation)
Temperature, Pain score, Body mass index (BMI)

Inspection:

Inspection of the Face

Eyes 👁️👁️

- Inspect the sclera for jaundice
 - Comment: **No jaundice**
- Inspect the conjunctiva for pallor
 - Comment: **No pallor**
- Assess for Horner's syndrome:
 - No ptosis, No miosis, No anhidrosis
 - Comment: **No features of Horner's syndrome**
- Assess for features of superior vena cava syndrome:
 - No facial swelling, No facial plethora
 - Comment: **No features of superior vena cava syndrome**

The Mouth

- Ask the patient to open their mouth
- Assess oral hygiene
 - Comment: **Good oral hygiene**
- Inspect for oral ulcers
 - Comment: **No oral ulcers**
- Inspect under the tongue for central cyanosis
 - Comment: **No central cyanosis**
- Inspect the lips for peripheral cyanosis
 - Comment: **No peripheral cyanosis**
- Inspect for angular stomatitis
 - Comment: **No angular stomatitis**

Impo: Facial examination reveals no pallor, jaundice, or peripheral cyanosis/ central cyanosis (specifically no blue discoloration of tongue.) Furthermore, no signs of Horner's syndrome (such as ptosis, miosis, or anhidrosis are observed) The face is free from swelling or plethora (indicative of SVC obstruction). Oral assessment shows no angular stomatitis or ulcers, and dental hygiene appears satisfactory."

Inspection of the Neck

Inspect the neck for:

- No dilated veins
- No scars
- No visible subcutaneous masses
- I want to examine the cervical lymph nodes
- I want to examine jugular venous pressure (JVP)

Imp:

Comment: Neck examination reveals no vein engorgements, scars, or visible subcutaneous masses. Lymph nodes are not palpable, and Jugular Venous Pressure (JVP) is not elevated."

Inspection of the Hand

from distal to proximal

- Inspect the dorsum of the hand
 - Comment: **No tar staining**, No yellow nail syndrome, No apparent clubbing, No muscle wasting, No peripheral cyanosis
- Inspect the palmar of the hand
 - Comment:
 - No palmar erythema, No thenar wasting & hypothenar wasting.

Impo

On inspection of the hands, there is no evidence of tar stains, yellow nails, thenar/hypothenar atrophy, peripheral cyanosis, or clubbing. Palmar surfaces show no erythema."

Palpation:

Palpation of the Hand

- **Maintain eye-to-eye contact with the patient throughout the examination**
- Ask for permission to touch the patient
- Ensure hand hygiene
- Ensure your hands are warm
- Compare both hands with each other
- Assess for:
 - Pain
 - Tenderness
 - Muscle wasting
- Palpate for tenderness of the joints:
 - Distal interphalangeal (DIP) joints
 - Proximal interphalangeal (PIP) joints
 - Metacarpophalangeal (MCP) joints
 - Wrist joint
- Assess the hands for:
 - Temperature, Sweating
- Palpate the radial pulse and comment on:
 - Rate, Rhythm, Character
- Assess the respiratory rate:
 - Count for 15 seconds
 - Multiply by 4 to obtain breaths per minute

Imp.

On palpation, the hands are bilaterally warm, dry, and non-tender to touch, including the wrists. Radial pulses are bilaterally symmetrical, regular in rate and rhythm with good character. A normal respiratory rate of (XX) breaths per minute was noted during this assessment

Additional Hand Maneuvers

- **Check capillary refill time (CRT)**
 - Comment: **Normal capillary refill time (within 2–3 seconds)**
- **Check for clubbing (Schamroth's window test)**
- **Check for tremor**
 - **Fine tremor**
 - **Flapping tremor (asterixis)**

Imp

Capillary refill is brisk at less than 2 seconds, Schamroth's window is present, and no fine tremor or asterixis is observed

Noor Marzooq.

Physical Examination Techniques: 1. Inspection 2. Palpation 3. Percussion 4. Auscultation

Respiratory Examination Checklist

General Introduction & Setup:

Introduce yourself

Obtain permission

Ensure privacy, adequate lighting, and comfortable temperature

Confirm chaperone presence (if needed)

Wash hands and put on gloves

Position the patient: semi-sitting at 45 degrees

Ensure adequate exposure: from the neck to the umbilicus

Inspection from the foot of the bed:

*Take a deep breath :

symmetrically bilateral movement of the chest

*Pattern of breath :

thoraco-abdominal/abdominal-thoracic breathing

*Chest is not tachypneic.

*Inspiration/Expiration ratio: Ins>Exp

*Deformities: Kyphoscoliosis ,Pectus carinatum/excavatum,Barrel chest.

*Confirm nipples are in line.

*Shape: normal elliptical shape.

*Accessory Muscles: Sternocleidomastoid muscles,Scalene muscles

*Observe for indrawing.

Inspection reveals symmetrically bilateral thoraco-abdominal chest movement without tachypnea, with the inspiratory phase longer than the expiratory phase. The chest maintains a normal elliptical shape with nipples in line. No apparent kyphoscoliosis, pectus carinatum or excavatum, or barrel chest. There is no use of accessory muscles, (sternocleidomastoids or scalenes) and no indrawing is observed.

✓ Inspection from the Right side of the patient: with axella

Scars (Previous surgeries)

Swelling

Superficial nodules (Metastatic cancer)

Visible dilated veins (SVC)

Hair distribution

inspection of the chest and axilla reveals no scars, swelling, superficial nodules, visible dilated veins, or abnormal hair distribution

Palpation:

Preparation:

Obtain permission,Check for pain,Warm your hands,Maintain eye-to-eye contact (IMPORTANT).

Areas

Apex (always)

Lateral/axilla (always)

Anterior OR posterior chest

!! 90% of the time, the

Palpate:

Superficial mass

superficial tenderness

subcutaneous emphysema.

palpation of the chest, including the apex, lateral/axilla, and anterior/posterior regions, reveals no superficial masses, tenderness, or subcutaneous emphysema

Special maneuvers:

Tracheal deviation:

place your index finger in the suprasternal notch, pointing upwards. Carefully eyeball the distance between your finger and the sternocleidomastoid muscle on both sides to confirm if the trachea is centrally located.

