Observed History Taking

Contents

| Dyspnea – | 4 |
|---------------------------------------|----|
| Cough | 4 |
| Hemoptysis | 4 |
| Palpitations – | 5 |
| Diarrhea | 5 |
| Visual loss / disturbance | 7 |
| Limb weakness | 8 |
| Vertigo | 8 |
| Constitutional symptoms / weight loss | 8 |
| Anemia | 10 |
| Polyuria / polydipsia | 10 |
| Fatigue | 11 |
| Edema | 12 |
| PUO | 12 |
| TLOC | 13 |
| Chest pain | 14 |
| Hematuria | 15 |
| Red eye | 15 |
| Dysphagia | 15 |
| Numbness of feet | 15 |
| Neck pain | 16 |
| Backache | 16 |
| Dyspepsia | 17 |
| Abdominal distension | 18 |
| Short stature | 19 |
| Recurrent infections | 19 |
| Jaundice | 19 |
| Joint pain | 20 |
| Recurrent falls | 21 |
| Peripheral neuropathy | 22 |
| Difficulty in walking | 23 |
| Abdominal pain | 23 |
| Acute fever | 25 |

| Vomiting | 26 |
|----------------------------------------------------------------------------------------------|----------------------------------|
| Diplopia | 26 |
| Headache | 27 |
| Recurrent UTI | 30 |
| Recurrent urinary calculi | 30 |
| Erectile dysfunction | 31 |
| Sleepiness | 33 |
| Forgetfulness | 34 |
| Constipation | 36 |
| Bleeding PR | 36 |
| LUTS | 37 |
| Tremor / movement disorders | 37 |
| Weight gain | 38 |
| Newly diagnosed hypertension | 38 |
| | |
| Raynauds | |
| Raynauds Confusion | 40 |
| | 40 41 |
| Confusion | 40 41 41 |
| Confusion Foot ulcer | 40 41 41 |
| Confusion Foot ulcer Gait difficulty | 40 41 41 41 |
| Confusion Foot ulcer Gait difficulty Facial swelling. | 40 41 41 41 |
| Confusion Foot ulcer Gait difficulty Facial swelling Funny turns | 40 41 41 41 41 |
| Confusion Foot ulcer Gait difficulty Facial swelling Funny turns Hoarse voice | 40 41 41 41 41 41 |
| Confusion Foot ulcer Gait difficulty Facial swelling Funny turns Hoarse voice Pruritus | 4041414141414141 |
| Confusion | 4041414141414142 |

Observed History Taking

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),
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

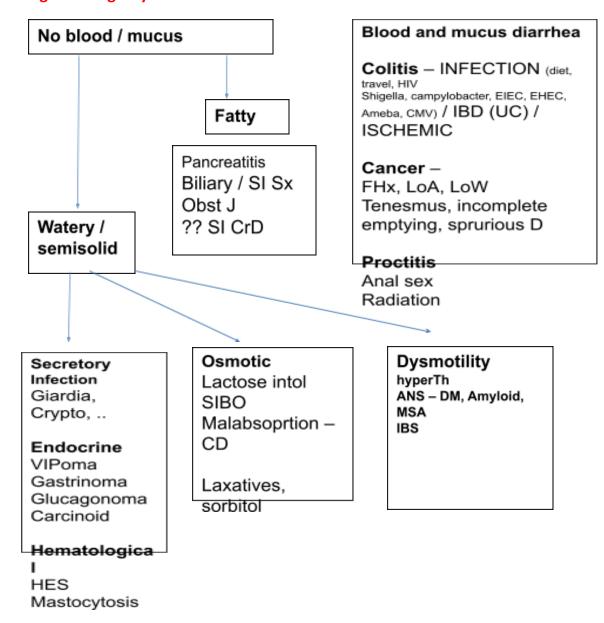
Hx

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
DΙ
       psychogenic
       dipsogenic - hypothalamic disease
               sarcoid – cough, lupus pernio
               WG - epistaxis, nasal block, cough, hematuria
               Tumor mets – breast lump, cough hemoptysis, BO, B symptoms
               ΤB
```

Neurosurgery, radiation

Barter

Pituitary tumor Fx – visual loss, headache, galactorrhea

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

PHO

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)

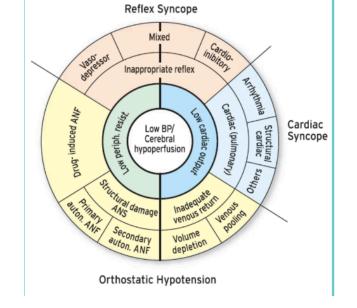
Hypovolemic – vomiting, diarrhea,

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 burning, relation to meals, GORD, hematemesis, melena, dysphagia, LoW,

LoA

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

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)

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

```
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 He

With pain

Gallstones, Biliary stricture Cholestatic hepatitis – WD,

drugs

Budd chiari – DVT, OCP, PRV, FHx

Without pain

Cirrhosis - edema, UGIB, alcohol,

IBV, 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

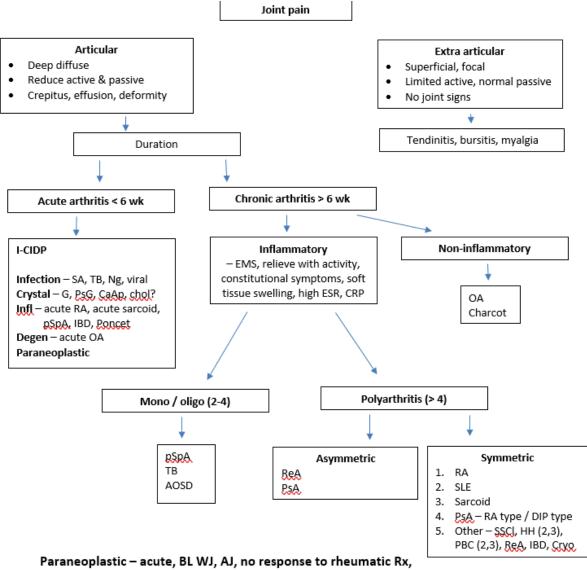
PMHx, PSHx, Allergies, FHx (liver disease, neuropsychiatric, blood disorders), **LRMP, SHx** – job, alcohol (amt, CAGE, social and legal issues), smoking, travel

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



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 : hypoglycemia4. 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

lχ

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

PΝ

PM

LEMS

Cord

Cerebellum

tumor, paraneo, SCA,

Brainstem / brain

EPS

NPH

MSK

OA

Spinal stenosis \square 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 | Spleen L LL pneumonia MI |
|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| | Medical – DKA, AIP, angioedema | |
| 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
        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 / Ilry
 - 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

FT

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

lxn

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 $\hfill\Box$ 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, Slitis

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 |
| | |

|--|

| Age | > 50y | 2 nd or 6 th 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 | Tremor temporarily disappears with action | Tremor persists |
| action | (holding a cup) and returns after few | |
| | <mark>seconds</mark> | |
| Distribution | Hands, legs, chin and tongue. Never head | Hands, head, voice. (Legs spared – pt |
| | | in wd 16) |
| Associations | Bradykinesia, rigidity, gait, posture, | Deafness, dystonia, parkinsonism |
| | micrographia | |

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 SSCI, SLE, PAN

Hemat PRV, cryo-l

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