Introduction to the clinical medicine

Lecture 1 for 2nd year dentistry faculties students

Docent Borzykh Oksana Anatoliivna

DEPARTMENT OF INTERNAL MEDICINE # 3

- THE HEAD OF DEPARTMENT
- Docent
- BORZYKH OKSANA
- ANATOLIIVNA

DEPARTMENT OF INTERNAL MEDICINE # 3

PROFESSOR

- IGOR PETROVITCH KAYDASHEV

English student's teachers:

Professor

- Kaydashev Igor Petrovich

Docent

- Borzykh Oksana Anatoliivna

Assistent

- Hlistun Katerina Aleksandrovna

Propedevtic = diagnostic

- A Greek word «Propaedeutics» means «introduction into discipline».
- The course of **Propedeutic of Internal Medicine** is intended for the study of the principles of diagnostics diseases of internal organs and systems.

Ultimate goal of the course

- ***be able to inspect patients with certain internal diseases and their complications and determine a syndromes' diagnosis, render the first aid at the urgent states and organize the care of patients***.

Propedeutics of Internal Diseases

- **A. Basic definitions**

- **1. Symptoms** are any problems experienced by the patient that may be related to a health condition. Symptoms usually are used to identify the underlying pathology.

- **2. Signs** are physical indications of the disease or syndrome. They may be visible to anyone or specifically to the clinician in the course of the examination.

- **3. Diagnosis** is a determination of the underlying cause of a symptom or sign or set of symptoms or signs.
- **4. Prognosis** is the predicted course of a disease-that is, its duration, progression, and outcome.

Signs and symptoms

- Such abnormal phenomena as pain, dizziness, nausea, vomiting, occurring in sick persons are called **signs or symptoms** of the disease.
- Subjective and objective symptoms are ***differentiated!***

Subjective symptoms are those that cannot be found on examination of the patient – pain, dizziness, nausea, and so on.

Objective symptoms are those that can be found on examination of the patient – cyanosis, jaundice, enlarged internal organs, tachycardia, and so on.

Syndromes

- Symptoms and signs are the displays of pathological process.
- A pathological process rarely shows up an only one symptom or sign.
- Different pathological processes can have some identical symptoms.
- Complex of symptoms, incident to this pathological process **is a syndrome**

Checklist of symptoms

GENERAL

- Fatigue
- Anorexia
- Weight change
- Itch
- Rashes
- Low mood
- Fevers/night sweats
- Heat/cold intolerance
- Change in appearance

Gastrointestinal

- Swallowing difficulty
- Nausea and vomiting
- Haematemesis
- Heartburn
- Indigestion
- Abdominal pain

Checklist of symptoms

Cardiorespiratory

- Chest pain
- Breathlessness
- Orthopnoea
- Paroxysmal nocturnal dyspnoea
- Palpitation
- Cough
- Sputum
- Wheeze
- Haemoptysis

Genitourinary

- Dysuria
- Frequency/nocturia
- Change in colour/smell of urine
- Prostatic symptoms
- Urethral/vaginal discharge
- Incontinence
- Menstrual difficulties
- Postmenstrual bleeding
- Sexual difficulties

Checklist of symptoms

Central nervous system

- Headaches
- Fits/faints/funny turns
- Weakness
- Sensory symptoms
- Changes in taste/smell
- Hearing disturbance
- Visual disturbance
- Speech disturbance
- Dizziness

Locomotor

- Pain
- Immobility
- Loss of joint function
- Stiffness
- Swelling

Syndrome

Syndrome, a group of signs and symptoms, that occur together and are typical of a particular disorder or disease.

- For example: after skin trauma there are inflammation in the area of trauma.
- We see at that place: redness, edema, high temperature, pain and some disorders of function. That is **syndrome of local inflammation**.

Disease

- Disease – it, usually, combination of a few syndromes.
- Disease has reason – etiology and mechanisms of development – pathogenesis.
- Diseases are classified, have certain codes.
- Protocols of inspection and treatment of diseases are developed.