Crico-sternal distance

From the suprasternal notch move your index finger upward until you feel the cricoid cartilage. Place your fingers vertically between the cricoid cartilage and the suprasternal notch (three fingers, or ~ 5 cm)

Tracheal tug

Observe the trachea for any downward tugging movement synchronous with the pulse (can feel carotid pulse)

Chest Expansion

Place your hands on the patient's chest, both anteriorly (at two levels: at level of nipples and below them) and posteriorly (at one level: under scapulae), with thumbs meeting in the midline, and observe the symmetrical outward movement of your thumbs during a deep breath

Tactile Vocal Fremitus

Place the palmar surface of your hand firmly on the patient's chest in symmetrical areas and ask them to repeat "44" assess by asking patient to say "44".

Apex Beat

Use four fingers to generally locate the apex beat, then localize it more precisely with two fingers, noting its character. **The apical pulse is located in the fifth intercostal space**

Right Ventricular Heave

midclavicular line, and its character is gently tapping

Place the heel of your hand vertically (fingers point up) over the lower left sternal border and apex area.

Percussion:

Areas

Apex (always)

Lateral/axilla (always)

Anterior OR posterior chest of

Percuss systematically:

Apices (above clavicle), Clavicle (directly at middle third), Anterior to the 6th rib or posterior to 11th rib

From Axilla to the lateral chest

Bilaterally symmetrical resonant percussion all over the chest.

In
the
neck.

In lung
Area

In the
heart
region.

Auscultation (Use diaphragm; bell if hairy):

Areas

Apex (always)

Lateral/axilla (always)

Anterior OR posterior chest

Listen for:

Air Entry & Breathing Sounds: اطلب من المريض كل مرة ان ياخذ نفس

Bilateral symmetrical good air entry

Bilateral symmetrical vesicular breathing

Expiration longer than inspiration (normally)

Added Sounds:

Crackles, Pneumothorax click, Wheezes, Crepitations, Pleural rub.

On auscultation of all lung fields, including the apices, lateral/axilla, and anterior/posterior chest, there is bilaterally symmetrical good air entry with bilateral symmetrical vesicular breathing, where expiration is longer than inspiration. No added sounds such as crackles, pneumothorax clicks, wheezes, crepitations, or pleural rub are heard.

Special maneuvers:

Vocal Resonance:

Auscultating with diaphragm, ask the patient to repeat "44", confirming symmetrical bilateral vocal resonance.

Whispering Pectoriloquy:

Auscultating with diaphragm, ask the patient to whisper "44", confirming whispering pectoriloquy is absent.

Aegophony:

Auscultating with diaphragm, ask the patient to say "Eee" and listen for a "Ayy" sound; Confirming aegophony is absent.

Concluding Remarks (State that you want to Examine):

Pitting edema in lower limb and sacrum

Deep Vein Thrombosis (DVT) and erythema nodosum

Abdomen to check for hepatosplenomegaly and ascites

NOTE:

If the examiner asks you to examine the posterior chest ONLY, the student must also examine:

The apices

Lateral chest

Apex beat

Right ventricular heave

Tracheal deviation

Cricosternal distance

Tracheal tug

Noor Marzooq.

Lower limb examination (for both arterial and venous diseases)

position: is flat, 45 degrees and Dependent position.

Exposure: whole leg and abdomen.

Inspection

- No Color changes (cyanosis, pallor, redness)
- No Thin, dry, shiny skin
- Normal Hair distribution
- No Muscle wasting
- No swelling (comparison bilateral and the level of swelling)
- No Charcot deformity
- Venous guttering
- Superficial dilated veins
- No Nail changes: Thick, brittle, onychomycosis
- Ulcer

If ulcer is present then comment on :

Site, size, Margin (regular or irregular), Depth, Base of ulcer (Granulation tissue, necrotic tissue, sloughy ..etc.), surrounding skin

- Open between toes to inspect for fungal infections
- Elevate the leg to inspect the heel for ulcers

Palpation Temp & Tender

Preparation:

Wash & hand hygiene / ask about pain/ maintaining eye to eye contact do not forget to compare bilaterally .

- Muscle tenderness (ensure Eye to eye contact, compare same level bilateral each time)
- Temperature (Examine with dorsum of the hand, compare same level bilateral each time)
- Capillary refill: <2 seconds.
- do calf circumference 10 cm below the tibial tuberosity and compare bilateral
- Edema :If edema present, detect if it is pitting or non-pitting and ask to examine JVP
- Pulses

Femoral pulse: mention.

- against femoral head in the mid-inguinal point
- Use the middle and index finger
- Check for Radio-femoral delay
- Auscultate femoral artery using diaphragm of stethoscope to check for femoral bruit.

Impo

Popliteal pulse:

-Knee flexion for 30 degrees

-Both thumbs are on the tibial tuberosity, other fingers are in the popliteal fossa and press (if palpated easily then think of popliteal artery aneurysm)

Should impalpable, if palpable = aneurysm

-Posterior tibial artery:

2cm below and 2 cm behind the medial malleolus using pads of middle three fingers

rate / rythm / volume / character

-Dorsalis pedis pulse:

Pads of three middle fingers lateral to the extensor hallucis longus

rate / rythm / volume / character

Special test:

- Beurger's Test (Indicates PAD):

patient is on supine position

elevate the leg of the patient 45 degrees for 2-3 minutes

watch for pallor and venous guttering

Ask the patient to sit up and hang their legs over the edge of the bed

watch for reactive hyperemia.

-Ankle brachial pressure index (ABPI) *Mention only.*

Needs hand-held doppler and Sphygmomanometer

Normal ABPI > 1

Abnormal ABPI < 0.9

?

DVT Examination

General inspection

-General condition of the patient: stable, breathlessness, pain

-Vital signs

-inspect for DVT risk factors: pregnancy, immobility, bed ridden, Cast, signs of recent trauma/surgery

Leg examination

inspection

While patient is standing:

Skin and color changes

Swelling (compare bilateral, level of swelling)

Venous dilation.

