

Describing Your Patient

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1. General Considerations

You will be taking patients' histories, doing physical exams, and writing up (or otherwise presenting) what you find. You should expect to have some difficulty with histories and physicals, and, indeed, to be only a little bit better a few weeks from now than you are now. On the other hand, you should soon be able to present a patient in an efficient, professional-sounding manner. It's not hard.

1.1 History-taking

Taking histories is difficult because taking a good history may require knowing a lot of medicine. Someone who sees a young man with urethritis and fails to ask him about possible ocular symptoms may not be an intrinsically poor history-taker; probably this examiner is just not aware of Reiter's syndrome. You will be handicapped in your history-taking because you just don't know enough medicine yet.

1.2 Physical examination

Learning how to do physical exams also takes a long time, mainly because much of it consists of physical skills that require practice. You won't recognize some things until you've seen, heard, felt, or smelled them before, and it will take time to accumulate the necessary experience.

Even so, you have a nonzero chance of discovering things that have been missed by other examiners. My experience suggests that in any given encounter over the next few weeks, you have about a 5% chance of making a discovery that we will want to pass on, with the expectation that your finding will affect the patient's care.

2. Talking to patients

2.1 Be grateful

You should thank patients for letting you see them. There is a small but real chance that the interaction will be medically beneficial to the patient (see Section 1.2 above), and some patients will find interaction with you to be an enjoyable diversion. For the most part, though, the patients you examine will be doing you a favor and getting nothing in return.

2.2 Don't be too grateful

Don't let the gratitude and sympathy that you feel for the patient keep you from doing the best workup you can. The patient may not be eager to get out of bed to stand (for a Romberg test) or to walk (so that you can evaluate his or her gait). That's fine; if

he or she really doesn't want to do something, don't insist. But don't preempt the patient's decision by not even asking.

2.3 Sex

You may be the best thing the patient has seen in a long time. Distinguish between

- involuntary reactions (erections of the penis or (less commonly) the nipples) and
- voluntary inappropriate behavior (flirting or even groping).

Most patients who find themselves involuntarily aroused will be acutely embarrassed, as if they had noticed in ordinary life that their clothing were agape. You need not pretend not to see what you've seen, but you should respond as you normally respond to companions' involuntary belches.

Context-inappropriate voluntary behavior most often consists of excessive exposure. You arrange the patient's gown to expose the abdomen down to the pubic hairline, but the patient then rearranges it to expose his or her genitalia. Don't comment, but rearrange the gown the way you had had it. Remember that the patient may have no prior experience of being exposed and touched without sexual intent.

More flagrant inappropriate behavior by the patient is much less common, and it may need to be handled as you would handle it in ordinary life. Don't let yourself be abused.

2.4 Don't let patients' requests be lost

Notwithstanding your disclaimer of any clout within the hospital, patients may expect you to provide goods or services that must ultimately come from others. Sometimes it's OK to say "You'll have to ask your {nurse, doctor} for that," but often that's not good enough. The patient may be unable to get the right person to understand the request, or the request may seem to have been ignored, and now the patient may believe that repeating it will be irritating to the original requestee. You may be recruited exactly **because** you are so powerless. If (for example) the patient doesn't like his roommate and wants to be moved, don't promise that it will be done, but promise — and keep your promise — to tell the charge nurse about it.

2.5 Fielding questions

Similarly, patients may ask you medical questions. Sometimes it will be appropriate to tell the patient to save the question for more senior people, but this shouldn't be your most frequent response. Of course, you need to start with an appropriate disclaimer as to the depth of your knowledge. The trick, after that, is to figure out what and how much the patient really wants to be told.

Thinking about the worst case makes all the other cases seem easy. The patient who asks "Am I going to die?" is not wondering whether he — like Socrates and you and everyone in between — is mortal. Trying to get away with "We're all going to die" is condescending. It's a little like being asked "Do you know how to get to Dupont Circle?" and answering "Yes." You owe the patient some information.

On the other hand, the patient in this scenario probably doesn't want to be told everything you know about his disease. He is like the 4-year-old who asks you where babies come from, but who surely doesn't want to hear everything you know about sex and reproduction. The child told that he grew inside his mother's body might in principle have any number of immediate follow-up questions, but he might just want to digest the short answer for a while. He will let you know. Similarly, it might be enough to tell the patient that indeed, people with his disease generally succumb to it.

If you sense that the patient is asking "Am I going to die?" at another level, the right answer may be "What are you really worried about?" This won't happen often, but when it does, it's because the patient has selected you for special trust. Feel honored, and sit down.

3. Vocabulary

For the most part, patient presentations should be composed in the same med speak that you've been absorbing since you got to medical school. Some wrinkles may be new:

3.1 Abbreviations

Abbreviations are ubiquitous in medical notes, but you will find in your medical travels that an abbreviation can be universal in one hospital, but unknown or differently-interpreted in another. When you have doubt about an abbreviation, don't use it, or, as in ordinary scientific and legal writing, give a definition with the abbreviation's first appearance.

3.1.1. Circled letters

The most frequently used handwritten abbreviations are circled capital letters.¹ Some of these are local or ambiguous, and therefore to be avoided, but some universal ones are

- B = bilateral,
- G = gallop (that is, S₃ or S₄),
- L = left,
- M = murmur, and
- R = right (or, in context, = rub. "R ventricular heave; no M, G, R" is pretty clear, even though the two Rs are different).

In some contexts you will see circled letters for close family members (H = husband, W = wife, F = father, M = mother), and even constructions like MGM (in one big circle, not with each letter separately circled) for maternal grandmother. Again, watch out for ambiguity. Context will keep M = mother from being confused with M = murmur, but

¹ To facilitate preparation of this version of this document, text that in holograph would be circled is here [blue and double-underlined](#).

don't leave the reader wondering whether the patient caught his nasty infection from his GF = girlfriend or his GF = grandfather.

3.1.2. Other acceptable abbreviations of widespread use

There is an enormous number of these, and no list could hope to be comprehensive.

- **2°** = secondary, used in the sense of *attributable* (as in “emphysema 2° to 40 pack-years of tobacco abuse”; see Sections 4.1 and 5.6.4)
- **BMI** = body mass index (weight in kg divided by the square of height in meters)
- (lower-case cee with overline) = with, as in “both knees FROM”
- **CC** = chief complaint
- **c/o** = complaining of
- **c/w** = consistent with (see Section 4.1 for sample usage)
- **DTR** = deep tendon reflex
- **DZ** = disease
- **EAC** = external auditory canal
- **FH** = family history
- **FROM** = full range of motion
- **G₄P₃A₁** and the like (see Section 5.1)
- **Hx** = history
- **HPI** = history of present illness
- **IVDA** or **IVDU** = intravenous drug (ab)user
- **LE** = lower extremity
- **LLQ, LUQ** = quadrants of the abdomen
- **NAD** = no acute distress
- **NC** or **NP** = nasal cannula or nasal prongs (O₂-delivery apparatus)
- **OC** = old chart
- **ō** (lower-case oh with overline) = without, as in “heart ō M, R, G”
- **PE** or **Px** = physical exam
- **PMH** = past medical history
- **PRN** = *pro re nata* = as required (for), as in “aspirin prn pain”
- **PTA** = prior to admission
- **RA** = room air, as in “ABG 90/45/7.35 on RA”
- **RLQ, RUQ** = quadrants of the abdomen

