Observed History Taking

Contents

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In my opinion

Common presentations
Examines
- ability to rule out / consider sinister diagnoses that can present in this manner
- triage patients for further evaluation
- identify patients concerns and address those appropriately
- decision making, F/U planning

1. **INTRODUCTION, RAPPORT, CONSENT**
   Good morning. Im Dr Harsha. Would you mind if I ask you a few questions and discuss? Is this time convenient for you? Do you want someone to accompany?
   Great thanks. Are you Mrs ….. ? and how old are you? Where are you from? Do you work? How would you prefer me to call you?

2. **PRESENTING COMPLAINT, DURATION, OPEN QUESTION – TIME LINE**
   Mr X, can you tell me what brings you here today? / can you tell me about your problem? Is there anything else you want to discuss?
   Great thanks, can you tell me more about your cough / fever etc…?
   Pain severity score

3. **DIFFERENTIAL ALGORHYTHM, AETIOLOGY, COMPLICATIONS, Rx SO FAR**

4. **COMPLETE HISTORY – PMH, PSH, DRUGS, ALLERGY, REPRODUCTIVE, FH, SH**
   Now that I have understood your current problem, I need know about your health in the past?
   To help you best, I would ask a few more question about. Do you smoke? How about alcohol? [CAGE] Have you ever consumed any recreational substances? Did you ever consider quitting?
   If you won't mind me asking, could you tell me whether you are sexually active? Any difficulties you've encountered? Have you had any other partners, male or female?
   Recent change in weight? Are you happy about your current weight?
   Rash
   Sleep, Headache, Numbness, weakness, vision, hearing
   Cough, SOB, CP, syncope
   Swallowing, vomiting, abd pain, BO, UOP, Swelling
   Joint pains
   Weight, appetite, skin colour, fever

5. **IMPACT, IDEAS, CONCERNS, EXPECTATIONS**
   How has this affected your day to day life? And your work? How have you being coping up with this?
   What worries you most?
   What do you think is the reason for this illness?
   Did you ever think it has any link to …. Smoking?

6. **SUMMARIZE AND PLAN – Ex, Ix, Rx, R.V**
   Thank you very much Mr X. let me briefly summarize. Tell me if Im wrong or anything I ve missed.
   Is there anything else you think I should know, or you want to discuss?
   Thanks a lot

Dyspnea –

heart, lung (OAWD, CA/collapse, ILD, pul edema- renal/cardiac, PHT, PE, pneumonia, pleural), acidosis, anemia

heart – ex SOB, orthopnea, PND, CP, palpiation, edema, IHD, CMpathy (PHx, FHx, syncope - AS), RhF
lung – wheezing (atopy, exposures), cough, sputum, hemoptysis, chest pain, fever, stepwise, LoA, LOW, hoarse voice, progression, CTD
- OAWD
  - Asthma
  - COPD
  - Bronchiectasis
- ILD – CTD, HP, sarcoid, HIV
- PHT – CTEPH (APLS), CTD, CHD, PPHTN, syncope

renal – UOP,
anemia – bleeding, J
muscle - MG

exposure Hx
smoking
occupational fumes
brids, farms, animals cats, dogs
drugs

Cough

– cancer (hemoptysis, B symptoms, voice change), TB, ILD, PND, other infection, bronchiectasis, COPD, HF
GORD, cough variant asthma
ILD – HP – occupational exposures, smoking,

Hemoptysis -

Cancer
Tb
Bronchiectasis
Mycetoma
PE
Pneumonia
Coagulopathy / anticoagulants

Palpitations –

IHD, SSS, SVT, paroxysmal AF, structural, arrhythmia
hTh, pheo, anxiety, hypoglycemia

tap out the feeling – regular or irregular
aetiology
Hx of ex angina, RhHD, CHD,
HTh Sy (neck swelling, obstructive Sy, eye pain, fingers change, shin rash,), pheo triad (headache, palpitation, sweating), hypoglycemia (early morning, middle of the night, relieved with meals drugs, insulin, weight gain, CAM, Addison, CLCD, CKD, cancer)
Events ppt palpitations – anxiety etc

Complications
Ex intolerance, presyncope, syncope, falls, injuries, strokes / TIAs, ALI, HF (SOB, orthopnea)

What has been done so far
Rx, CAM

PMH – DM, HTN, DL
PSH
D & A
FHx –
SHx – alcohol, caffeine, smoking, recreational

What do you think is wrong with you?
What would have caused it?
What concerns you most about this illness?
Anthing else you think I should know or discuss?

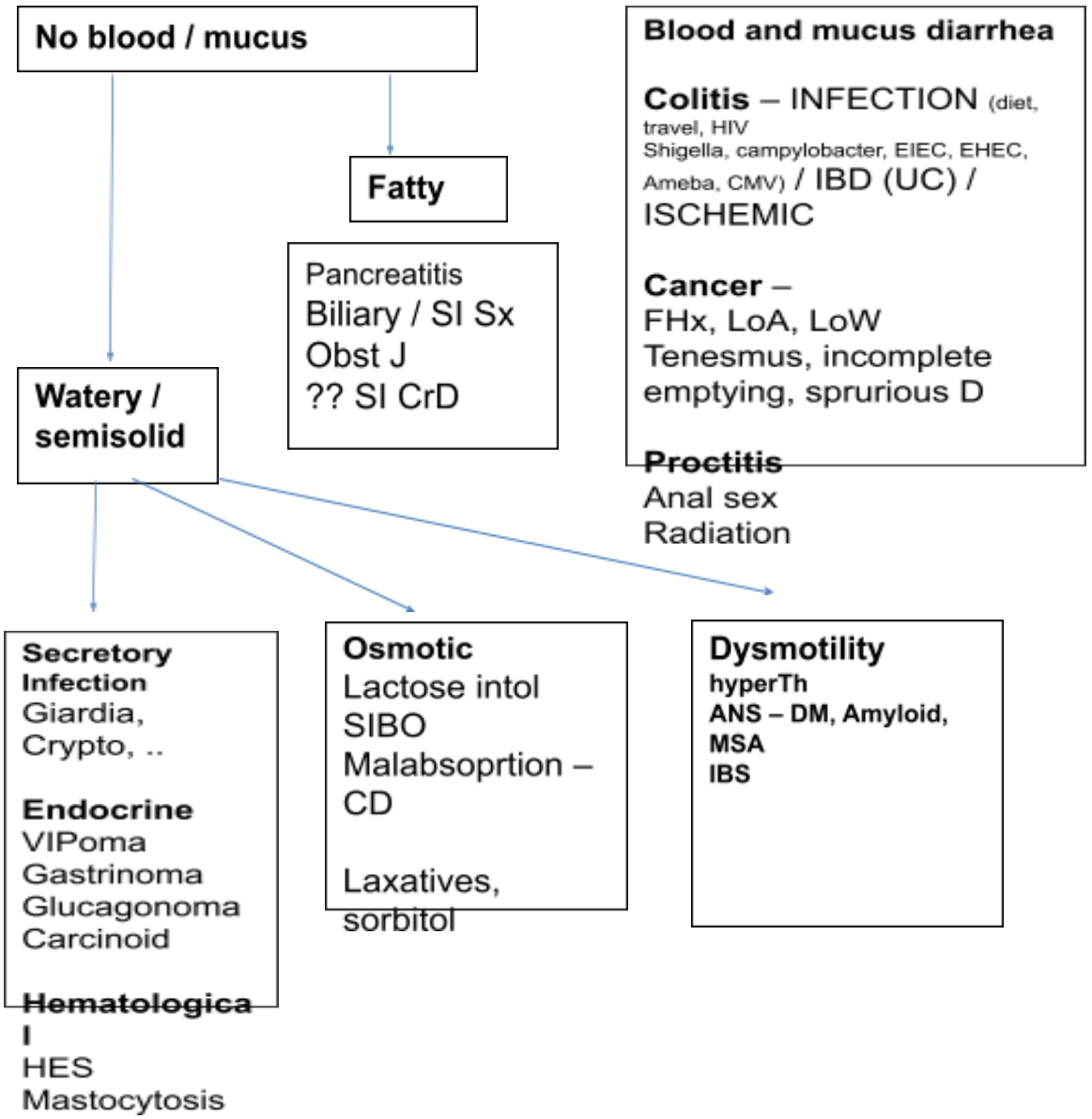
Let me recap. Correct me if im wrong or add if I have missed anything