+ previous Inspection

Palpation:

Tenderness (keep eye to eye contact)

Temperature (by dorsum of the hand)

Edema (pitting or non-pitting edema) *check for JVP*

Thyroid examination :

- Introduce yourself +permission
- Privacy
- Environment (Temperature & Lighting)
- Chaperone
- Hand hygiene
- Exposure : neck fully exposed
- Position : sitting upright on chair

General look

- Consciousness , alert & oriented
- No signs of distress or pain
- Expression: Comfortable , not agitated , not anxious, not apathic

Movements :no restlessness, no slow movement

-Clothes are suitable for weather (heat / cold intolerance)
not underdressed or overdressed

-Speech : no pressure , slow speech, no hoarseness *Malignancy*

Comment: The patient is conscious, alert and oriented to time, place and person. appears comfortable, not in distress or pain, with no signs of agitation, anxiety, or apathy. No restlessness or slowing of movements .Not underdressed or overdressed (no signs of heat or cold intolerance). No pressured speech, slowness, or hoarseness.

-Vital signs:

HR: (tachycardia Hyperthyroidism)(Bradycardia Hypothyroidism)

Irregular rhythm → A.fib (Thyrotoxicosis)

BP: diastolic/ systolic HTN

BMI: weight loss or gain

RR, O2sat ,Pain score, Temperature

Face :

- No dry / coarse hair , No hair loss
- No loss of lateral 1/3 of eyebrows
- No dry / sweaty skin

EYES :

- No lid retraction إذا الابيض الي جوا العين كله واضح
- No exophthalmus (Proptosis) بتشوفها من فوق المريض
- No periorbital puffiness
- No conjunctival redness (injection)
- No lid lag



حرك عينيك مع اصبعي مش راسك !!

-Ophthalmoplegia:

Do H =>

no nystagmus ,
ophthalmoplegia
double vision , pain



Testing for ophthalmoplegia

Tongue: (open the mouth and protrude the tongue) 🤔

-Macroglossia

-Lingual thyroid

-Signs of iron deficiency (autoimmune) ➡ Atrophic glossitis

-Vitamin B12 deficiency (autoimmune) ➡ Beefy red

!! Mention only: **Pemberton's sign** (facial congestion)

Neck :

INSPECTION: (Extension) ارفع راسك لفوق

-No scars

-No skin changes

-No masses (SPACE SPIT)

-No thyroid enlargement (goiter , nodule)

-No asymmetry

-Tongue protrusion ➡ no movement (no thyroglossal cyst)

-Swallowing ➡ normally thyroid moves upward

PALPATION : (Flexion) نزل راسك تحت. To relax the SCM

Locatio 📍 : thyroid cartilage ➡ cricoid cartilage ➡ thyroid gland
(4 cm below the superior notch of the thyroid cartilage)

-Preparation: Ask for permission & pain + warm hands + hand hygiene + eye to eye contact

-Palpate thyroid gland : no tenderness, no asymmetry, no palpable mass (SPACE SPIT), no thrills , no hotness.

- Swallow+ protrude his tongue with hands still on thyroid ➡ no masses

- I want to examine the Lymph node ➡ not palpable, no lymphadenopathy (mainly Cervical)

PERCUSSION

-Percuss over manubrium ➡ normal (resonance)

if dullness ➡ retrosternal goiter

AUSCULTATION

- Both lobes ➡ no thyroid bruits (Graves disease)

-Mention : cardiac auscultation exam for mid systolic flow murmurs

Hands :

INSPECTION

Nails 🖐️ 3: No brittle nails, onycholysis, thyroid acropachy (clubbing)

Palm 🖐️ : No sweaty / dry hands, No palmar erythema

No vitiligo For Auto immune diseases

PALPATION : 3T

-Temperature: symmetrical bilateral normal temperature

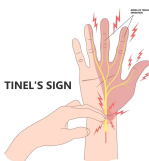
-Fine tremor

-Carpal tunnel syndrome:

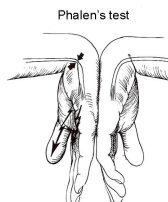
Tinels sign:

Phalens sign:

Thenar muscle wasting



TINEL'S SIGN



Phalen's test

For 10s

في تنميل؟ خدران؟

في تنميل؟ خدران؟
Reverse prayer

Special Maneuvers

- I want to examine Neural Reflexes :(bicep + knee)

delayed relaxation in hypothyroidism

hyperreflexia in hyperthyroidism

-Proximal myopathy ➡ no proximal myopathy (negative) in:
Upper Limb



قاومني

Lower Limb



مقوم
الكروسي

- Inspect lower limb for:

1) pretibial myxoedema (Graves' disease)

2) non pitting edema (ankle swelling in HF)

3)coarse dry skin

Thank the patient

Done by: Noor Marzooq

General GI exam:

Introduce yourself

Permission

Privacy, lighting and temperature

Chaperone

Wash your hands

-Position: Supine position 15 degree ,Arms stretched by his side head resting on 1-2 pillows (to relax abdominal wall muscles).

-Exposure: from the xiphisternum to the symphysis pubis.

-Conscious, alert, oriented to 3

-Not distressed or in pain

overall body -Not cachectic(thin loose skin folds) or obese (truncal, generalized , striae)

-No gynecomastia (in men), breast atrophy (in women)

-No Tachypnea and signs of fluid overload

color - no jaundice

- no abnormal discoloration/pigmentation

- no bruising

- no spider nevi

- no excoriation, pruritis

-No loss of body hair

-No Late neurological features : spasticity, extension of the arms and legs, abnormal movements.

الرائحة - no abnormal Odors: fetor hepaticus, alcohol, uremia, ketones

Vital signs : **IMP**: BMI , BP, HR (tachycardia and hypotension in hypovolemia vs HTN in renal diseases) Renal

Face:

Eye 🧐:

"Jaundice" شرف العين من عروق

شرف العين من تحت

-No yellowish discoloration of sclera , no Conjunctival pallor

Mention: Fundoscopy for HTN and DM changes

-No parotid swelling (sialoadenosis in chronic alcohol misuse)

-No Spider nives up to 5

الإفراط المزمن في شرب الكحول قد يسبب تضخمًا غير التهابي للغدد اللعابية، خاصة الغدة النكفية.