- **ROM** = range of motion
- (lower-case *ess* with overline) = *sine* = without, used exactly like \bar{o}
- **SZ** = seizure
- **TNTC** = too numerous to count (as in “torso with scattered pustules TNTC”)
- **UE** = upper extremity
- **VA** = visual acuity
- **W/B** or **WB** = weight bearing
- **WDWNWM** and the like (see Section 5.6.3.1)
- **WHSS** = well-healed surgical scar
- **WNL** = within normal limits
- **yo** = year-old (as in “19-yo male”)

3.1.3. Abbreviations that are offensive in some contexts

Some abbreviations are spoken without intended offense, but they shouldn't make it into any permanent record. The borders of this category are fuzzy; the commonest unequivocal member of the class is **FLK** (“funny-looking kid”), used universally in pediatric circles, with no intended disrespect, for children with miscellaneous congenital dysmorphisms. Another example is **LMD** or **PMD** (“local MD” or “private MD”), used widely to refer to a referring primary caregiver, but perhaps at times to hint at “caregiver lacking the qualifications for practice here.”

3.2 Words to use with care or not at all

3.2.1. *Normal and (especially) abnormal*

When describing physical findings, you may be able to get away with describing something as “normal” or “unremarkable,” but be prepared to supply details. An orthopedist, for example, is unlikely to let you describe a joint's range of motion as “normal” unless he or she believes that you measured the joint's range of extension and flexion in degrees, and that you believe that these measured values are within the respective normal ranges.

No one will ever let you describe something as “abnormal” or “altered.” In what way is it abnormal? Too hard? Too soft? Too loose? Too tight? Quantitate it, if you can (see Section 4.2 below). If possible, quantitate it in a way that others could replicate (*e.g.*, measure the circumference of a swollen limb at a level that you identify in relation to anatomic landmarks).

3.2.2. *Above and below*

“Below” is notoriously ambiguous. Sometimes it is used to mean *sub-* (= deep to), but sometimes it is used to mean *infra-* (= caudal to). If you say that the patient felt pain

“below his sternum,” are you talking about pain in the chest (substernal or retrosternal) or pain in the abdomen (infra-sternal)? Never use “below.”

“Above” sometimes avoids the problems of “below”: A mystic might report the perceived presence of energy “above” his umbilicus, and you wouldn’t know whether he meant that this presence was anterior to his body or within it, but you wouldn’t care, either. Once the point of reference passes into the body, “above” is no better than “below.”

3.2.3. *Inward and outward*

Similarly, “inward” and “outward” can be ambiguous if they’re used to describe the positions of joints. Instead of saying that an ankle is “turned inward,” say that it is *internally rotated* (the toes rotated medially, about a vertical axis through the ankle) or *everted* (the great toe rotated down and the small toe rotated up, about the horizontal long axis of the foot), as the case may be. (The other movements of the ankle are *external rotation* (toes out), *inversion* (great toe up, small toe down), *flexion* (toes up) and *extension* (toes down, often confusingly spoken of as *plantar flexion*).

3.2.4. *Positive and negative*

Do you call a Babinski test “positive” when it has successfully detected dysfunction of the pyramidal tract (toe up), or should “positive” be interpreted to mean that the pyramidal tract is OK (toe down)? In some contexts *positive* and *negative* are unambiguous (“stool guaiac was positive,” *etc.*), but in many contexts they are of uncertain meaning. For the Babinski, write “toes ↑↑” or “toes ↓↓” to report your findings. Incidentally, there’s no strong left-before-right convention, so “toes ↑↓” is inadequate. You need to say “toes L↓R↑” or “toes L↑R↓,” as the case may be.

3.2.5. *Dizziness*

In ordinary discourse, “dizziness” sometimes means *lightheadedness* (that is, the feeling of impending faint), but it sometimes means *vertigo* (that is, the false perception of motion). Don’t use “dizzy” or “dizziness.” When a patient uses one of these words, quiz the patient to pin down what he or she actually felt.

3.2.6. *Weakness*

Similarly, you must ask your patient to explain what she means if she says that she is “weak.” Is she just generally *lethargic*, as she might be if she were sedated? Is part of her body *paralyzed* or *paretic*, suggesting some kinds of neural dysfunction? Is she unduly *fatiguable*, as in depression or myasthenia gravis? Or is she speaking carefully, and correctly reporting her perception that some or all of her muscles are truly weak, as in simple deconditioning?

3.3 Common words with specialized meaning

In medical usage, the *arm* is bounded distally by the elbow, which proximally bounds the *forearm*, and the arm, elbow, forearm, wrist, and hand together make up most

of the *upper extremity*. Some of this usage differs from that of non-medical discourse, in which the “arm” includes the forearm, and “upper arm” is used where med speak says *arm*.

Similarly, the *lower extremity* includes the thigh, knee, leg (not “lower leg”), ankle, and foot.

The *hip* in medical parlance is the iliofemoral joint, not — as in common discourse — the lateral aspect of the buttock.

In medical usage, “mole” is unlikely to be misunderstood as a reference to an embedded spy, an insectivorous mammal, or a Mexican sauce, but there is still room for confusion. Use *pigmented nevus* for the familiar skin lesions; *moles*, in med speak, are a variety of abnormal placentas.

Sex and *gender* are distinct in medical usage, even though the distinction is often missed in colloquial discourse. *Sex* is biological. *Sex* is an explanatory variable in modeling the spread of HIV because male-female transmission of the virus is more efficient than female-male transmission. *Gender* is social. *Gender* is an explanatory variable in modeling the spread of HIV because extreme promiscuity has been part of some gay male subcultures.

In healthy people, the interval between successive heartbeats varies slightly from beat to beat, but the variation is usually too small to appreciate without special tools, and in any event the rhythm in such people is called *regular*, using the term as it is used in ordinary discourse or in music. After that, medical usage becomes peculiar. Patients with certain cardiac conduction disorders have patterned beating, so that successive intervals between beats might, for example, alternate between 700 ms and 1050 ms. That pattern would be called “regular” in ordinary discourse, but it’s termed *irregular* in medical language. When the cardiac rhythm becomes chaotic (as is typically the case in patients with atrial fibrillation), the rhythm is called *irregularly irregular*.

3.4 Fancy words instead of common ones

Doctors say *laceration* (or *wound*), *long finger*, *scapula*, *small finger*, and *uterus* in place of *cut*, *middle finger*, *shoulder blade*, *pinky*, and *womb*. No precision is gained, but that’s what doctors do, and that’s what you should do too. I’m sure there are many other examples.

3.5 Specialty-specific anatomic nomenclature

The great majority of anatomic nomenclature comes from the international *Terminologia Anatomica*, but some of the surgical specialties make use of convenient shortcuts. For example, hand specialists speak of each digit and its associated metacarpal as a numbered *ray*, so that (e.g.) the long finger and the third metacarpal constitute the “third ray.”