Diarrhea

Hx
Ascertain true diarrhea (not incontinence)
Consider IBS and Drugs

Key questions
1. Frequency
2. Volume
3. Consistency
4. Blood, mucus, water, semisolid
5. Nocturnal (secretory, dysmotility, inflammatory)
6. Weight loss, malabsorption
7. Incontinence

Diagnostic algorhythm



Aetiology

Go through the algorhythm

Complications

Dehydration
Malabsportion – anemia, KADE

General Hx

PMH – DM
PSH – abdominal Sx
Drugs – laxatives, metformin,
FHx – IBD, CRCA, endocrine surgeries
Reproductive
SHx

Alcohol – causes diarrhea, chr pancreatitis
Smoking – exacerbates CrD, RF for CRCA
Job
Diet
HIV risk – BT, Tattoo, IVDA, unprotected sex

Ideas, concerns, expectations

Summarize

Plan Ex, Ix, Rx, R/V

Visual loss / disturbance–

Onset, progression, duration, fluctuation
One eye Vs one side
Eye
Retina
ON
Chiasma
Temporal lobe
Parietal lobe
Occipital lobe
Migraine, epilepsy

Visual disturbances
Aura – migraine, epilepsy (posterior – non formed, temporal - formed), tumor, infection (abscess, TBoma), TIA / amourosis fugax, hypoglycemia,
Eye – pain, redness, symptoms limited one eye, visual acuity
Retina – CRAO / CRVO - RD – floaters, DM
ON – pain on movement (MS – PHx, cerebellar Sy, hiccups/vomiting, limb weakness), GCA Hx (temporal headache, jaw claudication), amourosis (curtain),

SINISTER HEADACHE (worse mane, vomiting relieves, LSCS)
Optic pathway – pituitary, hormonal Sy (galactorrhea,)
Lobes – field loss, temporal Sy (smells, memory aura – de ja vu), parietal symptoms (hemisensory loss, calculation, writing difficulties), occipital (non formed visual hallucinations)
Primary tumor
2ry tumor – B symptoms, breast lumps, cough hemoptysis, altered bowel habits
Migraine aura – classical headache

Limb weakness

DD
- Stroke
- TIA
- Hemorrhage
- Tumor
- MS
- Metabolic – hypoglycemia
- Migraine
- Cardiac - Arrhythmia, ischemia

Vertigo

- True vertigo
- Peripheral – hearing, tinnitus, pain, fullness, discharge
- Central – bulbar, ocular, limb – sensory/motor symptoms

- DD – BPPV, Meniere's, CP angle tumor, brainstem – infarct, demyelination, tumor

Ear – hearing, tinnitus, pain, fullness, dsicharge
VIII – facial numbness, mouth deviating to side, closing eye
Brainstem – stroke (atherosclerosis, dissection, vasculitis, mimics), TIA, tumor, MS, vertiginous migraine
Cerebellar symptoms – slurring, ataxia

Constitutional symptoms / weight loss

Hx –
Ascertain weight loss, duration and significance. Identify other associated symptoms
Voluntary or involuntary

DDx
Voluntary – diet and physical activity
With normal appetite
1. DM – osmotic Sy, sugar checks
2. Hyperthyroidism – palpitations, heat intolerance, diarrhea
3. Pheochromocytoma – episodic triad
4. Malabsorption – diarrhea (CeD. CrD, Sprue, Giardia, Whipple, Cryptosporidiosis, pnacreatitis - steatorrhea)
5. Dysphagia

With loss of appetite
1. Cancer
    a. GI cancer – stomach, colon
    b. Hemat cancer – BMF, hyperviscosity, bone pain, backache
    c. Other cancer – hemoptysis/smoker, hematuria, breast lumps
2. Organ failure

    a. Heart
    b. Renal
    c. Liver
    d. Respiratory
3. Chronic infection
    a. TB
    b. HIV – contact Hx, BT, tattoos
    c. Endocarditis, osteomyelitis – poorly healing wounds,
    d. Fungal
4. Chronic inflammation
    a. AI: RA, SLE, vasculitis (GCA, PAN)
5. Psychiatric
    a. Depression
    b. Dementia
    c. Anorexia nervosa

Aetiology

Go through the DD
Diet history
Drug Hx –
Reduce appetite - metformin, SSRI, theophylline, digoxin, levodopa, GLP1 agonists -
Illicits – cocaine, amphetamine

Complications

Macronutrient deficiency – edema, wasting
Micronutrient deficiency – anemia, easy bruising, bone pain / #, night blindness

Treatment so far and progress

Ideas, concerns, expectations

General Hx

PMHx, PSHx, Drugs allergies
SHx – alcohol, smoking,

Ex – complete systemic and general

Ix plan

ESR, CRP
FBC, organ functions, CXR, USS abdomen
Nutritional status-
Electrolytes –

Rx plan

Exclude sepsis
Enteral feeding – thiamine first up to prevent Wernickes
Monitor K Mg P to detect refeeding Xd early and correct

Anemia

Anemic Sy
WBC – rec infection
Plt – bruising

Fe / Bleeding, B12 (vegan, GI Sx, RIF pain, chronic diarrhea), FA
Epo – CKD
Hypothyroidism

Marrow failure – cancer, infection, chemical, drugs, AA, PRCA

Destruction –
- HA – inherited, non immune (PNH), Autoimmune (SLE, CLL, lymphoma), drugs
- Hypersplenism

Polyuria / polydipsia

Polyuria Vs frequency
Onset duration
Thirst

DM DI Diuretics Ca Coffee

DM
Coffee
Diuretics
hyperCa
- abd pain, constipation, renal stones, pancreatitis, PUD, depression
- hyperPTH – FHx of renal stones / neck surgeries, hyperCa (FHH), Lithium
- cancer / myeloma – bone pain, backache, peripheral neuropathy, breast lumps, hemoptysis
  - (malignancy Fx are obvious when hyperCa is detected)
- Milk alkali, HCT, vitamin D, thyrotoxicosis, addisons, sarcoidosis

DI
- psychogenic
- dipsogenic – hypothalamic disease
  - sarcoid – cough, lupus pernio
  - WG – epistaxis, nasal block, cough, hematuria
  - Tumor mets – breast lump, cough hemoptysis, BO, B symptoms
  - TB
  - Neurosurgery, radiation
- Pituitary tumor Fx – visual loss, headache, galactorrhea

Barter

Fatigue

50y old male executive coming with fatigue for 8 months
Work stress, overworked, drained, have had enough, increased alcohol, working overnight, trying for a promotion, Over eating, static weight
Headache, worse mane, snoring
Yesterday accident – didn't see the three wheeler coming from a cross road
Poor libido, not shaving as usual, ED +
Something is seriously wrong. Brother committed suicide. Will it happen to me?