-Rash in inflammatory connective diseases

Mouth, throat and tongue for 🗨️: + يرفع لسانه باستخدام القو الملبس من البريق يعنق

- angular stomatitis (painful/ iron def)

- atrophic glossitis (pale, smooth tongue/ iron def)

- Beefy, raw appearance tongue (folate and vit B12 def)

- aphthous ulcers (celiac and IBD)

With my Nose 🧠 :

No abnormal Smell :**Fetor hepaticus, alcohol, uremia**, melena or ketones.

Hands

-No clubbing (in liver cirrhosis, IBD)

-No koilonychia (spoon shaped)

-No leukonychia (white nails/ in liver disease, celiac, nephrotic)

-No Lindsay's nails (half and half in CKD)

-No Muehrcke's lines in hypoalbuminemia

-No Tar stain

-No palmar erythema

-No spider nevi (in liver disease, may be normally in pregnancy)

-No Dupuytren's contracture (in alcoholic liver disease)

-No muscle wasting

-No Flapping tremor (in hepatic encephalopathy)

-No Needle marks

-No Av fistula on the arm for dialysis → Renal

- Chest (signs of chronic liver disease):

Gynecomastia in men or breast atrophy in women

Spider nives

Scratch marks (Generalized itching)

Hair distribution



Nails

in the palm

Abdominal Examination

Introduction

Introduce yourself

Permission

Privacy, lighting and temperature

Chaperone

Wash your hands

-Position: Supine position 15 degree ,Arms stretched by his side
head resting on 1-2 pillows (to relax abdominal wall muscles).

-Exposure: from the xiphisternum to the symphysis pubis.

Inspection

From the foot of the bed

- ☐ Ask the patient to take a deep breath.

Comment:

- The Abdomen moves symmetrically with inspiration.
- No respiratory distress.
- Abdomen is flat (or slightly scaphoid).
- No abdominal distension.
- Umbilicus is centrally located, rounded and inverted.
- No flank fullness.

From the patient's right side

The 6 S's

1. Scars

Kocher's scar (Cholecystectomy)

Mercedes-Benz incision (Liver transplantation)

Midline laparotomy scar

2. Skin lesions

senile warts

Cherry angiomas (Morgan spots)

3. Scratches

Scratch marks suggesting pruritus (e.g., obstructive jaundice).

4. Striae

Striae (stretch marks).

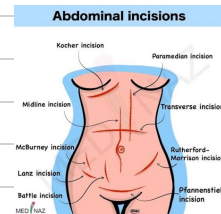
5. Stomas

Ileostomy → Right iliac fossa.

Colostomy → Left side.

Loop stoma → Two openings.

6.No spider nives



Normal hair distribution

The 4 V's

1. Visible masses(hernias)

2. Visible pulsations

3. Visible peristalsis (*Visible peristalsis suggests early intestinal obstruction*).

4.Visible Dilated Veins

Caput medusae → Portal hypertension.

Bruises

Cullen's sign → Periumbilical bruising.

Grey Turner's sign → Flank bruising.

(Both may indicate acute pancreatitis)

Hernia assessment

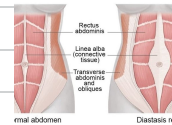
Ask the patient to turn the head away and cough:

- No cough impulse.
- No apparent hernia.
- Dumphy's sign negative.(increased abdominal pain in the right lower quadrant (RLQ) when the patient coughs.)

Divarication of Recti

☐ Ask the patient to lift the head or sit up slightly:

No divarication of recti.



Palpation

- ☐ Maintain eye contact.
- ☐ Ask if there is any abdominal pain.
- ☐ Warm your hands.
- ☐ Ensure hand hygiene.
- ☐ Obtain permission.

!  Chair or Kneel



A. Superficial palpation

☐ Palpate all **nine abdominal regions**.(Gain trust of patient)

Always leave the painful area until last.

- Abdomen is soft and lax.
 - No superficial tenderness.
 - No guarding.
 - No superficial masses.
- (No guarding, No rigidity)

If guarding is present:

☐ Ask the patient to flex the knees or distract them to determine whether the guarding is voluntary or involuntary.

B. Deep palpation :

! Warn the patient that you are going to press deeply and that it may cause some discomfort.

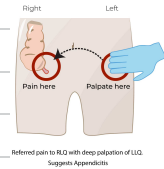
No deep tenderness

No deep masses

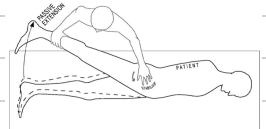
No rebound tenderness (indicates acute peritoneal irritation)

Mention that you want to do (Specific signs)

1. Rovsing's sign: palpation in the left iliac fossa produces pain in the right iliac fossa; in acute appendicitis



2. Iliopsoas sign: painful response when ask the pt to flex their thigh against the resistance of your hand; in inflammatory process.

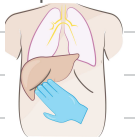


Also, painful response when you extend the hip and knee

3. Obturator sign: painful response you flex the knee and internal rotation of the thigh



4. Murphy's sign: As the patient takes a deep breath in, gently palpate in the right upper quadrant of the abdomen, evoking pain with the arrest of inspiration in acute cholecystitis.