Hospital chart

- The basic method of diagnostic is the hospital chart evaluation
- The hospital chart has two main parts:

Obtaining medical history or “anamnesis”

Physical examination

Hospital chart

Chief components of medical history (anamnesis) are:

- ***A. Identifying data (Passport data).***
- ***B. Main complaint.***
- ***C. History of present illness (HPI) (Anamnesis morbi).***
- ***D. Past medical history (PMH) (Anamnesis vitae).***
- ***F. Review of systems (ROS).***

Identifying data (Passport data).

Identifying data give the reader or listener a brif picture of the patient, including the:

- name
- age
- sex
- occupation
- In some clinics also include the number of admissions to the hospital.

System for gathering information

- Give the patient your undivided attention
- Keep your note-taking to a minimum when the patient is talking
- Use language which the patient can understand
- Let patients tell their own story in their own way
- Steer patients towards the relevant

System for gathering information

- Use open questions initially and specific (closed) questions later
- Clarify the meaning of any lay terms or diagnoses patients use
- Remember that the history includes events up to the day of interview
- Summarize (reflect back) the story for the patient to check
- Utilize all available sources of information

Main complaint

- **Main complaint**, a statement made by a patient describing his or her most important symptoms of illness or dysfunction; the reason for seeking medical attention.
- *For example :* Patient X., is a 50-year-old female, magazine editor, who comes in with a 3-month history of fatigue. She say: "I am so tired all the time."

video

Main complaints

History of present illness (HPI) (Anamnesis morbi)

includes obtaining of following information:

- the time of disease onset (acute or gradual)
- the cause (if known)
- the first symptoms and their character
- previous examination and results (if any)
- treatment and results (if any)

Past medical history (PMH) (Anamnesis vitae)

- **Definition and significance.** The PMH is obtained to ascertain any medical information from the patient's past that may have an impact on the present or future. The patient should be told that the interviewer plans to focus on major health problems.

Content

Childhood illnesses **Adult illnesses.**
Surgical procedures **Accidents and injuries**
Occupation **Activities of Daily Livings**
Patient concerns **Immunizations**
Obstetric history **Psychiatric history**

Medications: Current prescribed medications
Nonprescription medications
Health habits: Diet. Exercise. Tobacco. Alcohol
Allergies: Medication allergies. Food allergies. **Other:** Seasonal allergies, bee-sting reactions, ets.

Family history (FH)

Video

Past medical history - Anamnesis vitae

Review of systems (ROS)

Definition:

- The ROS is the final part of the history. Its purpose is to determine that no major problems have been missed.
- It is important to let the patient know that, unlike the prior parts of the history, the ROS will be acquired by means of multiple closed-ended ("yes" or "no") questions.

video

Review of systems

Hospital chart

PLAN OF THE PHYSICAL EXAMINATION

- **1. General appearance and statistics**
- **2. Vital signs: body temperature, pulse, rhythm, respiratory rate and rhythm, blood pressure**
- **3. Inspection**
- **4. Respiratory system examination: inspection, palpation, percussion, auscultation**
- **5. Cardiovascular system examination: inspection, palpation, percussion, auscultation**
- **6. Abdomen and gastro-intestinal system examination: inspection, auscultation, palpation, percussion, stool**
- **7. Kidney examination; inspection, palpation, back symptom, urine excretion**
- **8. Endocrine system examination: inspection of endocrine glands diseases signs, palpation of thyroid gland**
- **9. Nervous system examination**
- **10. Conclusion: major symptoms, syndromes.**
- **Plan of laboratory and instrumental examination.**

General appearance and statistics. Vital signs

Vital signs:

- **BP:** Both arms, sitting, 110/72
- **Pulse rate:** 68 /min, and regular
- **Temperature:** 36.9 °C
- **Respiratory rate:** 18/min