Causes
Organ dysfunction
- Cardiac failure – Ex SOB, edema, orthopnea
  - SSS – exercise intolerance
- Lung, liver, CKD

Endocrine
- Addison – postural dizziness
- Hypothyroidism – cold intolerance, constipation, weight gain
- Hypopit – hypothyroid, hypocortisolism, headache
- Menopause – hot flushes, dry vagina, dyspareunia

Depression – low mood, anhedonia, lack of energy, guilt, e?, suicide, sleep poor, appetite loss, concentration, hopelessness
Myopathy
Hypokalaemia – diuretics, polyuria
PBC – itching
OSA/OHS – snoring, sleepiness

DD
Pit tumor with hypopituitarism
Depression

1. Vomiting
2. Haematemesis
3. Hirsuitism
4. Easy bruising

Edema

Duration
Extent – legs, scrotum, abdomen, peri-orbital
Diurnal – more vesper : dependent

Hydrostatic pressure
- **CCF, RHF, IVCO, CKD**

Oncotic pressure
- **Nephrotic, CLCD, PLE, malabsorption**

Vessel permeabilty
- **CCB**

Lymph pressure
- **Lymphedema**
- **Hypothyroidism**

PUO

Describe the fever
- Measurement
- Intermittent, remittent, persistent, relapsing
- Chills rigors, LoA LoW night sweats
- PDCs

Fever pattern
Pel ebstein

Look for a clinical focus

RS - Cough, sputum, dyspnea, hemoptysis
CVS - Palpitation, chest pain, syncope, recent tooth extraction, PHx of heart disease
GI - Dysphagia, vomiting, abdominal pain, diarrhea, constipation, bleeding per rectum
Yellow eyes, itching, pale stools
GU - Dysuria, frequency, loin pain, LUTS, hematuria, per urethral bleeding, PV bleeding
MSK - Backache, joint pains, joint swelling
Skin - Skin rash, lumps, oral ulcers, tooth ache
Hemat- Bleeding, bruising, recurrent infections, neck lumps, groin lumps, axillary lumps
CNS - Headache (TBM, typhoid), FNS

Fever without an obvious clinical focus

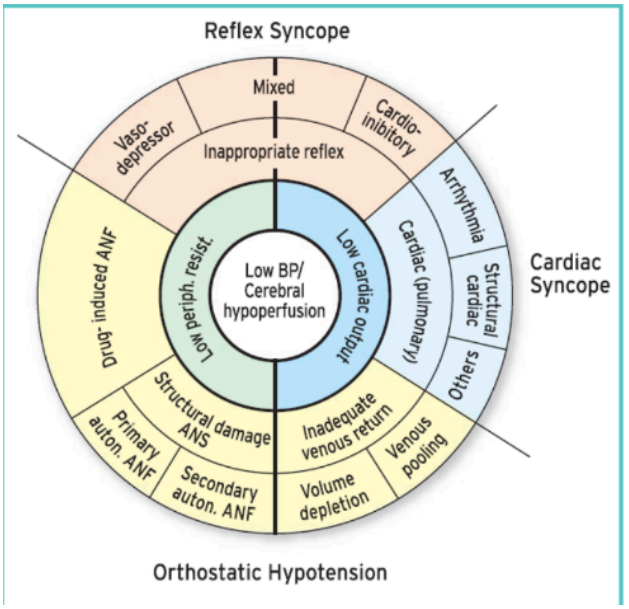
Infection – TB, HIV, IE, malaria, typhoid, abscess (tooth, lung, peritoneal, pelvic, prostate)
Cancer – HL, CML, HCCA, RCCA, lung
CTD – SLE, AOSD, GCA, PAN, AAV, sarcoidosis
Thyrotoxicosis
Drugs

Travel – departure, arrival, stay, meals (street food, sick contact), recreational (forest, bathing, water rafting), sex, health of co-travellers

TLOC

trauma,
TIA,
hypoglycemia,
seizure,
syncope – reflex, cardiac (arrhythmic, structural, PHTN), orthostatic hypotension (ANS, hypovolemia/Addison, drugs)
psychogenic

Syncope
- Cardiac
  - Arrhythmia
  - Structural – AS, HOCM
  - PHTN
- Reflex ppt □ pallor □ sweating □ nausea
  - VVS
  - CSS
  - Situational
- Orthostatic
  - ANS – primary ANS failure (DM, amyloid, MSA, PD)
  - Hypovolemic – vomiting, diarrhea, sweating
  - Drugs – antihypertensives, ?antidepressants, diuretics
  - POTS



Posterior circulation TIA
- Vertebral artery dissection, atherosclerosis, embolism (IE, cardiac thrombus)

Seizure
- Epilepsy
- Mass – tumor, bleed, abscess
- Encephalitis – infection, AI
- Encephalopathy – uremia, HTN, CLCD, electrolytes (Na, Ca, Mg, P, Glc), toxin (alcohol, overdose)

NEAD

Hypoglycemia
- Insulin (overdose, lipohypertrophy) / drugs, meals, exercise
- CAM
- CKD (impaired insulin excretion, low glcneogenesis), CLCD, Addison

Insulinoma, mesenchymal tumors, dumping
Recognize – Whipple triad, hypoglycemia unawareness (NSBB >> B1 blockers), ANS neuropathy, hypos in sleep, majors (fits, LOC, needing others help), risks (driving, swimming, machines)

Reflex syncope
- Long history of recurrent syncope, in particular occurring before the age of 40 years
- After unpleasant sight, sound, smell, or pain
- Prolonged standing
- During meal
- Being in crowded and/or hot places
- Autonomic activation before syncope: pallor, sweating, and/or nausea/vomiting
- With head rotation or pressure on carotid sinus (as in tumours, shaving, tight collars)
- Absence of heart disease

Syncope due to OH
- While or after standing
- Prolonged standing
- Standing after exertion
- Post-prandial hypotension
- Temporal relationship with start or changes of dosage of vasodepressive drugs or diuretics leading to hypotension
- Presence of autonomic neuropathy or parkinsonism

DD

Absence / complex partial	intact posture
Cataplexy –	sudden paralysis (REM sleep) ppt by emotions. No LOC, but may go in to sleep. After waking up, no amnesia of the event.
Post circ TIA	FNS
SAH	headache
Subclavian steal	
Metabolic	longer duration. Altered consciousness than LOC

Chest pain

ACS
Myocarditis
AD – abrupt. Tearing, interscapular radiation
PE / PHTN
Pn thorax
Pericarditis – plerutic, worse with breathing movements, reduce with leaning forward, radiate to trapezius muscles
Esophageal spasm

MSK – localized, worse with movement, preceding weight lifting (pec mjr)
Pneumonia
Zoster
Radiculopathy

Hematuria

Red eye

Dysphagia

Dysphagia vs odynophagia
Duration
Persistent vs intermittent vs worsening
Solid vs liquid

Pharynx
- Bulbar palsy –
  - BS tumor
  - Stroke
  - Cancer mets
  - MS
  - MG
- Pseudobulbar palsy
- Pharyngeal pouch

Esophageal
- Cancer – progressive
- Stricture (solid)
  - GORD
  - Caustic injury
- Dysmotility (liquids)
  - Scleroderma
  - DES
  - Achalasia (solids and liquids)
- Esophagitis
  - Alendronate, NSAIDs
  - E- esophagitis
  - Candida

Complications – aspirations, nocturnal cough

Numbness of feet

Diagnosis
Onset, duration, symmetry, progression, sensory – pain, JPS, motor
ANS, upper limbs, swallowing, speech, higher functions, vision, hearing

Aetiology
Common
- Alcohol
- B12
- Cancer, paraproteinaemia, CIDP
- DM
- ESKD
- Familial

druGs – INAH, metronidazole, metformin / B12, dapsone, lead
Hypothyroidism
Infections – leprosy, HIV

Complications
Falls
Ulcers
Pain – sleep

What has been done

What can be done
Prevent falls risk
Relieve pain
Retard progression

Summarize

Plan – Ex, Ix, review, Rx

Neck pain

Backache

HPC – onset, duration

DD

Sinister

Cancer / MM	localizing Symptoms, LoA, LoW, night sweats
Fracture	acute onset, preceding trauma
TB / abscess	fever, constitutional Sy
Inflammatory	morning stiffness, enthesitis, red eyes
Cord compression	

Benign

Posture – occupation, bed, travel, back pack, weight lifting
Disc prolapse , sciatica
Pagets disease
Unusual causes – pancreatitis!, AAA, RCCA