Percussion:

General Percussion for all **nine abdominal regions**

Comment: **Tympanic** resonant note all over the abdomen

Bladder percussion: **يمكن تكليها آخر شئ بعد الصبر شئ لا تسامها!**

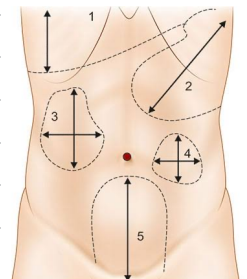
in suprapubic region → dullness

Test for organomegaly :

Liver (Palpation & Percussion)

Spleen (Palpation & Percussion)

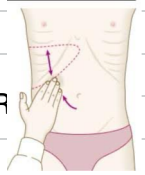
Kidney (Palpation)



Liver

1. Palpation for lower edge:

Take deep breathes by mouth until you reach costal margin from R
can be: **impalpable**



palpable, comment on its size, lower edge (sharp/rounded, regular/irregular), surface (smooth/nodular), consistency (soft/firm/hard), tenderness, pulsatility

2. Percussion for upper edge :

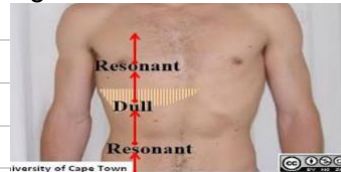
hold breath on full expiration

اطلب مساعدة المريض ان يثبت انفسه على ان يمسك

From: right 5th intercostal space midclavicular line till dull

- If lower edge is **impalpable** → Percussion for lower edge from RIF

- Measure Liver span : Normally (8-12 cm)



Spleen

1. Palpation (take a deep breath) :

diagonally → impalpable



Location of spleen



Hand placement to palpate

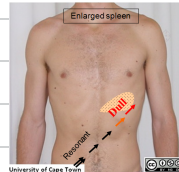


Palpate during deep breath

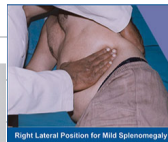
2. Ask patient to roll on side facing you (take a deep breath)

diagonally → impalpable , no splenomegaly , no tenderness

3. Percussion => 9th - 11th rib midaxillary line → dull



University of Cape Town



Right Lateral Position for Mild Splenomegaly

Kidney

1. Bimanual test (take a deep breath)

2. Ballotment

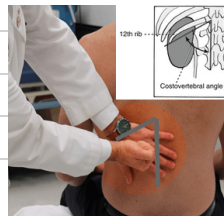
اصفد باليد اليمنى من تحت



Comment: Kidney is impalpable by bimanual

ballotable , no tenderness

4. Renal angle tenderness → no renal angle tenderness



لا تنس تدب المريض + eye to eye or اسأل ان افني الصم

Ascites :

1. shifting dullness:

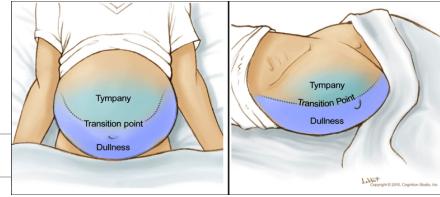
vertical to find dull area (midline tympanic) → **horizontal** (flank dull) → roll to OPP side → percuss again after 10 secs

Comment: negative shifting dullness (dullness didn't become resonant)

2) Transmitted thrill :

ask patient to place his hand in middle then 🙌🙌

Comment: no transmitted thrill



Auscultation:

👂 Bowel sounds (right to umbilicus)

Comment: normal bowel sounds (if absent up to 2mins) or normal gurgling bowel sounds every 5-10 seconds

👂 Abdominal aorta (above umbilicus)

Comment: no bruits

👂 Renal artery (2-3cm above and lateral to the umbilicus)

Comment: no bruits

👂 Liver

👂 Spleen

comment: no bruits, no friction rub



Mention : Succussion splash. (shake patients abdomen by lifting him with both hands under his pelvis (normally within 4hrs from meal))

Further examination:

Inguinal region (lymph nodes+ hernia) , **Femoral** artery (bruits+ hernia) , **Genitalia** (testicular atrophy), Digital **rectal** examination, Back for **sacral** edema

Lower limbs:

Edema , Hair loss, Pyoderma gangrenosum .

Upper limbs:

JVP, Heart sounds, Chest exam for pulmonary edema or pleural effusion

Thank the patient 🤝

Done by: Noor Marzooq

شروع غلطی
اماکن؟

۴P

down

General CNS checklist:

Introduction.....

No specific exposure and position: "Appropriate"

General observation:

-The patient is conscious, alert and oriented to time, place and person **+Not in D or P**

-vital signs

-Level of consciousness (Glasgow coma scale)

-Speech is normal in volume, character, rhythm and fluent, clear.

*اطلب من المريض يحكي (ب ب ب ب) و (ت ت ت ت) و (خيط حرير على حيط خليل)

-comment: normal, lingual, and labial speech.

*اطلب من المريض يعد من 1-30

-Comment: No fatigue (myasthenia gravis)

Say: Ahhh & cough *اطلب من المريض

-comment: no nasal quality of sound and Soft palate elevates symmetrically and uvula in central

Please repeat after me: Today is a sunny *اطلب من المريض يعيد وراك جملة sunny day
day

-Comment: no conduction aphasia

• Ask the patient three stage command
comment: no Wernicke's area encephalopathy or receptive aphasia.

• Show patient a common object to name it
comment: no anomia sensory dysphasia

• Ask the patient to write anything
comment: no agraphia or dysgraphia.

• Give the patient a simple calculation like one plus one
comment: no acalculia.

• Give the patient a word to read it
comment: no alexia or dyslexia.

Final commitment: No dysarthria, no dysphonia, no dysphasia.

Stance and Gait:

Examine stance:

- Ask the patient to stand and extend their hand, while you position yourself on the right side of the patient and be ready to hold them if they fall, with their eyes open

comment: no cerebellar ataxia.

- Then ask the patient to close their eyes

comment: no sensory ataxia (Negative Romberg sign).

Examine the gait:

ask the patient to walk four times:

- First, walk with their normal gait.
- Second, walk on their heels.
- Third, walk on their toes.
- Finally, perform tandem gait.



Comment: normal gait, no foot drop, no hemiplegia, no steppage gait, no chorea, no tremors.

Upper limb examination :

Introduction

Exposure : arms exposed till shoulder

Position: sitting on a couch

* Inspection :

- No deformities
- No muscle wasting or hypertrophy
- No asymmetry
- No abnormal movements (fasciculations, myoclonic jerk, tremor)

* Palpation :

Intro:Ask about pain, warm your hand, hand hygiene, keep eye to eye contact.

- No tenderness
- Normal muscle bulk (No muscle wasting or hypertrophy)
- No masses

DON'T FORGET TO DO EVERYTHING BILATERALLY !!!

* Tone & clonus:

-Preparation: Ask patient to go floppy. ارحي حالك.