The foot specialists use *ray* analogously. Also, they accord honorary malleolar status to the posterior lip of the tibial articular surface of the tibiotalar joint, so they speak of certain complex ankle fractures as “tri-malleolar” fractures.

Constructions like these are sufficiently widespread (at least within the U.S.) that they appear in even relatively formal medical writing.

3.6 Units

The strong convention is for metric units. Stop using bushels, carats, furlongs, inches, ounces, pounds, and stones.

Smoking histories are often given in *pack-years*, computed as packs-per-day \times years. This unit is like *man-hours* or *foot-pounds*; “pack/years” is wrong.

3.7 The patient’s own words

Rarely, the patient’s words may be worth quoting. Sometimes the patient’s eloquence is worth sharing (for example, a patient once told me that getting a contrast-enhanced cerebral angiogram was “like having a white-hot spider web dropped onto my face”), and at other times you may believe that the patient’s words convey meaning that you cannot immediately extract (for example, the patient may mention his exposure to “locomotive-cleaning fluid” — I made that one up — or he may in some other way describe an exposure or event whose chemical or biological meaning is obscure to you, but probably definite). Most of the time, the patient’s exact words are not useful.

3.8 Medications

When you mention a medication, use the generic name rather than the trade name. Do this because

- the generic names give clues as to what the medications are. For example, it is not obvious that ACCUPRIL, ACEON, ALTACE, CAPOTEN, LOTENSIN, MAVIK, MONOPRIL, PRINIVIL, UNIVASC, VASOTEC, and ZESTRIL have anything to do with each other, but the generic names (respectively quinapril, perindopril, ramipril, captopril, benazepril, trandolapril, fosinopril, lisinopril, moexipril, enalapril, and lisinopril (again)) tell the story (they are all angiotensin-converting-enzyme inhibitors);
- medications mentioned in first-line journals are mentioned by generic name;
- almost all generic names are international, but many trade names differ from country to country; and
- using generic names is the correct, high-class, academic, professional thing to do.

Every time you come across a drug name, you should look the drug up to get at least a vague idea about what it does. This practice may be especially fruitful if some of the patient’s prescribers are organ-centered specialists (psychiatrists, ophthalmologists, *etc.*) at risk of missing the larger picture. A couple of years ago, we met a patient who was a few days into an elaborate workup for mysterious fevers. The patient was a middle-aged woman with various mild chronic conditions, taking one or two medications for hypertension, venlafaxine for depression, a proton-pump inhibitor for dyspepsia, and so on. The team taking care of her was looking for obscure infections and malignancies;

someone on our team casually looked up venlafaxine and found that it occasionally causes fevers. Bingo.

3.9 Spelling

Don't confuse *-itis* (inflammation) with *-itus*, which is a nonspecific ending. *Pruritus*, *fremitus*, *tinnitus* are all so spelled. Similarly, the *-osis* suffix denotes having, or having too much (*carcinomatosis*, *diverticulosis*, *endometriosis*), but watch out for *-osus*-based homonyms (*systemic lupus erythematosus*).

3.10 Pronunciation

Because the natural pronunciations of “abduction” and “adduction” sound so similar, it is customary — especially among orthopedists — to say “ay-bee-duction” and “ay-dee-duction,” as the case may be.

4. Presenting patients

Presenting patients is no more difficult (but not necessarily easier) than any other form of technical writing or speaking. There is a modest special-purpose vocabulary, and there are some genre-specific conventions, but the form is not difficult to master.

Some of those hearing or reading your presentation of a patient will — like me — be doing so for purely educational purposes; others will be listening/reading in order to help you solve a medical puzzle; and still others will be temporarily taking over care of the patient, so they will be listening to you in order to know what to expect.

A nice thing about presenting patients is that medical knowledge is helpful, but not necessary. You should be able to describe things that you don't understand. If you know enough to say

My car won't start.

then you almost surely know enough to say

I have a 1995 Toyota Camry with 96 000 miles on it. For the past few months, it has been hard to start — it turns over, but it often takes a few tries before it catches. Today it will not turn over.

and the mechanic will be much better off with the second description, **even if you aren't.**

4.1 Causation

Think twice before asserting that one thing caused another. If your patient has rheumatoid arthritis and you find that her fingers are ulnarly deviated, then it's tempting to describe your physical finding as “fingers ulnarly deviated because of rheumatoid arthritis,” but this temptation should be resisted. Your **physical finding** is what her fingers are like now, not how they got that way. If you want to capture the fact that not only are her fingers ulnarly deviated, but they are deviated in the manner typically seen in patients with RA, then you can say “fingers ulnarly deviated c/w longstanding rheumatoid arthritis.”

Another useful hedging phrase is *suggestive of* (“high-pitched diastolic murmur suggestive of aortic regurgitation”); you can get the same effect by flagging your theory with a preceding question mark (“high-pitched diastolic murmur (?AR)”).

Classic is sometimes used. When your patient with known dermatomyositis has textbook findings, you can say “classic periungual telangiectasia” to tell the reader what you think is going on, but “periungual telangiectasia due to her dermatomyositis” is illegitimately definite.

4.2 Quantitation and pseudo-quantitation

Some descriptions are subject to obvious and immediate improvement by quantification. Instead of saying that the patient “cannot fully flex” his elbow, you should estimate that (say) “elbow flexion is limited to $\sim 75^\circ$.” Instead of saying that the patient’s “left leg looks swollen,” you should carry a (metric) tailor’s tape measure, so that you can report that “measured 6 cm below the tibial tubercle, the circumference of the L leg is 36 cm, while that of the R leg is 33 cm.”

In other situations, no simple physical measurement will be available, but there may be a conventional system of pseudo-quantitation.

4.2.1. Heart murmurs

Heart murmurs are conventionally graded in sixths, spoken as “one out of six,” “two out of six,” and so on, and written using Roman numerals:

- I/VI murmurs are of uncertain existence
- II/VI murmurs are ordinary
- III/VI murmurs are extraordinary
- IV/VI murmurs are loud
- V/VI murmurs can be heard when only the edge of the stethoscope is on the chest wall
- VI/VI murmurs can be heard without the stethoscope

This doesn’t seem very precise, and it isn’t, but two observers will usually agree within a grade or so.

4.2.2. Muscle strength

Muscle strength is conventionally graded in fifths, spoken as “zero out of five,” “one out of five,” and so on, and written using Arabic numerals:

- A muscle graded 1/5 can be seen to contract slightly, but not to move anything to which it is attached
- A 2/5 response is sufficient to move the attached part, but not against gravity. Thus, a 2/5 quadriceps could extend the knee when the patient is in a lateral decubitus position, but not when the patient is sitting in a chair.

- A 3/5 response can move the attached part against gravity, but not against additional resistance. A 3/5 trapezius can shrug the shoulder, but not when you are trying to hold the patient's shoulder down.
- A 4/5 response is pretty good, but still not what the examiner thinks that the patient should be able to do.
- A 5/5 response is normal.

4.2.3. The plus system

When there is no other established convention, pseudo-quantitation is conventionally expressed on a scale running trace, +, 2+, 3+, and 4+. For example, normal DTRs are described as 2+, while reflexes that are unusually brisk might be 3+ or 4+.