PMHx, PSHx, Drugs, Allergy, FHx (SpA), SHx (alcohol, smoking, job)
Impact, concerns, expectations

Summary

Plan for
Examination, analgesia, MRI

LS spine X ray : limited utility – mets, fracture of vertebrae, spodylolisthesis

5. Nasal symptoms

Dyspepsia

History **duration, SOCRATES**

Dx / DDx

1.	Stomach LoA	burning, relation to meals, GORD, hematemesis, melena, dysphagia, LoW,
2.	Pancreas	radiation to back, reduced by leaning fwd, worse after meals, jaundice
3.	Gallbladder	colics, radiation to inf scapula / shoulder tip, jaundice
4.	Transverse colon	bleeding PR, relieved with defecation, lower abdominal pain
5.	Heart	exertional symptoms
6.	Lung	cough, fever
7.	*Ovary*	*abdominal distension*
8.	*Aorta / arteries*	*worse after meals (mes ischemia), LL claudication*

* post prandial pain – PUD, pancreatitis, Gallbladder disease, mesenteric angina

Aetiology

PUD	NSAIDs, steroids, CAMs, alcohol, smoking, meal pattern (hyperCa Fx)
Cancer	LoW, LoA, FHx of GI cancer (FAP, HNPCC, PJS)

Complications

PUD	GI bleeding – anemia
Pancreatitis	DM, malabsorption, steatorrhea

Treatment, compliance and control

Ideas, Concerns, Expectations

General History
PMHx, PSHx, Drugs, Allergies
SHx – smoking, alcohol, job, family background, impact on ADL

Ex plan
Pallor, Jaundice, LN, edema
Abdomen – mass (GB), tenderness, FF
Lungs – pneumonia
Cardiac – BP, murmurs (AS)

Ix plan
FBC
H pylori testing
USS Abd – GB, pancreas, ovary, AAA
UGIE (In : > 55y, red flags for CA, non response to Rx)

Rx plan
PPI x 4m trial
H pylori eradication if +ve
Simple measures
- Avoid NSAIDs, spicy meals, alcohol, smoking, caffeine, other ppt foods
- Avoid tight garments over tummy
- Avoid late night meals
- Tilt head end up
- Advice on compliance – PPI before meals?, domperidone if GORD +

Abdominal distension

Ascites
Stools – constipation
Tumor – ovarian, organomegaly, PCKD, pancreatic pseudocyst, HSM, LN
Pregnancy

Ascites

High hydrostatic P = PHTN
- PVT + CLCD
- CLCD – alcohol, NASH, CAM, AIH, Familial
- Pre hepatic – BCXd (Tphilia) RHF (CHD, PHTN) Constrictive pericarditis (radiation, TB)

Low oncotic pressure
- CLCD
- Nephrotic
- PLE / malabsorption

Serosal inflammation
- Cancer mets
- TB
- Pancreatitis
- SLE

High tissue / lymphatic pressure
- Lymphoma, lymphangiectasia
- Hypothyroid

Short stature

Recurrent infections

Sinu pulmonary

Jaundice

HPC

Duration, listen to the evolution of disease – progressive / fluctuating / recurrent
Obstructive symptoms
Pain
LoA, LoW, fever
Drugs
HAV, HBV R/F – food habits / BT, tattoo, IVDA, needle sticks, unsafe sex

DDx

Obstructive? Pale stools, dark urine, itching

Cholestatic

With pain
Gallstones, Biliary stricture
Cholestatic hepatitis – WD, drugs
Budd chiari – DVT, OCP, PRV, FHx
Without pain
Cirrhosis – edema, UGIB, alcohol, HBV, FHx
Drugs, PBC, PSC (IBD Hx)
With LoW ± pain
HCCA, mets, panc head CA
With fever
Cholangitis, lepto

Hepatitic

With pain
Hepatitis- viral, alcohol, toxic (RHC pain, LoA, N, V, dirty meals, fever, BT, needle sticks, sexual contact, PHx, Drugs, CAM), WD, AIH
Without pain
Hemolytic anemia (Anemic Sy, PHx or FHx of blood dis, SLE Fx, drugs, lymphoma)
Gilbert Xd

Complications

Liver failure – bleeding, confusion
Cirrhosis – UGI bleeding, ascites, encephalopathy, hypoglycemia
Fat malabsorption – Steatorrhea, Easy bruising, bone/muscle pain /#, Night blindness
Bile salt diarrhea

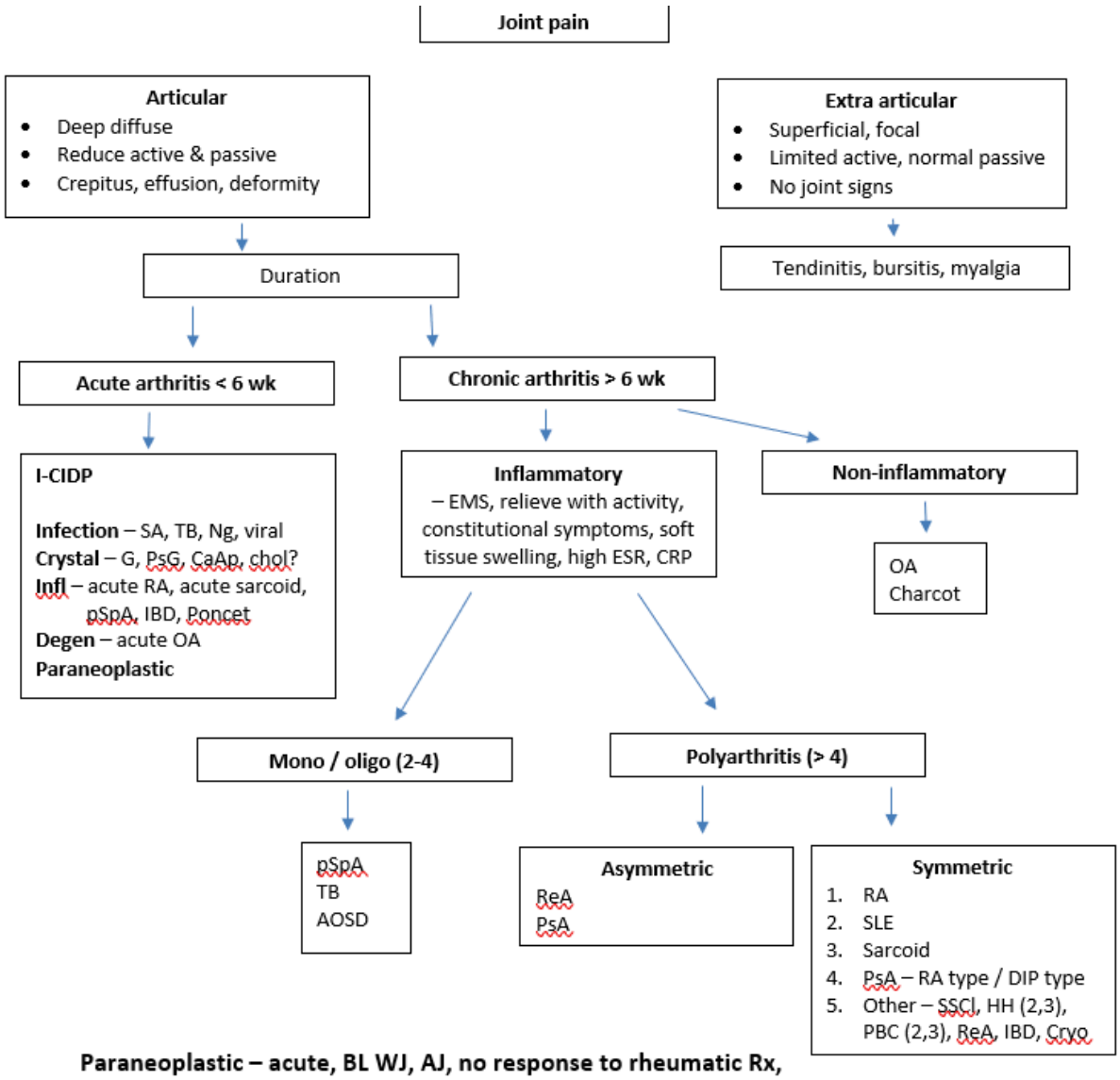
Ix and Rx so far

PMHx, PSHx, Allergies, FHx (liver disease, neuropsychiatric, blood disorders)**, LRMP, SHx** – job, alcohol (amt, CAGE, social and legal issues), smoking, travel