Hold as if shaking hand & support the elbow with the other hand,

- Assess **abduction and adduction of the shoulder.**
- Assess **flexion and extension of the elbow.**
- Assess **supination and pronation of the forearm.**
- Assess **flexion and extension of the wrist.**

Comment :normal tone, no hyper or hypotonia, no rigidity/spasticity

(There is no test for clonus in the upper limbs).

*Power + pronator drift:

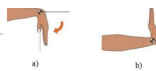
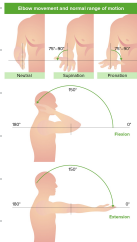
First assess power against gravity: Ask the Pt to raise their arms above their head+ Ask them to play the piano.

-Shoulder : abduction & adduction

- Elbow : flexion & extension

- Wrist : extension

- Fingers : abduction ,Flexion ,Extension



-Thumb: Abduction

-Pronator drift: Patient holds hands outstretched forward, palms up and fingers straight, Eyes closed, wait 10+ seconds to rule out drift.

Comment :normal power 5/5, no pronator drift.

DON'T FORGET TO DO EVERYTHING BILATERALLY ! ! !

*** Reflexes :**

-Bicep (C5) put finger on tendon

-Tricep (C7) directly

-Supinator (C6) on the thumb side of the forearm, about 2 to 3 centimeters (1 inch) above the wrist. To find it, locate the radial styloid process

-Hoffmann (look for abnormal flexion of thumb)

-Finger jerk (C8) on palmar surface of hand, place your index and middle finger on the pts proximal phalanges and with the hammer on them

Comment :increased, normal, diminished, present only with reinforcement, or absent

Positive or Negative Hoffmann's and finger jerks

Sensory examination:

1. Light touch: **بستندم ستي، ناعم زي قطن او فاين، وبديكه كل صاتحس اكيبي**
Patient should close his eyes

Dabbing rather than stroking

shoulder C5, thumb C6, middle finger C7, little finger C8 ,
inner arm T1

2. Pain

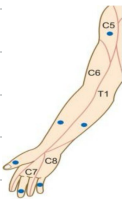
3. Temperature

4. Vibration:

• first demonstrate on sternum

DIP Joint of forefinger, If impaired progress proximally

Patient should close his eyes



عشان بس يعرف المشعور

5. Joint position sensation demonstrate on middle finger with eyes opened then ask the patient to close eyes start examination with the middle finger*3

6. Stereogenesis and graphesthesia:

Patient should close his eyes

Stereognosis :Place a familiar object in his hand and ask him to identify it.

Graphaesthesia: Use the blunt end of a pencil trace letters or digits on the patient's palm and ask him to identify its

7. Point localization and sensory inattention:

Patient should close his eyes

point localization: Touch his arms in turn and ask which side has been touched ,Touch different fingers and ask the patient which is touched .

sensory inattention :Touch both sides simultaneously and ask whether the left, right or both sides were touched.

DON'T FORGET TO DO EVERYTHING BILATERALLY ! ! !

To further finish my examination :

-Examine lower limb

-Examine abdominal reflexes T8-T12

-Examine cremasteric reflex L1, L2

-primitive reflexes (Snout, Grasp, Palm omental, Glabellar tap)

Lower limb examination

Introduction

Position: supine on a couch

Exposure: complete leg exposure, but for social reasons (mid thigh)

* Inspection :

- No deformities
- No muscle wasting or hypertrophy
- No asymmetry
- No abnormal movements (fasciculations, myoclonic jerk, tremor)

* Palpation :

Intro: Ask about pain, warm your hand, hand hygiene, keep eye to eye contact.

- No tenderness
- Normal muscle bulk (No muscle wasting or hypertrophy)
- No masses

DON'T FORGET TO DO EVERYTHING BILATERALLY !!!

* Tone & clonus:

لا تنسى تكميله ارجي !

- Roll the leg + flex knee & leave

Comment: normal tone , no spasticity or rigidity , no hyper or hypotonia

- Clonus (ankle) Sudden passive dorsiflexion with eversion.

Comment :no clonus



*Power + pronator drift:

Ask the patient to do the following movements:

1. Hip extension and flexion
2. Knee flexion and extension
3. Ankle dorsiflexion, plantar flexion, eversion, and inversion.
4. Big toe extension

Ask the patient to do the same thing but resist the movements .

Comment: Power is 5/5 all over four limbs,
No pronator drift in LL

Reflexes :

- Knee jerk L3, 4 (Tap directly on patellar tendon)
- Ankle jerk S1 (Tap directly on Achilles tendon)
- Planter response: blunt object from the heel laterally towards the little finger. The normal response is plantar flexion of the great toe (downward movement).

Comment :increased, normal, diminished, present only with reinforcement, or absent

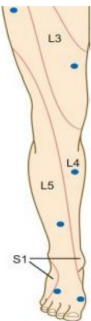
Negative plantar response or if present positive Babinski sign

Sensory examination:

1. Light touch: **بستخدم ستي نا عمري قطن او فاين ، وبديكه كل ماتحس اكيدي**
Patient should close his eyes

Dabbing rather than stroking

- **L1, L2:** Just mention — inguinal region; no examination required.
- **L3:** Thigh.
- **L4:** Medial aspect of the leg.
- **L5:** Lateral aspect of the leg.
- **S1:** Sole of the foot and Achilles tendon.



2. Pain

3. Temperature

4. Vibration:

- first demonstrate on sternum

عشان يبين يعرف الشعور

Big toe Joint of forefinger, If impaired progress proximally

Patient should close his eyes

5. Joint position sensation demonstrate on big toe with eyes opened then ask the patient to close eyes

start examination with the big toe *3

6. Point localization and sensory inattention:

Patient should close his eyes

point localization: Touch his Legs in turn and ask which side has been touched ,Touch different fingers and ask the patient which is touched .

sensory inattention :Touch both sides simultaneously and ask whether the left, right or both sides were touched.

DON'T FORGET TO DO EVERYTHING BILATERALLY ! ! !

To further finish my examination :

-Examine lower limb

-Examine abdominal reflexes T8-T12

-Examine cremasteric reflex L1, L2

-primitive reflexes (Snout, Grasp, Palm omental, Glabellar tap)

Coordination (for cerebellum)

- **Introduction**

- **Exposure and Position**

- Not specifically mentioned.