The plus system is calibrated differently in different contexts. For example, a body part that is normal and normally tender is not described as being 2+ tender. In fact, it is not described as being tender at all. A report that a testicle or tympanic membrane is 2+ tender will be understood to mean that the part is rather more tender than such parts normally are.

4.2.4. Miscellaneous

Many symptoms can be pseudo-quantitated if you ask the patient to give you more detail than he or she might at first have volunteered. **How many times a night** does your patient with nocturia need to get up to void? In order to breathe comfortably, **how many pillows** does your patient with congestive heart failure need? **How many times a night** does your patient with night sweats need to change her nightclothes? **How many pads or tampons** (and of what absorbency) does your patient with menorrhagia use per day? These data often show up in presentations in such constructions as “nocturia × 2” and “1-pillow orthopnea.”

4.3 Presentation styles

At least three different styles of presentation are in common use. Choosing among them is partially a matter of local custom, but more a matter of picking the style that is best suited to the task at hand.

4.3.1. Chief-Complaint-Centered

The patient identifies a problem, you accept the patient's notion, and you describe what you think is going on. For example,

CC: 33-yo F with pain and swelling of **L** ankle of 6 hours duration

HPI: Patient forcibly inverted **L** ankle stepping off curb this AM, with immediate pain just inferior to lateral malleolus and with progressive swelling since, with severe pain on attempted W/B. No prior Hx of injury to this ankle or other pertinent PMH.

PE: **L** ankle with 3+ lateral swelling, + layered ecchymosis inferior to lateral malleolus, 3+ point tenderness inferior aspect of this malleolus. Joint stable, but with 3+ pain on passive inversion, none on passive eversion.

Presentations don't get any shorter than these, because these contain only what might be directly related to the patient's problem. The reader of this presentation must take on faith that there is no reason to suspect a pathological fracture, that some unrelated problem is not more important (the patient does not have petechiae everywhere; she is not at term with ruptured membranes), and so on.

This style is ill-suited to complex situations. If you decided that this same patient had a more interesting story than the one she thought she had, then your presentation would necessarily have taken on the traditional style, perhaps starting

Ms. X is a 33-yo F with newly-discovered acute bacterial endocarditis. She came to the hospital today after a fall on the street that seems to have been the result of a septic embolic stroke.

She has been an intermittent IVU for many years, but with no known prior systemic manifestations. She had noted night sweats for the past several weeks, but she attributed them

In this latter presentation, you'd get to the ankle in due course, but it would get only the minor emphasis that it deserves.

4.3.2. The SOAP format

Many medical notes are incremental, either outpatient notes on a longstanding patient or progress notes on an inpatient. The reader in these cases may be identical to the writer, and in any event the patient's full story is available in the preceding pages. Neither the chief-complaint-driven nor the traditional presentation styles is well adapted to this situation, but unstyled progress notes can tend to be unstructured and disorganized. In the SOAP style first developed by Dr. Lawrence Weed of the University of Vermont, the note is segmented into

- Subjective data (how does the patient say he or she has been doing?),
- Objective data (physical findings, lab values, and so on),
- an Assessment (what does the writer think is going on), and
- a Plan (what is the writer going to tell the patient, prescribe, *etc.*).

Whole books and conferences have been devoted to the SOAP style, and it really does improve the organization of progress notes. When it is used for an initial patient presentation, it becomes a variant of the chief-complaint-driven style, and it is less successful. It is not further considered here, except insofar as the Problem List component now used in traditional assessments was actually introduced as part of the SOAP style.

4.3.3. Traditional

The chief-complaint-driven style of presentation is rarely appropriate for inpatients. The patient may have entered the hospital for only a limited purpose (say, for open reduction of an unstable ankle fracture), but even so, those taking care of him are responsible for everything else that happens. For example, the orthopedic patient may have well-controlled diabetes that affects his operative management trivially or not at all, but he still needs to have his diabetes managed during his hospitalization. Also, by the

time the patient has been in the hospital for more than a day or two, his problem is often much better understood than it was when he first appeared; the original chief complaint may have been decoded from the Emergency Department's

CC: 19-yo M with RLQ abdominal pain of 6 hours duration

to your narrative 5 days later

Mr. X is a 19-yo M who was admitted with acute appendicitis; he is now in his 5th hospital day and 4th post-operative day.

He was well until 12 hours PTA, when he noted nausea and dull pain in the epigastrium,

In this case, it no longer much matters that the patient's presenting complaint was abdominal pain instead of fever or vomiting.

Sometimes the entire initial problem becomes secondary. The same patient might have been so unlucky as to have instead been described as

Mr. X is a 19-yo M with ARDS, now in his 23rd hospital day. He is being weaned from respiratory support, and we hope to extubate him today.

He originally presented with acute appendicitis, and he underwent appendectomy on his first hospital day. While awaiting transfer from the recovery room to the floor, he was observed to vomit and aspirate. He was re-intubated and brought to the ICU. Despite prompt treatment with. . . .

The point here is that the reader or listener wants to understand what the patient's **current** problems are; in this scenario, the patient's original problem is of only minor interest.

A presentation in this style consists of

- a **lead sentence** or two to describe the patient, giving enough detail that the sophisticated listener can anticipate what is likely to follow, alert to unusual features of the case;
- a **history of the present illness**;
- a summary of other **past medical history**;
- **family history & social history** not captured elsewhere;
- the **physical exam**; and
- a **problem list** .

All of these sections will be described in further detail below. The simple idea is that the reader/listener should, to the extent possible, be protected from surprise. If she is trying to solve a puzzle for you, don't withhold a key clue; if she is taking over the care of the patient for the night, don't let her be surprised by a nurse's query about a major medication that the patient is taking for no evident reason.

5. Traditional Presentation in Detail

5.1 The Lead

This portion of the presentation can be difficult, because it's hard to decide what's important enough to include. It's easy when the patient has only an isolated problem

Mrs. Smith is a 43-yo woman who came to the Emergency Department after forcibly inverting her L ankle stepping off a curb this afternoon. She turns out to have an unstable fracture of the distal L fibula.

because the lead can contain most of the HPI. Perhaps surprisingly, it's again easy in the most complicated cases

Mr. Jones is a 73-yo man, now in his 54th hospital day and his 48th day in the ICU. He is being treated for congestive heart failure now complicated by *Klebsiella* pneumonia.

because the listener is expected to realize that there is no simple overview to be had (except that this patient is very ill), and that many other major problems are probably about to be described in the HPI.

In the middle ground, it can be tricky to select the patient's most important characteristics. There is probably a most prominent medical problem, but there may be no way to think about the problem before knowing more about the patient. Some of the background details that might be included are listed here.

It's good to get the patient's **name** into the lead, if only because your listener may have only your lead in mind when he or she tries to talk to the patient. For the same reason, if the patient has a **medical or paramedical background**, it's conventional to mention it in the lead:

Mr. Jones is a 63-yo retired pharmacist, now in his 3rd hospital day, admitted for treatment of an acute inferior MI.

The patient's **age** and **sex** are always part of the lead, because it's hard to start thinking about a patient without these data.