Patients concerns

Plan of Ix
Ex for LN, HSM, ascites, flaps, CLCD stigmata
Ix with – LFT, USS abdomen, FBC, PT, RBS, UFR, ESR, viral studies, AI markers, ferritin, ceruloplasmin, KF ring,
H'lysis – FBC, B pic, retic, bilirubins, LDH, haptoglobin, DAT

Joint pain



Paraneoplastic – acute, BL WJ, AJ, no response to rheumatic Rx, responds to CA Rx. Precedes CA by 3-20m
Sarcoid – acute : mono-oligo. Chronic – symmetrical RA type
IBD – mono/oligo acute. Chronic – Small Js, SI.

Recurrent falls

80y M 3rd fall within 1 year
HTN, prostatism, bodyaches, neckpain
Prazocin, amitriptyline, PCM sos
Alcohol+, non smoker

Possible causes
Cervical myelopathy
Alcohol related polyneuropathy
Strokes (HTN)
Frailty
Dementia
Drugs

HPC

Onset, duration, frequency, progression
Describe an event – prodrome (palpitation, lightheaded, aura), LoC / fits / incontinence / time to recovery, post fall – time to get up – alone/ needed support / injuries

DD

With LoC

1. Syncope : reflex (VV, CSH??), cardiogenic (arrhythmia – brady / tachy, LVOTO), postural hpotension (ANS, drugs, hypovolaemia)
2. Seizure :
3. Metabolic : hypoglycemia
4. Ischemia : post circ TIA

With intact LoC

Neurological:

1. P neuropathy – DM, alcohol, hypothyroid, B12, CKD, vasculitis, hereditary, drugs
2. Myopathy / frailty – osteomalacia, statin
3. PS : spasticity – recurrent strokes, cervical myelopathy, NPH
4. EPS : PD, PPS
5. Cerebellar
6. Vestibular system
7. Vision
8. Hearing
9. Dementia

Skeletal

Arthritis, KJ instability?, poor grip

Multifactorial;

Comorbidities
Frailty – weak muscles, imapaired neuromuscular co-ordination
Drugs
- Sedatives
- Hypotensives

Environmental
- Foot wear
- New environment
- Alcohol

Complications

- Injuries
- Fear of falling – limited mobility

What has been done / can be done

- Home environment – steps, slippery, toilet, railiing

Rest of the history
PMH (DM, stroke, PD), PSH, Drugs, FHx (neurodegenerative disease), SHx

Ideas, concerns, expectations

Plan
Ex
Tools – Get up and Go test (10ft. < 20s: NL, > 30s – high risk of falls / dependence)
Functional reach test (> 15cm = good balance)
Ex of CNS, CVS, Carotid massage

Ix
Cardiac (rhyhthm. Murmur, post hypotension), neuro
Metabolic – FBS, CBS, Hb, Cr, TSH

Rx
Environmental adjustments
Modify drugs

Peripheral neuropathy
Duration
Sensory, motor, sphincters

DD
CES – backache, sphincters
Vascular – intermittent claudication
Spinal stenosis – neurogenic claudication
Parasaggital?

Causes
DM, alcohol, B12, paraneoplastic, paraproteinaemic, thyroid, CKD, HIV, Leprosy, vasculitis, drugs
CIDP

Difficulty in walking

Number, frequency, duration, injuries, home env risks for falls, occupation, risks to the others, carers

Neurological
PN
PM
LEMS
Cord
Cerebellum tumor, paraneo, SCA,
Brainstem / brain
EPS
NPH

MSK
OA
Spinal stenosis neurogenic claudication

CVS
Intermittent Claudication
Postural hypotension
Ex SOB
Syncope / pre syncope

Abdominal pain

65y M
Left abdominal pain x 3d, constant dull
Constipation, 1 episode of scanty PR bleeding, mixed with stools
IHD, HTN – on aspirin and nifedipine, atorvastatin

DD
Acute Diverticulitis
CRCA
UC

Explore constipation
Drugs
Hypothyroidism
Hypercalcemia

Acute diverticulitis

DDx for LIF pain

Dx	CFx	Etiology / RF	Complications
Diverticulitis	Recurrent pain LIF > RIF Fever, N, V Constipation > diarrhea May have bleeding PR May have urgency, freq, dysuria	Chronic constipation	Abscess – severe pain, fever Fistula – peritonitis Perforation Obstruction – absolute constipation
Cancer		FHx	Anemia Cachexia / LoA in liver mets
IBD (UC)	Diarrhea > pain Blood and mucus		Anemia Dehydration

	Subacute / chronic CrD and UC Fx		Infections / SIRS / fulminant colitis
Infective colitis	Acute / subacute Diarrhea predominate	Diet, toddy, travel, contact Hx	Sepsis
Ischemic colitis	Acute pain and bleeding PR	ASCVD / AF	Bowel necrosis Bleeding shock
Ureteric colic	Colicky Radiation	PHx Calcium, dehydration	Obstruction Infection
Tubo-ovarian abscess			
Ovarian tumor			
Cystitis	Predominant LUTS	Preceding LUTS, instrumentation, neurogenic bladder	

Dx of diverticulitis – Clinial + CECT. Colonoscopy is not useful (will see the diverticular orifice, but inflammation is outside!)

Liver Biliary R LL pneumonia	Stomach – PUD, cancer Pancreas Biliary AAA MI Medical – DKA, AIP, angioedema	Spleen L LL pneumonia MI
Ureteric colic AAA Colitis	AGE Mesenteric angina AAA Early appendicitis Medical – DKA, AIP, angioedema	Ureteric colic AAA Colitis
Ilieitis Appendicitis CrD TB Ureteric colic Ovarian abscess / tumor Cystitis Diverticulitis	Cystitis Colitis PID	Colitis - infl, infec, ischemic Diverticulitis Colorectal CA Ureteric colic Ovarian abscess / tumor

Renal calculi think, hyperPTH, sarcoidosis, RTA, gout, Crohns

6. AFI

Acute fever

38 year old businessman
Fever, frontal headache for 6 days
Returned from India
- Outside meals
- Bathed in a lake
- Not received malaria prophylaxis, typhoid / Hep A vaccine

DD
Typhoid
Malaria
Rickettsial
Viral

Mgt
Ex – rash, spleen ..
Ix – MP thick thin films, rapid diagnostic test, blood culture, FBC, B pic,
Rx – 3GCP. Consider antimalarial (contact AMC)
Notification – AMC,

Approach

Duration Onset progression, pattern (chills, rigors, measured temperature)
Associated symptoms
Systemic inquiry
- Cough, SOB, hemoptysis, chest pain, palpitations
- Headache, vomiting, photophobia, confusion
- Abd pain, diarrhea, bleeding PR
- Dysuria, hematuria, loin pain,
- Joint pain / swelling,
- Skin rash, wounds, ulcers / eschars

Travel history
When, where, why, with whom (are they well?) – get exact temporal relationship of symptom onset and travel
Exposures
- Animal
- Sex
- Exotic activities – forest trekking, fresh water activities, caves
- Food and water – ouside meals, meat / poultry (egg, chicken), unpasteurized milk