- **Eye**

- Perform an **H-test** using your finger and ask the patient to follow your finger with their eyes without moving their head.
- Ask the patient if they have **double vision**. شفت الرؤية مضاعفة
- Comment: **No nystagmus, no diplopia.**

- **Speech**

- Ask the patient to say a sentence. المملكة الأردنية الهاشمية.
- Comment: **No dysarthria, no slurred speech.**

- **Hand Examination**

- **Pronator drift:** Ask the patient to extend both arms with their palms facing upward, close their eyes, and wait for **10 seconds** to see if pronation occurs.
- Comment: **Negative pronator drift / no pronator drift.**
- **Rebound phenomenon:** Ask the patient to extend both arms and close their eyes, then lower both arms and observe whether they will return to the same level .
- Comment: **Negative rebound phenomenon.**
- **Rapid alternating movements :** Demonstrate the test to the patient and ask them to perform it.
- Comment: **No dysdiadochokinesia.**
- **Finger-to-nose test:**
- **Comment :no Dysmetria, no intention tremor, dyssynergia.**

Stance and Gait:

Examine stance:

Ask the patient to stand and extend their hand, while you position yourself on the right side of the patient and be ready to hold them if they fall, with their eyes open

comment: no cerebellar ataxia.

Then ask the patient to close their eyes

comment: no sensory ataxia (Negative Romberg sign).

Examine the gait:

ask the patient to walk four times:

First, walk with their normal gait.

Second, walk on their heels.

Third, walk on their toes.

Finally, perform tandem gait.

Comment: Normal star, normal gait, no wide steppage.

- **Upper Limb Tone and Reflexes**

- Ask the patient to lie down on the bed.

- **Upper limb tone and reflexes .**

- Look for **upper limb tone and reflexes**, including the **pendular reflex**.

- **Lower Limb Coordination**

- Perform the **heel-to-shin test** on both lower limbs.

- **Lower limb tone and reflexes**

- **Apraxia**

- Ask the patient to perform a purposeful action, for example, **buttoning their shirt or pretending to drink tea**.

cranial nerves

Olfactory (I) nerve:

-Check nasal passage

Optic nerve (II):

Inspection :

1)Normal position of head

2)eyelids , eyeballs

Periorbital edema , redness, skin changes

Ptosis

Proptosis(protrusion, examine from back by looking from above)

Lid retraction

Lid lag

3)Pupil :

symmetrical bilateral , normal gaze , normal size , in center, No miosis

4)Normal sclera

5)Normal conjunctiva

Palpation:

Palpate around orbital rim and orbit

Comment : No masses, no tenderness

Special test:

1.Visual acuity using Snellen chart (mention)

2.pupils tests:

Direct and consensual Light reflex :

Ask the patient to look at a point in the distance, shine the torch from the temporal side into one eye and look for constriction of the ipsilateral pupil (direct light reflex). Shine the light again at the same eye, but now look at the other eye and look for constriction in it too (consensual reflex). Repeat for the other pupil (so in total you use the torch 4 times 2 for each eye).

Comment: Intact direct and consensual papillary reflex.

أهم خطوة إن الفؤجي على عين واحدة ← temporal!
Don't forget the other side! +

Relative afferent pupillary defect (RAPD)

Move the torch from one eye to another for 3 secs in each eye

Comment : symmetrical constriction of both pupils or No RAPD

Accommodation

المطلب من المريض يطلع على بشي بعيد كحد اصبعك متدام يكونه وخليه يطلع عليه

Comment : normal accommodation + pupillary constriction

3. Visual field :

Set 1m away from the patient

خليه يلبس نظاراته

فخصين بس وصور كيون 2 ممتوحة اما الباقى بالتقارب

Homonymous defect: Both eyes are open

Ask the patient to keep looking straight at your face with both eyes & you do the same. Hold your hands out and move your fingers up and down and bring them in from the periphery towards the center. Always keep your hands in the plane exactly halfway between you and the patient. Ask the patient to point to it when he first sees them. Test the upper quadrants then the lower. (test all 4 quadrants)

كل ماتشوف اصبعي اذكيلي

Comment: No homonymous defect.

Sensory Inattention (both eyes open):

Ask the patient to keep looking straight at your face with both eyes & you do the same. Both you and the patient should keep your eyes open. Hold your hands stretched in halfway between you and the patient, ask him to tell you which side is moving, move the fingers in the right then the left then both.

comment: No sensory inattention.

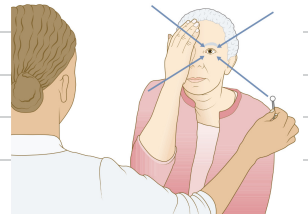
For the following tests each eye will be tested separately (they aren't both open) ! ! !

Peripheral visual field m:

Ask the patient to close or cover one eye and keep looking at your opposite eye; you also close your other eye. (the four quadrants). Hold your other hand out and move your fingers, bring your hand in from the periphery towards the center and keep it halfway between you. Ask the patient to point when he first sees your finger.

Comment: No peripheral visual field defect.

لا تنسى العين الثانية !!



Central visual field:

Repeat the same test using a red hatpin

comment: No central visual field defect.

Color desaturation : من جبب مشي اجر كل مرة يعطى كيف حد اللون مار افتح ؟! اخف ؟

Show the patient the red target and ask them to say what color

comment: No color desaturation.

Blind spot Test :

one eye at a time, Ask the patient to cover one eye and look directly at you, cover your eye that is opposite the patient's covered eye, and tell the patient tell you when the target disappears. Hold a red-tipped target between the patient and yourself at the visual fixation point, move the target temporally until it disappears for you (usually at 15 degrees), then move the target slowly up and down, as well as from side to side.

!! Test the other eye.

Comment: Normal Blind spot

ophthalmoscope to look for optic disc swelling from compression.(mention)

Color blindness using ishihara plate (mention)

oculomotor(III), trochlear (IV), abducent (VI) nerves:

Sit you and the patient 1 meter away, both eyes are open, head not moving

draw a **wide H** shape with your finger

Ask the patient to say if he had diplopia ^{horizontal or vertical}

Look for nystagmus and see if the eye movement is smooth. Examine direct and consensual light reflex.