The lead in the presentation of an inpatient should generally include mention of **how long the patient has been in the hospital**. If the patient was only recently admitted, then the listener is put on notice that the patient may not yet be well understood. If the patient has been hospitalized for a long time, then the listener knows up front that the patient must have unusually severe or complex disease.

If surgery has been a major focus of this admission, then the patient's post-operative symptoms and complications can be expected to vary over time in a more-or-less predictable way, so the lead often includes **how long ago the surgery was**.

Here in the lead and elsewhere, when you mention a procedure, the reader should have no doubt as to why the procedure was performed.

Mr. Smith is a 64-yo man now in his 2nd hospital day and first post-operative day after 3-vessel coronary-artery bypass grafting.

is fine, because there's only one reason to do CABGs. But

Mr. Smith is a 64-yo man now in his 2nd hospital day. He came to the hospital complaining of vomiting, and was immediately brought to dialysis.

is bad, because while dialysis is usually performed for renal failure, it is sometimes done for other reasons (*e.g.*, to treat lithium toxicity).

The lead's most important function is to tell the reader **why the patient is here now**. This might be quite different from why the patient came to the hospital:

Mrs. Smith is a 43-yo woman admitted yesterday after a WBC of 80 000 (mainly immature granulocytes) was found on routine laboratory studies performed in contemplation of elective foot surgery.

Some body-system-specific information is given special attention by the respective specialists. Neurologists, for example, consider **handedness** to be an essential part of every lead

Mr. Jones is a 73-yo R-handed man, now in his 3rd hospital day after a L middle cerebral artery CVA.

and obstetrician-gynecologists will be unhappy with any lead that omits the patient's **gravidity and parity**.

Mrs. Smith is a 43-yo woman, G₄P₂A₂, admitted today for elective hysterectomy after 3 months of dysfunctional uterine bleeding.

(The code is G_xP_yA_z to indicate *x* pregnancies, *y* live-born offspring, and *z* abortions (spontaneous or therapeutic). Sometimes the code is expanded to cut more finely, as in G₄P₂TAB₁SAB₁.)

It's not often useful to bloat the lead with **PMH**, or with **racial, ethnic, occupational, gender**, or other information of uncertain explanatory value, but sometimes including these data can indicate the line of your thinking, letting the listener guess how you're going to organize the HPI. Data of this sort may be especially valuable if without them, the lead opens a particularly wide range of possibilities. If your punch line is going to be a strong suspicion of malaria, recurrent deep venous thrombosis, or metastatic bone disease, then

Mr. Jones is a 27-yo Gambian man, admitted yesterday *c/o* drenching night sweats of 2 weeks duration.

Mr. Johnson is a 58-yo man, admitted yesterday after a day of LLE swelling and pain in the setting of longstanding intermittent DVT of this extremity.

Mr. Smith is a 73-yo man with known advanced bronchogenic carcinoma, admitted yesterday *c/o* low back pain of 2 weeks duration.

are much more helpful than

Mr. Jones is a 27-yo man, admitted yesterday *c/o* drenching night sweats of 2 weeks duration.

Mr. Johnson is a 58-yo man, admitted yesterday after a day of LLE swelling and pain.

Mr. Smith is a 73-yo man admitted yesterday *c/o* low back pain of 2 weeks duration.

even if your organizing thought turns out to be wrong. If the patient is one whose disease is especially well understood here, that's good to note:

Mr. Jones is a 27-yo man with known SS DZ, well known to this hospital, admitted yesterday with a new painful crisis, subjectively a little worse than (but otherwise similar to) the one for which he was admitted two months ago.

Some PMH (metastatic cancer, end-stage renal disease, AIDS) is intrinsically so important that it's worth mentioning in the lead even if it's probably not directly related to the acute problem.

Many patients who have agreed to **Do Not Resuscitate orders** are at only moderate risk of death. When the patient's condition makes death during this hospitalization reasonably likely, the existence or non-existence of a DNR order should be mentioned in the lead.

Finally, when you are presenting a patient for a **narrow purpose**, it's appropriate to tell the listener what that purpose is. Representing an Internal Medicine service, you might begin a presentation to a consultant surgeon with

Mr. Jones is a 43-yo man, admitted 4 days ago with an exacerbation of long-standing asthma. We are asking your help in evaluation of two subcutaneous nodules, incidentally noted during routine examination of his anterior abdominal wall.

5.2 History of the Present Illness

Taking the history from the patient is not necessarily the same as getting all of what you need to compose the patient's HPI. For one thing, the patient may be demented or intoxicated. Even an alert, educated, and articulate patient may not be aware of some of the critical points in his own medical history. For example, most of the HPI of a patient with hematologic disease usually consists of laboratory results and drug dosages, probably not known to the patient. Often, you won't be able to put together a coherent HPI without looking at the patient's chart.

Early in the course of reading or listening to an HPI, the reader or listener should be able to formulate a theory of what is going on with the patient, and then to refine it as details unfold. Without a theory, the data may be overwhelming. Almost always, the best way to ease the reader's task is to spin the HPI as a strict **chronological** tale, starting at a time when the patient was well or, at least, in some sort of steady state. Instead of

Six hours PTA, he noted the acute onset of R flank pain, radiating to his R testicle, and then noted the appearance of gross hematuria. These symptoms were like those he had had 8 years PTA; the earlier symptoms were milder, they were self-limited after a few hours, and they were never brought to medical attention. . . .

it's better to write

He had been in good health until 8 years PTA, when he suffered one self-limited episode of R flank pain, with accompanying gross hematuria. This episode was self-limited after a few hours, and he never sought medical attention. He was then again well, taking no medications. Six hours PTA, he again noted the acute onset of R flank pain, this time radiating to his R testicle, and he again noted gross hematuria. . . .

As demonstrated in these examples (even in the bad one), **the anchor of the HPI's timeline should be the date of the patient's admission to the hospital.** Using a calendar date or a patient age — except in pediatrics, which has its own conventions —

forces the reader to do unnecessary math, unless the date is so remote that no one would bother to figure out how long ago it was.

She might have had second-hand exposure to asbestos from contact with the clothes of her father, who worked in a shipyard for a year or so during World War II.

and

She has had occasional seizures ever since early childhood. . . .

are OK, but

She has had occasional seizures ever since she was 63. . . .

and

She has had occasional seizures ever since April of 2001. . . .

are not.

The baseline steady state at which you start may need a few words of description if it is not one of youth and vigor. For example, a 90-year-old patient who is confused and nonambulatory might be assumed to be in her usual state, but your history might reveal that

She has had osteoarthritis for many years, and 7 years PTA underwent R total hip replacement for that reason, with no complications, no limitations on the subsequent use of her RLE, and prompt return to active independent life in her own apartment.

The information available may not necessarily make sense. If the first symptom of a bronchogenic carcinoma was scapular pain, then the patient's first related medical contact could not plausibly have been with the pulmonary clinic, but that may be all that he remembers. If your presentation does not acknowledge the gap, the reader will wonder whether you perceived it. Don't let yourself be thought to be inattentive. Instead of

He was well until 2 years PTA, when he noted the onset of nagging L scapular pain, worse on abduction of the shoulder. Transbronchial biopsy at the pulmonary clinic 18 months PTA revealed. . . .

it's better to write something like

He was well until 2 years PTA, when he noted the onset of nagging L scapular pain, worse on abduction of the shoulder. The history is then obscure, but he ultimately found his way to the pulmonary clinic, where transbronchial biopsy 18 months PTA revealed. . . .