Precautions
- Vaccines – HAV, typhoid,
- Prophylaxis – malaria – timing,

Vomiting

DURATION
FREQUENCY
COLOUR, CONTENT
BLOOD – FROM FIRST OR LATER

1. GI – PUD, pancreatitis, cholecystitis, hepatitis, gastritis, gastroenteritis, IO, gastric cancer
2. CKD
3. CNS – high ICP, area postrema, migraine, glaucoma, brainstem stroke, vestibular disease: HEADACHE, VERTIGO, FNS
4. ENDOCRINE - Addison, Calcium, hyponatremia
5. DRUGS
6. TOXINS – alcohol

PTB – ATT – vomiting
- Drug induced
- Hepatitis
- Addison
- Brain mets
- GI cancer

Diplopia

36y three wheel driver dematagoda
Diplopia x 7 days
All directions, painful R eye, no diurnal
Red eye+
LoW+, LoA -, smoking+
PHx of TB – Rx completed 10y ago

DD
Graves orbitopathy
Orbital apex syndrome - TB
Details
Confirm diplopia – two images

Onset

Progression
- Progressive – comrepssive
- Improving – ischaemic
- Intermittent – MG, Graves, GCA, decompensated phoria

Alignment
- Lateral – MR, LR
- Horizontal – SR, IR, SO, IO
- Oblique – SO, IO

Worst in
- Lateral gaze – LR / MR
- Inferior gaze – SO (/ SR / IR)
- Distant gaze – LR
- Near vision - MR
- Superior gaze – SR / IR
- All directions – multiple neuropathies, MG< myopathy, Graves

Associated symptoms
- Eye pain – orbital tumor, myopathy, Cavernous sinus thrombosis, ischemic CN III
- Red eye – orbital tumor, CSA / CST
- Headache – pit tumor, brain tumor, aneurysm, GCA
- Neurological
  - Ptosis – MG, CN III, myopathy,
  - Reduced vision – orbital apex
  - Facial numbness – SOF, CST
  - Limb weakness, numbness, sphincter – brain stem
- LoW, LoA – TB, cancer
- DM, HTN, DL mononeuropathy, stroke, aneurysm
- MS
- Epilepsy drugs phenytoin, CBMZ, top, SSRIs
- Smoking – atherosclerosis, Graves eye
- Thyrotoxic symptoms

Headache

HPC
Site, onset, character, severity, timing, exacerbation and relief

Red flags
Fever, photophibia
Fx of raised ICP – LSCS, worse mane, vomiting
FNS
Headache screen
1. How often do you get severe headaches?
2. How often do you get mild headaches?
3. How often do you use analgesics for headache?

1 – good Sn for migraine
2 & 3 – good Sn for medication overuse headache

CSF leakage – change with posture
cervicogenic

DDx

Acute

1. SAH – occipital, sudden, peak within seconds, worst ever. RF: FHx, PCKD, coagulopathy, cocaine
2. CVST – acute, may have altered LoC / FNS. RF for clotting : thrombophilia, OCP, migraine
3. Pituitary apoplexy – Hx of visual problems, hypopituitarism / acromegaly
4. Carotid / vertebral dissection – onset during neck movements (EC vert dissection)
5. PRES / RCVS – HTN, visual disturbance, altered LoC. RCVS occurs in cannabis / amphetamine users. MRA – beaded cerebral vessels
6. Accelerated HTN
7. Meningitis

Recurrent
Migraine
TTH - featureless
Cluster – clustering, unilateral (side locked within a cluster, shift in between clusters possible), Horner, conjunctival injection, tearing, nasal congestion. 15-180min. running around in pain (cf migraine)
TACs

TN	stabs, spont > triggers
SUNA	sec-min. triggers +
SUNCT	sec-min. triggers +
PH	10-30min, triggers – no.
HC	continuous.

Subacute - Chronic persistent
1. Chronic meningitis (TB, HIV related, spread from sinusitis, otitis, penetrating head injury) /
2. other infections – systemic (typhoid, Legionella,), local (sinusitis)
3. Raised ICP
    a. IIH
    b. Tumor – Iry / IIry
    c. Blood - SDH
4. GCA
5. Referred pain – C spondylosis, toothache, earache
6. Drug induced headache
    a. Vasodil – nitrate, CCB, dipyridamole (unclear mechanism)
    b. IIH – vit A, steroids, TC
    c. Bleeding – warfarin, clopid, aspirin, cocaine (SAH),
    d. CVST - OCP

Aetiology
See DD

Complications
According to etiology

So far
Treatment and response – worsening headache with frequent analgesic use indicate medication overuse headache

COMPLETE HISTORY –
PMH – Cancers, thrombotic events,
PSH
DRUGS – drug related headache, medication overuse headache

ALLERGY
REPRODUCTIVE
FH – SAH, PCKD, migraine, thormbophilia
SH –
- Job, stress
- Alcohol
- Smoking
- Cocaine

IDEAS, CONCERNS, EXPECTATIONS

SUMMARIZE AND PLAN – Ex, Ix, Rx, R.V

Ex FNS, papilledema, TA pulse

Ix FBC, ESR, NCCT / CECT / MRI / MRA / MRV, LP – CSF

For SAH
NCCT 95% Sn within 24h. If negative do CSF for xanthochromia (after 12h. Sn up to 14d)

Migraine
Preventers – propranolol, topiramata, NaV, amitriptyline
Relievers – PCM, NSAID, antiemetic, triptans
- Short acting triptans – suma, zolmi
- Long acting – nara, frova
- Ergotamine if triptans are contraindicated

CH
Reliever – 100% oxygen for 15min, SC / IN sumatriptan, octreotide
Preventer – verapamil, lithium, steroid short course

Medication overuse headache
F > M
Preceding recurrent headache disorder (TTH, migraine)
Treated with analgesics (acute symptomatic medication) with > 3 days a week, for > 3m (PCM, NSAIDs, opioids, caffeine, tryptan)
Daily morning headaches on waking up – migraine type in triptan users, TTH type in ergot / opioid users

Criteria
Headache on 15 or more days a month
Analgesics used for 3m or more

Mgt
Stop culprit drug stat (taper if was using high dose regular opioid / BDZ / barbiturate)
Bridge with long acting NSAID (naproxrn) or prednisolone
Start preventer simultaneously
Restrict reliever in the future (NSAIDs < 14d/month, tryptan / ergot < 9d/month)

Recurrent UTI

Dx

Recurrent – LUTI, UUTI, sepsis. Duration and frequency

Prostate – prostatitis, BPH, prostate CA
Urethral – trauma, catheter, surgeries, obstetric history
Neurogenic – LUTS, back injury, spinal surgery
Immune – DM
Renal – calculi, PCKD, TB-strictures

So far
Abtcs, compliance, prophylaxis

Chronic bacterial prostatitis - CFx
Recurrent UTI often with the same organism
pain (in the perineum, lower abdomen, testicles, penis, and with ejaculation), bladder irritation, bladder outlet obstruction, and sometimes blood in the semen.
Persistent bacteriuria, chronic low grade fever

Recurrent urinary calculi

hyperCa – hyperCa symptoms, FHx – Ca, neck surgeries,
hyperuricemia – PRV, HCT, psoriasis
familial metabolic – FHx of renal stones
RTA-1

Erectile dysfunction

HPC

DD

Psychogenic	partner specific, situation specific, may lose libido in depression etc. performance anxiety (high SNS), partner conflicts, fear of preg or STD, sexual abuse
Organic	loss of morning and REM sleep erections
Hormonal	other Fx – loos of libido, reduced shaving, gynaecomastia hypopit (tumor, infiltration – HH, sarcoid), testicular failure (infection, torsion, Chemo, radiation, surgery), hyperPRL

Non hormonal

Drugs	may lose libido anti HTN (BB, HCT >> CCB, ACEI >> alfa blockers Spiro, H2RBs, estrogens – anti testos effects TCAD, SSRI, antipsychotics
Vascular	DM. smoking, ASCVD
Neurological	postural hypotension, PN - DM, Alcohol, spinal cord