The other eye !!

Comment: eyes have full range of motion, No nystagmus No diplopia.

اسال اذا شاف روي صماعة

H لازم تكون كبيرة ، مشان تشمل كل حركات العين

Trigeminal (V) nerve

Sensory exam: both sides.

1. light Touch: Ask the patient to close their eyes and say 'yes' each time they feel a light touch (you use a cotton-wool tip for this test). Do this in the areas of V1, V2 and V3.

2. superficial pain. (Mention only)

Comment : Normal ^{not fast} ^{only jaw} sensation in anterior two thirds of the tongue & intact sensation all over the face

Nasal tickle test: not done routinely.

Muscle Exam:

1. Inspect for wasting of the muscles of mastication at temples.

Comment: No muscle wasting of temporalis.

2. Ask the patient to clench their teeth; feel the masseters estimating bulk.

Comment: Good bulk at masseter.

3. Ask the patient to open their jaw and note any deviation, ask the patient to resist your movement and push his jaw up to close.

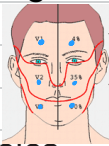
Comment: good power of pterygoids, no jaw deviation.

Corneal reflex (just mention mostly)

Jaw jerk :

Ask the patient to let their mouth hang loosely open. Place your index in the midline between lower lip and chin. Percuss your finger gently with the tendon hammer in a downward direction.

Comment: An absent, or just present, reflex is normal.



Facial (VII) nerve

-**Inspection**: no asymmetry, no difference in blinking, symmetrical closure of the eyes, no involuntary movements

Motor Examination:

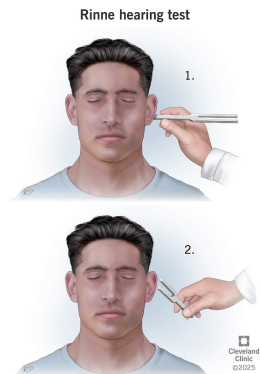
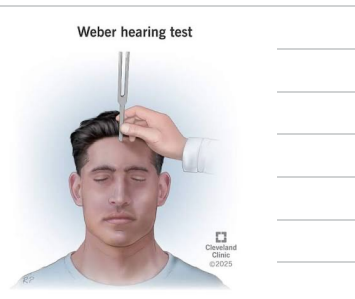
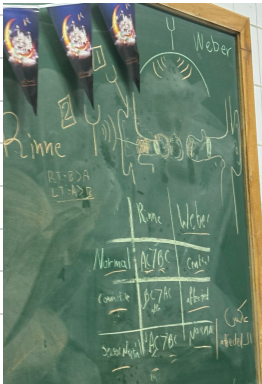
- 1) raise eyebrows (frontalis) => symmetrical wrinkles
- 2) close eyes (orbicularis oculi) tightly shut + resist to open them
- 3) blow cheeks and other mouth closed (buccinator)
- 4) Bare teeth اضحك وبين اسنانك

Comments: Symmetrical face, symmetrical wrinkles, no deviation in angle of mouth, no ptosis, no abnormal movement, mention the muscles and say that they are normal

Mention: taste over the anterior 2/3 of the tongue + corneal reflex

Vestibulocochlear (VIII):

1. Whispering voice test (stand behind the patient, start at 15cm, Mask hearing in the patient's other ear by rubbing the tragus ('masking')). Ask the patient to repeat a combination of multisyllable numbers and words. Start with a normal speaking voice to confirm that the patient understands the test. Then Lower your voice to a clear whisper. => Repeat the test but this time at arm's length from the patient's ear. (People with normal hearing can repeat words whispered at 60 cm.)
2. Rinne's => on mastoid process then in front of ear, ask pt where does he hear it louder normally AC >>> BC
3. Weber => normally sound is equal in both ears



Glossopharyngeal(IX) & Vagus(X) :

-“Ahh” => symmetrical elevation of palate & no uvular deviation

-Cough => assess strength of cough

-Speech المملكة الأردنية الهاشمية => dysphonia , dysarthria

-Puff cheeks with lips tightly closed => no air escaping from the nose
اطلب منا يعجب هوا ٤ هذا ايديك تن nose ٤ air?!

-Mention : gag reflex , swallow test (Administer 3 teaspoons of water and observe for absent swallow, cough or delayed cough, or change in voice quality after each teaspoon. If there are no problems, observe again while the patient swallows a glass of water.)

Accessory nerve (XI):

SCM:

Inspect: no wasting, or hypertrophy.

Palpate: normal muscle bulk.

Turn head side to side then against resistance → **power 5/5 bilaterally.**

Neck flexion then against resistance by palm → **power 5/5.**

Trapezius:

Inspect from behind: no wasting or asymmetry.

Palpate: normal muscle bulk.

Shoulder shrug then against resistance → **power 5/5**

Hypoglossal nerve (XII) :

Ask patient to open mouth and inspect the tongue 🗑️:

No wasting , fasciculations , involuntary movements

Put the tongue out:

No deviation and involuntary movements

Move tongue right & left زغرت 😊

Press tongue against inner aspect of the mouth,

حاوله امسكه عليهما من برا

normal power (5/5)

Speech “ yellow lorry” => normal labial sounds

Mention: assess swallowing by water swallow test

Done by: Noor Marzooq

اللهم إِنَّا نَسْأَلُكَ أَنْ تَرْحَمَ عَبْدَكَ عَمْرَ عَطِيَّةَ الْمَرَابِيِّ رَحْمَةً وَاسِعَةً، وَأَنْ تَجْعَلَ هَذَا
الْعَمَلَ صَدَقَةً جَارِيَةً فِي مِيزَانِ حَسَنَاتِهِ.
اللهم اغفر له وارفع درجاته في المهديين، ونور قبره، واجعله روضةً من رياض
الجنة، وافتح له بابًا من أبواب رحمتك ورضوانك.
اللهم اجزه عن الإحسان إحسانًا، وعن الخير خيرًا، واجمعه بمن يحب في جنات
النعيم، واجعل ذكره الطيبة وأثره المبارك نورًا لا ينقطع.