Some of the HPI will implicitly have no source but the patient (when did the pain start?), but other information will implicitly have been generated medically, passed to you by the patient or the chart (did she already have papilledema at the time of admission?) **Specialty-related findings that were actually made by specialists** are often worth flagging, especially in the case of a nonfinding often overdiagnosed

. . . An otolaryngologist found the sinuses to be clear. . . .

a positive finding often missed

. . . An ophthalmologist found her to have bilateral papilledema. . . .

or any finding in areas where non-specialists are inconsistently reliable:

. . . The gynecologist found that the L Fallopian tube was diffusely tender. . . .

Your history of the patient's present illness should mention **mechanistically-pertinent medical or family history**, positive or negative. In describing a patient with a recent stroke, for example, it is pertinent that he had (or didn't have) a long history of hypertension. Whatever the acute problem, it's usually valuable to indicate whether the patient has had similar problems before. These data are especially important when the apparent diagnosis is rare, or rare in patients without predisposing history (opportunistic infections, myocardial infarctions in young patients, *etc.*).

Sometimes **unrelated history** is so important in any thinking about the patient that it would be disingenuous not to mention it early in the description. Information of this sort that doesn't quite make it into the lead can be supplied in the HPI:

Mrs. Jones had been in poor health since she developed scleroderma 3 years ago, but she had been living stably at a nursing home until 25 March, when she developed sharp, continuous epigastric pain, radiating to the left flank and left lower back, without nausea, vomiting, or change with position or with voiding. Upon admission the next day, she was found to be in diabetic ketoacidosis, with a blood sugar of 735 and a serum pH of 7.12.

When you mention one of the patient's diseases or conditions, it's a good idea to note any **medications** that she is getting for it. It may even be appropriate to record the dose of some medications, especially when — as with corticosteroids, insulin, opiates, or supplemental oxygen — dosing levels carry information about the patient's severity of disease. If you discover that the patient is receiving a medication not plausibly associated with any of her diseases or conditions, then bringing this discovery to others' attention is a useful service. Not only may it be appropriate to end the HPI with something like

Ms. Jones has also been receiving digoxin 0.125 mg PO QD, but there is no record (or hint in her current presentation) of what purpose this might be serving.

but the same discovery might lie behind an entry in the patient's problem list (see Section 5.6.4.

5.3 Past Medical History

Details that you learn during collection of the Past Medical History may deserve to be presented with the HPI. For example, a patient whose present illness is an acute myocardial infarction might not mention his femoral-popliteal bypass surgery and abdominal aortic aneurysm repair until you asked him about past surgery, but these badges of diffuse vascular disease would then be described in your HPI.

Some surgical procedures (*e.g.*, tonsillectomy) need no annotation, but often you'll need to ask why the procedure was performed. For example, a hip may have been replaced as an elective treatment of osteoarthritis, but it may instead have been replaced after a femoral neck fracture. In the latter case, you're still not done. How did the patient break her hip? Did she prosaically trip over something, or did she have a mysterious fall, perhaps as a result of a seizure or arrhythmia?

Ask the patient for details when his words are equivocal. For example, he may use "spell" or "fit" to denote a seizure, an anginal episode, a transient ischemic attack, or an emotional outburst. Don't ask "When you say you had a spell, do you mean that you had

a seizure?"; if he knew the word "seizure," he'd have used it. Ask "What happens during one of your spells?"

Few elderly people remember what diseases they had as children, and so it's fortunate that that information is not often useful. Asking the patient whether he was ever out of school for a long period of illness is more valuable; now and then you'll meet someone who probably had rheumatic fever.

5.4 Review of Systems

With every patient, your history-taking must include a Review of Systems. As you run through the list of possible past symptoms, the patient's memory may be jogged into revealing something that he hadn't mentioned when you were collecting data for the HPI & PMH.

This necessary component of your data-collecting behavior does not necessarily correspond to a separate component of your presentation. Much or all of what you learn during the review of systems should be merged into the HPI and PMH sections of the presentation.

When you ask the patient about **allergies**, be sure to ask how each putative allergy manifests itself. Many patients, for example, will describe "allergies" to antibiotics, but these often turn out on further questioning to have been manifest as diarrhea, vaginitis, or some other sign of antibiotic-induced alterations of normal flora. Those aren't allergies. Non-allergy reactions are not to be ignored, but don't say "Allergic to aspirin" when what you mean is "No well-defined drug allergies, but he reports GI distress on exposure to aspirin." At the other extreme, it would be good to know if your patient had required respiratory support after an exposure to aspirin had induced life-threatening bronchospasm.

Surprisingly many patients report that they are "allergic to all medications," or "allergic to all antibiotics." Don't bother trying to improve the patient's grasp of immunology, but do take a little time to see if a genuine allergic reaction is lurking in the fog.

Symptoms that the patient doesn't mention until your prompting during the ROS are usually of minor importance, but you can't assume this, and each positive finding must be explored, at least a bit. Is his cough productive? How much sputum does he produce in the course of a day? Do her leg cramps strike at night, for no apparent reason, or are they effort-related? And so on.

5.5 Social & Family History

Some elements of social and family history are properly part of the HPI. If your respiratory patient had occupational exposure to asbestos, or if he has a family history of α_1 -antitrypsin deficiency, the reader would want to know this early on.

The most commonly-cited reason to collect an **occupational history** is that your patient may have been exposed to interesting toxins. You will meet such patients, but only rarely. More often, the occupational history will help you to detect a probable

change in the patient's mental status. A given level of mental function might be of uncertain significance in a manual laborer or a waitress in a fast-food establishment, but surely pathological in an accountant or a waitress in an upscale restaurant.

Rare hereditary diseases in the **family history** speak for themselves, but common diseases may be important if they occurred unusually early. Knowing that an elderly patient's parents both died of coronary disease is not interesting, but knowing that they did so in their 30s may suggest a familial lipid disorder. Above all, you shouldn't miss an opportunity to find that whatever it is that your patient has, it's probably the same thing that has been hitting other members of his family.

Travel history is usually not too useful, but sometimes it is helpful when patients are infected. Within the US, histoplasmosis, coccidiomycosis, and borreliosis have strong regional associations, and every tropical country has diseases all its own. Here is another class of information that may be valuable in your presentation not because you know how to interpret it, but because your listener might.

5.6 Physical Exam

Most of your presentation of your patient consists of stories told to you by the patient or by other physicians. You don't really know that any of those stories is true. It's only when you get to the physical exam that you can describe what you personally have seen and felt. If there are discrepancies between what you were told and what you see, you should point them out, but you don't need to reconcile them. Descriptions like

General: WDNWWM in moderate respiratory distress, looking 10 years older than his stated age.

General: Cachectic elderly WF in NAD, gesturing in normal conversational manner with both UEs despite complaint of L-sided paralysis.

Abdomen: Midline 20-cm WHSS, unrelated to any surgical history from patient or OC.

are fine.