Rest of the history
PMH, PSH (pelvic spinal Sx, trauma), drugs,

Ideas concerns expectations – plans for fertility

Summary and plan for further evaluation

Examination – gonads, general
Assessment with partner
Hormone profile, general health screen

Discussion

Physiology of erection

Libido

Central N and reflexogenic innervation
- SmM of copora cavernosa relaxes, blood pools, CC distends and blocks emissary veins trapping blood
- NO from non adre non choli nerve endings cGMP SmM relaxation
- PGE2 from cavernosal tissue maintains it

Ejaculation

- SNS contraction of E, Vd, Prostate, seminal vesciles semen in to urethra
- Closed int urethral sph prevents retrograde ej (lost in DM, post op)

Detumescence

- SNS NE alfa
- ET
- SmM contraction, venous outflow
- Venous leak – intrinsic SmM defect causing them to relax early / failure to relax completely
- Priapism – SC injury, Sicke, vasodilator injection, procoagulant state

Evaluation

T, LJ, FSH, PRL
SFA – if planning for fertility

Treatment options

1. Obesity, smoking, alcohol, drugs

2. PDE5i
3. Testosterone if hypogonad
4. Sex therapy
5. Alprostadil (PDE5i) – intra urethral / penile injection
6. Vacuum constriction devices
7. Penile prosthesis

PDE5i

Inhibit break down of cGMP
Sildenafil, tadalfil, verdenafil – efficacy comparable. Tadalafil is longer acting
OoA – 60-120 min

SE

Headache, facial flushing, nasal congestion
Transient visual disturbance, blue halo
Non arteritic AION – avoid in those with a past Hx of this
[those are due to inhibition of PDE6 in retina. More with sildenafil]

CIn

Nitrate use (need to keep at least 24-48h gap)
Previous non arteritic AION
CCF

Caution

Hypotension
Multiple antiHTN
CKD
Interacting drugs

Ixn

With other vasodilators – alfa blockers, nitrates
With enzyme inhibitors – erythromycin, ketoconazole, cimetidine

Start low dose in

Elderly
CKD
Interacting drugs
PDE5 failure (at least 6 days with maximum dose not working)
Take pill after a high fat meal
Give enough foreplay to produce NO
Screen for hypogonadism

Alternative antiHTN

Alfa blocker (caution interaction), CCB, ACEi

Place of testosterone – useful if testos is low (exact contribution of testos to erection is no tclear)

Sleepiness

Duration
Timing / ESS – day time, inactive (post lunch, passenger, public – lecture, meeting etc), active (talking, driving in traffic)
Impact – work problems, driving, accidents,
Medical complications – HTN, pulHTN, memory impairment, edema (P'uria, PHTN), mood changes, arrhythmias, ASCVD

Sleepiness Vs fatigue
Unable to stay awake, falling sleep when you want to stay awake – reading, TV, meeting, etc
Need naps – frequent and long

DD
Hypothyroidism – other Sy
OSA – snoring, waking unrefreshed, obesity, collar size (> 17 in men, > 16 in women),
OHS – morning headache
CLCD – edema, J, hematemesis, melaena
Poor sleep hygiene – night shifts, poor sleep at night / insomnia, time, light, noise, others in room, last meal, GOR, smoking, alcohol, choking, gasping, witnessed apnea, prolonged apnea terminated by loud snoring / snort, alarms, nocturia, mid day nap, drugs (antihistamines, BDZ etc)
?hypoglycemia
Sleep disorders
Depression

Co-morbidities
DM
HTN
IHD

What have you done?

Forgetfulness

Assess the cognitive domains

Memory impairment
Of recent events – AD (inability to make new memories)
Of old events – advanced AD
Relatively preserved in

Language
Word finding difficulty
Perseveration – FTD
Understanding written instructions

Praxis

Dressing, washing, using household equipment

Agnosia

Indentify familiar objects, people etc

Executive function

Planned activities, complex mental tasks, finances etc

Demonstrate decline from previous level and impact on ADL

Assess evolution

Step wise progression – VD
Years – AD, FTD
Months – PD, LBD, NPH
Weeks – SDH, CJD

Cause

Primary dementia

AD – short term memory
FTD – behavior / aphasia
LBD – Visual hallucinations, fluctuating conscious level, parkinsonism, ANS dysfunction
PDD – PD dementia after 12m
VD - ASCVD RF – DM, HTN, DL, smoking, IHD, stroke, PVD. Abrupt onset after a stroke, step wise progression, frontal temporal
Mixed dementia – AD + VD
Subcortical vascular dementia

Secondary causes

INFECTION	AIDS, syphilis, CJD, Whipples, dumb rabies?
METABOLIC	Wilson, B12, hypoPTH / Fahr Xd
ENDOCRINE	Hypothyroidism, Cushing, SREAT
TOXIN	Alcohol, heavy metals, Recreational substances
INFLAMMATORY	SLE
DRUGS	anticholinergics
NEOPLASIA	primary / mets / limbic encephalitis
EVERYTHIN ELSE	Depression
	NPH
	SDH – falls, fluctuating LOC, FNS

Impact, risks

Living environment
ADL – feeding, toilet, mobility, grooming,
Risks to pt – getting lost, overdose pills, falls/heights, self harm
Risks to others - Homicide, leave cooker on, driving

Rest of the history

Examination – FNS, papilledema, other systems

Summarize

Dementia workup for reversible causes of cognitive impairment and confirmation of Dx

Other neurological features
Headache – tumor
FNS – tumor, VD

Gait

Shuffling – PDD, LBD
Ataxic – alcoholic pt (WKS + cerebellar degeneration)
Broad based, short steps, intact arm swing – NPH
Hemiplegic – VD

Postural instability and falls – PDD, LBD, NPH

Abnormal movements

Tremor - PDD, LBD, WD
Chorea – HD
Myoclonus – CJD
Dystonia – WD

Urinary incontinence – NPH

Psychiatric

Visual hallucinations – LBD
depression – Depressive pseudodementia
Disinhibition – FTD, advanced AD

Plan

Bloods
Imaging
Medication – discuss ACHEi (donepezil, rivastigmine, galantamine) and memantine

7. Ear symptoms

Constipation

IBS
Hypothytoidism
Hypercalcemia
Autonomic neuropathy
CRCA
Drugs

Bleeding PR

Describe
Fresh, quantity, frequency (with all BOs), bleeding w/o BOs, on stools Vs mixed with stools, streaks on stools, pain on defecation, lumps at anus (grade, hemorrhoids, polyps, rectal prolapse), rectal Sy (tenesmus), abd pain
Constipation Vs diarrhea fever, LoW, LoA

DD
Rectal cancer
- Fx – mixed with, chronic, constipation, LoW
- RF – FHx, ?smoking
- Mets – RHC pain, LoA, jaundice, cough, headache, backache

Colitis
- Infective – ameba, shigella, rectal syphilis : sick contacts, meal hygiene, toddy, anal sex
- Radiation proctitis
- Ulcerative colitis – red eye, oral ulcers, DVT, EN/PG, SIitis
- Ischemic – acute, abdominal pain, RF : AF / athersclerosis
- Diverticulitis

Haemorrhoids

LUTS

Tremor / movement disorders

HPC

1. Duration, Onset, progression

2. Distribution, evolution
   - Hands, legs, head, voice
   - Symmetry/asymmetry

3. When is the tremor worse
   Rest
   Posture
   Movement
   What worsens tremor : stress/emotion.caffeine worsens most tremors, sp ET and phys tremor
   Tremors in sleep : ?? (PD and ET disappear in REM sleep)

4. Associated other neurological symptoms
   Speech, Swallowing, Gait, Weakness, Sphincters / ANS symptoms

Algorhythm

Rest - EPS

PD – gait, falling forward, slowing, olfaction, constipation
MSA – sphincter, postural hypotension
LBD – dementia
PSP – truncal rigidity, falling backward
WD – liver disease, FHx fo neuropsychiatry
Drug – antiemetics, antipsychotics

Intention – cerebellar

Alcohol
Drugs – AED, Li, heavy metal exposures
Tumor – unilateral
Infarcts – acute unilateral
Paraneoplastic
SCA, FA, ?HD

Postural

Physiological
Exaggerated physiological – thyrotoxicosis, pheo, SNS (salbutamol, theo), TCAD, Glcc, T4, MDMA
BET

PD rest, asym, pill rolling, slow. Stops and start with action. BRADYKINESIA, spares head.
ET postural, persists in to action, sym / asym, fine, flexion, extension, fast. Can affect head.
Cere intention tremor, worse when reaching an object. Slow coarse. May affect head
Phys postural, fast, fine, worse with emotion and caffeine. Spares head
Dyst worse with posture (action – postural / kinetic)

Enhanced physiological tremor	ET
Never affects head	May affect head
Aggravated by caffeine	Not aggravated by caffeine

	PD	ET

Age	> 50y	2nd or **6th** decade
Sex	M>=F	M= F
FH	>25%	> 50%
Asymmetry	+++	+/-
Frequency	4-6	4-10
Characteristics	Rest. Supination – pronation.	Postural or kinetic. Flexion – extension
Effect of action	Tremor temporarily disappears with action (holding a cup) and returns after few seconds	Tremor persists
Distribution	Hands, legs, chin and tongue. Never head	Hands, head, voice. (Legs spared – pt in wd 16)
Associations	**Bradykinesia**, rigidity, gait, posture, micrographia	Deafness, dystonia, parkinsonism

PMHx – asthma (propranolol for BET will be CIn)
FHx – BET, WD
SHx – alcohol (relieves BET, causes withdrawal tremor and cerebellar tremor)
Impact on ADL

Ideas concerns expectations
Concerned about PD

Summarize

Plan for Ex, Ix

Weight gain

Newly diagnosed hypertension

Diagnosis **certainty (?white coat), duration, essential Vs 2ry**
- When
- Previous BP measurements / PIH
- How many readings
- White coat? – anxiety, out of office measurements, ABPs

Aetiology
- Renal disease – H,uria, childhood KD, recurrent infections, FHx of PCKD, urine calculi, CTD Fx, PAN Fx (LoW, LL rash)
- Endocrine – weight, bowel habits
  - Cushing – OTC steroids / anabolics, weight gain, prox muscle weakness
  - Conn – muscle cramps / weakness
  - Phaeo – episodes of flushing headache, palpitations
  - Thyrotoxicosis – LOW, diarrhea, heat intolerance, tremor, palpitations
- Vascular

- RAS – flash pul edemas
- CoA

- Drugs / toxins – steroids, OCP, alcohol, smoking, coccaine
- OSA obesity
- White coat – out of office BP measurements

Complications

- CAD – angina
- Stroke / TIA
- Vision – blurring
- Renal – edema, N, V, LoA

Therapy and control

- Compliance – drugs, low salt diet
- SE
  - HCT – impotence
  - CCB – edema, headache
  - ACEi - cough

What can be done

- Patients ideas, concerns, expectations
- Indications/ CIn for specific therapy – ACEI in CKD, HCT in DM, CCB in HF
- ASCVD prevention
  - Assess risk – DM, DL, FHx

PMHx DM, BA (BB), ASCVD
PSHx, DAHx,
FHx HTN, PCKD, IHD, stroke, DL, DM, MEN Xds
SHx

- Smoking, alcohol, substances
- Diet
- Occupation
- Marrital life – impotence

Ex

BMI
BP
Fundus
Cardiac apex, murmurs, bruits
Goiter, cushingoid
Pallor, edema

Ix

Cr, UFR, SE
ECG, 2D echo
FBS, A1c, Lipids

Summarize with patient

1. Device a plan

    a. Investigations plan
    b. Lifestyle plan – diet (low salt), exercise, smoking, alcohol
    c. Drugs, compliance
    d. Referrals
2. Schedule next visit
3. Advice on troubleshooting – call / ED visit / admit

Raynauds

Digital pain
Vascular – vasculitis (cryo, PAN, Buergers), thromboembolism, vasospasm (RP, BB), cold hemagglutination, hypreviscosity
Neuropathic – PN, CTS, radiculopathy, syrinx
Articular - arthritis
Soft tissue – dactylitis

Dx
Pale, blue, red with rewarming. Associated pain, paresthesia. Distribution – which fingers / toes, nose tip, ear lobe, lips. No symptoms in between attacks.
Symmetry, gangrene, ulceration, digital loss
Ppt factors – cold, bathing, fridge.

Aetiology
CTD SSCl, SLE, PAN
Hemat PRV, cryo-I
Cervical rib
Vasculopathy smoking / thrombangitis obliterans, vasculitis
Vibrating tool operators, OCP, ergots
Primary RP – ppt by cold weather / touching cold objects

DD
IE, thromboembolism – Aortic aneurysm,
CTS
Syrinx / cervical radiculopathy

Complications ulceration, digital loss

Impact - occupation

Features favouring secondary rather than primary RP
1. Onset after 40y
2. Female sex
3. Unilateral
4. Affects thumb
5. Digital ulceration
6. Features of SLE / RA
7. Auto Ab
8. Rashes

9. Rarely chilblains (painful itchy swellings on hands feet etc)

Confusion

Foot ulcer

Gait difficulty

Facial swelling

Funny turns

Hoarse voice

Larynx –

- inflammation (candida in inhaler users, GOR)
- edema (hypothyroidism)
- cancer
- polyp (voice abuse)

RLN palsy (dysphonia rather than hoarseness) – lymphoma, lung cancer

Pruritus

Duration
Persistent vs intermittent
Distribution

1. PRV - hyperviscosity
2. Lymphoma – B Sy
3. DM – osmotic sy
4. Thyroid
5. CKD – edema, UOP, hiccups, LoA, vomiting
6. CLCD –
    - CFx – J, H/M, edema, ascites
    - Aetiology – alcohol, NASH, viral, CAM, drugs
7. Scabies
8. Contact dermatitis
9. Urticaria +/- angioedema
    a. Hypothyroidism
    b. Urticarial vasculitis
    c. Chronic idiopathic urticaria (chronic spontaneous urticaria)
    d. Mastocytosis (? No angioedema)

Erythema nodosum

Site size shape palpable pain duration past history

IBD
Sarcoid
TB, Streptococcal infection, leprosy
Drugs – sulfa, OCP

Adult onset Wheezing

Shoulder pain

Shin pain

8. Abnormal Ix
9. High Ca
10. LFT
11. Macrocytic anemia

Stroke
Mimics – tumor, MS, hypoglycemia, seizure, cardiac syncope (palpitations, chest pain)
Cause
    Infarct, hemorrhage
    Dissection, vasculitis, CADASIL, migraine
    AF, thrombophilia

Angina
DD – AD, PE, pneumothorax, pericarditis, pneumonia, esophageal – GORD / gastritis
Causes
    Atherosclerosis
    Vasculitis
    Thrombophilia – past DVT, hypervicosity Sy,
    Embolism – IE Sy
Diabetes – assess autonomic neuropathy as well
Duration
Control
Drugs
Macro
Micro
Infections
Hypo hyper glycemias

IBD

Onset duration relapses frequency last relapse
Drugs compliance side effects
Biologics eligibility – TB
Extra intestinal – eyes, oral ulcers, EN, perianal, joints

CKD

Etiology DM, HTN, CKDu, NSAID, GN, obstructive, amyloid, PCKD

Complications

- Uremia – LoA, V, itching, hiccups
- Fluid overload
- MBD – bone pain, #
- HTN
- Anemia
- Acidosis
- hyperK

epilepsy

semiology, changes
ppt factors
Hx of status
Current drugs compliance control
Aetiology

- FHx
- Childhood CNS infections etc
- Tumor
- AIE
- CNS infections
- Metabolic – hypogly, Ca, Mg, Na