5.6.1. Completeness

During this sequence of exercises, you won't be doing breast, urogenital, or rectal exams. This is rather a pity, for two reasons. First, doing a discerning pelvic exam takes lots of practice, and the sooner you start doing them, the better. Second, exactly because these exams can be awkward, you need practice in integrating them into your routine of examination.

(You will not be examining the breasts of your patients, but it will be OK for you to expose their breasts in the normal course of cardiac examination. Similarly, not doing urogenital exams does not mean that you should not palpate femoral pulses.)

Even not counting the deliberate omissions just noted, you won't be doing complete physical exams. That's because there's no such thing as a complete physical exam. Whatever you do, you could do more. Did you check between the toes for a tiny melanoma? Of course you didn't (unless the patient had unilateral LE lymphadenopathy). Did you check the area between the first and second toes for a

sensory deficit attributable to a lesion of the deep peroneal nerve? Of course not (unless the patient had a motor deficit of the anterior tibialis, or some other reason to worry about the nerve). It can be tricky to decide how much to do.

Whatever your decision, it will sometimes be overruled. The patient may decide that he doesn't want to be examined any more, or you may find that the foot you want to examine is in a cast. **Every description of a physical exam should include all of the headings;** some of the entries may be "Not examined" or the euphemistic "Deferred," but that's OK.

5.6.2. Sequence of the Exam and Its Description

It's a good idea to establish a fixed sequence in which to perform your exam, mainly as a means of making sure that you don't forget anything major. Every once in a while someone describes a physical exam that somehow, because the examiner did not have a fixed sequence to follow, completely omitted the abdomen or the extremities.

The physical exam is usually described in simple cephalad-to-caudad order, with the skin, extremities, and neurological exam thrown in at the end, and with a brief introductory capsule description inserted at the beginning. **The presentation order is not necessarily the best order in which the exam should be performed.**

Even before you begin the formal physical examination, you should be taking note of the patient's appearance. Sometimes a patient can pull himself into a normal posture when he is aware that he is being examined, but in repose his configuration is revealingly abnormal. For example, the fingers of a hand in normal repose are flexed at each joint, with the interphalangeal joints of successive fingers from index finger to small finger successively more flexed. A patient with a mild flexor-tendon weakness may be able to hold her hand in a normal posture when her attention is drawn to it, but when her hand is relaxed, the affected finger is likely to be abnormally extended.

Speaking of hands, I start every physical exam by examining the hands. The patient is never threatened by my handling of his hands — they are the parts of the body most commonly touched by others — and at the same time I can quickly establish the mood of the examination, because I am dealing with his hands in a special way, not in the way that hands are socially shaken or fondled.

As you talk to the patient during the course of the exam, you may pick up snippets of history that belong with the PMH or even with the HPI. The patient may forget to tell you about the appendectomy that she underwent 40 years ago until you ask her about her scar, but that doesn't allow you to mention the appendectomy only as a part of the PE:

Abdomen: . . . 3-cm appendectomy scar RLQ. . . .

Instead, the appendectomy should be mentioned in the PMH (or conceivably in the HPI, if, for example, she's here with symptoms that might be related to adhesions). The PE entry should be

Abdomen: . . . 3-cm WHSS RLQ c/w PMH. . . .

Someday you will have finished (you thought) with the history relating to a chief complaint of cryptic unintended weight loss, you will have gone through an uninformative ROS, you will have started the physical exam, you will discover that the patient has an oozing malignant lesion of one of her breasts, and in the ensuing conversation with the patient you will get other new information that she somehow forgot to tell you earlier. **It will be part of the HPI.**

5.6.3. Subsection Notes

5.6.3.1. General

This heading is meant to capture what an observer might notice about the patient before beginning a formal exam. The usual features included are development, nutritional state, race, sex, comfort level, gross state of alertness, and relation (if there is one) to unusual apparatus.

Almost every patient is described as “well-developed” (usually as part of *WDWNWF* or the like), but occasionally you will see patients who have developed strangely. These patients are not described as “ill-developed”; instead, you might write something like

General: Alert small WF with dysmorphic features, consistent with her known osteogenesis imperfecta, in NAD.

Most patients are described as “well-nourished” (usually as part of *WDWNB* or the like), but some are cachectic, and others are morbidly obese. In place of the *WDWNxx* cliché, some presenters favor more vivid language that captures it all.

General: Fit-looking elderly WM in NAD, looking 10 years younger than his stated age.

is fine (if true). To reinforce your report that the patient is unusually thin or unusually fat, computing the **BMI** is often a good touch:

General: Well-developed, morbidly obese (BMI ~ 42) BF in NAD.

It’s customary to indicate the patient’s **race** here, to the extent that it is evident from the patient’s appearance. This usually shows up as part of *WDWNB* or the like. Remember that this is part of the physical-exam section, so you can’t draw on what the patient told you about his or her specific lineage. The available distinctions are usually limited to white, black, Hispanic, Oriental, and — in some settings — native American.

(*WDWNAAM* (= . . . African-American male) might seem to be a merely politically-correct version of *WDWNB*, but it is worse. Some of our black patients aren’t Americans. Even when you know that your patient **is** African-American, you don’t know it on the basis of the physical exam. All you know from the exam is that he is black.)

Your description of the patient’s **comfort level** should be based on your observations, giving only as much weight to the patient’s report as common sense dictates. For example, you may have had to awaken the patient from untroubled-looking sleep, and you may then find him cheerful and socially appropriate as you introduce yourselves to each other. If then in response to your questions he says “Oh, yes, as a matter of fact I am now having the worst belly pain I’ve ever had, 10 on a scale of 10,”

you must take your observations into account. While he was asleep, he was not telling you a lie.

This patient's report should not be ignored, even though you don't believe that it is true. When in doubt, describe what you've seen:

General: WDNWM initially asleep, easily aroused and in no apparent distress, although reporting severe abdominal pain.

When your patient really is in distress, try to describe why you think so:

General: Cachectic WDBM looking older than stated age, sitting upright in bed and in moderately severe respiratory distress, using accessory muscles of respiration and speaking in short phrases; on O₂ per NP at 4 L/min.

As in this example, respiratory distress is often pseudo-quantitated by noting how capable the patient is of speech.

Neurologists and anesthesiologists have detailed scales on which patients' **levels of consciousness** are scored, but in the General section of the physical exam it's probably more appropriate to describe the patient only as alert (= normally attentive), lethargic (= attentive if spoken to), stuporous (= attentive only if physically irritated), or unarousable.

If the patient is on, in, or connected to unusual **apparatus**, that's part of the General section of your exam. Ordinary IV lines are not worth mentioning, and mention of some devices may logically be deferred to a specific section of the exam, as in

Abdomen: Scaphoid. RUQ with healing stapled 10-cm surgical wound and tube to suction draining clear yellow fluid c/w HPI. . . .

but most other devices (respiratory apparatus, Stryker frames, *etc.*) are part of the General section.

5.6.3.2. Vital Signs

If there's any reason to suspect hypovolemia (for example, if the patient's history includes vomiting or diarrhea), then it's good to measure the blood pressure and heart rate with the patient in two different positions, optimally standing and recumbent. Young patients are often able to compensate for hypovolemia by increasing the heart rate alone, so it's not sufficient to look only for changes in blood pressure.

Counting the respiratory rate can be tricky, because most people will alter their breathing when they see that it is being observed. Even though the respiratory rate is subject to some voluntary control, you should never fail to record it. Tachypnea can be a sensitive sign of dysfunction, most often just a redundant sign of respiratory compromise but sometimes a sign of sepsis, acidosis, or aspirin toxicity.

In patients who have problematic fluid balance (*e.g.*, patients with renal failure or heart failure), it's common to include weight among the vital signs. You may be tempted to record just the weight of patients who are cachectic or massively obese, but in those cases a computed body-mass index is more informative.

5.6.3.3. Visual acuity

The two eyes must be tested separately, usually when the patient is **not** wearing his or her usual glasses. Formal testing with a Snellen chart is rather a luxury, but when the patient has a major visual disability, you shouldn't fail to learn if one (or both) of his eyes falls into the range of

- **NLP** (= no light perception)
- **NHM @ 3'** (= can't perceive hand motion at 3 feet; $\approx 2/200$)
- **NCF @ 3'** (= can't count fingers at 3 feet; $\approx 5/200$)

Other abbreviations that are ubiquitous here are **OS** (= *oculus sinister* = left eye) and **OD** (= *oculus dexter* = right eye), so one sees descriptions like "uncorrected VA: OS NLP, OD 20/50."

A patient is legally blind if he or she has best-corrected visual acuity less than 20/200 (roughly, the patient is unable to read tabloid headlines) or a visual field narrower than 20°.

5.6.3.4. The Abdomen

It's OK to describe splenomegaly in terms of the extent to which the spleen is palpable inferior to the left costal margin, but the liver is too variable to be treated analogously. To describe the liver size, you should try to percuss its vertical extent along the right mid-clavicular line.

5.6.3.5. Extremities

Your job has only started when you notice that the **range of motion** of one of the patient's joints is restricted. That observation should lead to a more focused exam, with the goal of determining the mechanism (not quite the diagnosis) of the restriction. Can you push the joint through a full passive ROM (suggesting that the patient's problem is neuropathic or myopathic)? Is passive ranging limited by pain, even when the patient has relaxed the muscles whose tendons bridge the joint (suggesting a ligamentous or arthritic problem)? Does passive ranging encounter simple mechanical obstruction from skin or ligament contracture, or from the scarring-down of injured tendons to their sheaths? Does the patient have pain when he attempts to move the joint against resistance, before any motion actually occurs (suggesting a problem in the muscles, tendons, or bony attachments)? Never say something like "**L** shoulder abduction limited to 45°" and leave it at that.

When you can't find a **peripheral pulse** (say, a dorsalis pedis pulse), then the physical exam must be extended a bit. First, is the distal extremity OK? In this case, is the foot warm, with good capillary refill in the nail beds, or is it cold, with atrophic skin changes? Is there a palpable pulse in a collateral vessel (in this case, the posterior tibial artery)? Second, how proximal does the problem go? In this case, can you feel a popliteal pulse? Can you at least find a femoral pulse? Once you find pulses somewhere, more proximal sites can more or less be ignored, but the reverse is not true.

5.6.3.6. Skin

Your exam is meant to serve clinical, rather than forensic, purposes, so it's not useful to catalog minor traumatic scars of the extremities.

Surgical scars related to major trauma or major invasive procedures are conventionally described with the exams of the regions in which they fall, even though they could theoretically all be grouped with other dermatological findings. The only scars usually described in a Skin category are keloids, scars that are the residue of burned-out dermatological disease, and the scars of burns that extend over multiple regions.

The description of a scar that you choose to describe should include a rough estimate of its size, and a scar following a common surgical pattern (sternal, intercostal, median, paramedian, Pfannenstiel) should be so described.

Your mention of a rash or pigmentation disorder should describe its extent. In particular, does the abnormality appear only in sun-exposed areas, only in areas underlying tight clothing (waistbands & bra straps), only in areas of special chemical exposure (under a bracelet, or on the hands and wrists of a dishwasher), or only in intertriginous areas? Does it appear to be a total body rash, sparing only the palms and soles? Does it involve the palms and soles too?

5.6.4. Self-doubt

Sometimes you will fail to find something, but not really doubt that it is present. You shouldn't claim to have found what you haven't found, but you must be careful not to mislead someone who is trying to understand the chart and reads your physical exam instead of any other, perhaps because yours was most recent, or because your handwriting is most legible. For example, pericardial friction rubs are notoriously evanescent. If you know that other observers have all heard your patient's rub, it may be appropriate to say something like

Heart: No M, R, G appreciated (but other observers have recently heard pericardial R).

At other times, you might indicate your uncertainty as to some findings by including disconfirmatory findings that might not otherwise have been worth mentioning:

Extremities: . . . R pedal pulses not palpable, but distal foot is warm with good capillary refill in toes.

Sometimes the problem will be a new (probably false) positive finding instead of a new (probably false) negative finding. If you're really sure that your finding is there, then it may be important, and don't hesitate to bring the finding to the attention of someone more experienced. If you are less sure, it's OK to hedge with "(?)" or "possible," as in

Abdomen: Anterior abdominal wall with possible rubbery nontender 2-cm SQ nodule about 5 cm inferior to L costal margin in mid-clavicular line and (?) similar nodule 3 cm inferolateral to that.

5.7 Problem List

This section is unique in at least two respects. First, none of its content should be new. It is an error to see something here that has not been mentioned earlier. Because there is no new content here, the writing can be terse, or even telegraphic. The usual way to gather the elements of the list is just to read through the rest of the writeup, taking notes.

Secondly, this section gives you your chance to put the whole case together, reordering your notes into a coherent sequence, allowing yourself bold speculations about what caused what. You'll probably find it easiest to order the list so that later items can refer to earlier ones. For example, if your patient is in the hospital with an acute manifestation of a chronic disease, it may make more sense to mention the chronic disease before the acute manifestation, as in

1. HIV infection, receiving HAART
2. Cerebral Toxoplasmosis, 2° to #1
3. Seizures, probably 2° to #2
4. decline in mental status, ? 2° to #2
5. Hyperlipidemia
6. Hyponatremia

or

1. Deep venous thrombosis of LLE, longstanding, with little evidence of recent change
2. Massive chronic swelling LLE, 2° #1
3. S/P remote placement of IVC filter device, 2° #1
4. Chronic pain LLE, 2° #1
5. Apparent history of schizophrenia, not on chronic medication
6. Homeless, probably in part 2° #5
7. Remote history of acute appendicitis & appendectomy
8. Grand-mal SZ disorder since childhood, 1-2 SZ/year in recent years, noncompliant with Rx of phenytoin and phenobarbital
9. Hepatitis by history, type(s) uncertain
10. Alcoholism by history, said to be inactive lately, but receiving prophylactic chlorthalidone, folate, and thiamine
11. Mild diarrhea and diaphoresis since 2 days PTA, ?etiology
12. Non-pleuritic sharp L-sided chest pain constant for past 12 hours, radiating to LUE with no other symptoms suggesting ischemic or embolic origin
13. Dysuria since 2 days PTA, ?etiology