# Abdominal pain

| |
|---|
| Introduce yourself , take permission |
| Patient profile (name , age , occupation , address , marital status) |
| Chief complaint + duration |
| Analysis of the Chief Complaint **(SOCRATES)** |

**Site**

**Onset** (sudden or gradual, progression, first time)

**Character**
- Colicky - Sharp/stabbing - Burning/pricking - Tearing - Dull

**Radiation**
- To back

-To testicles/groin

- To shoulders

- Loin to groin

**Associated symptoms (finish the CC analysis then ask about them ↓)**

**Timing** (episodic or continuous)

**Exacerbating:**
- Eating or fasting.
- increased by swallowing.
- fatty foods.
- acidic/spicy foods/coffee.
- Does it increase by movement or breathing?

**Relieving:**
- Eating or fating
- Certain position (lying on one side, or leaning forward)
- Bowel motion.
- Drugs

**Severity** (from 0-10).

**Associated symptoms**

• **GI symptoms**:
• Dysphagia, Regurgitation, heart burn, hoarseness of voice.
• Dyspepsia , N+V
• Bloating/abdominal swelling (generalized/localized)
• Early satiety
• Jaundice/ RUQP/ Steatorrhea, urine & stool changes, itching
• Bowel habit, diarrhea/constipation • Flatulence
• Melena and Hematochezia

**IBD symptoms**: arthralgia, eye symptoms, skin, oral ulcers, bloody diarrhea.

**Renal symptoms:**
• Loin to groin + flank + colicky: renal stones
• Suprapubic + dysuria: UTI
• Pruritus
• Ankle swelling

❖ **Gynecological + Obstetric symptoms** :
Correlation with menstrual periods • Menorrhagia • Possibility of patient being pregnant • Last Menstrual P.

**General**
• Fever, weight loss, loss of appetite, night sweat.

**Risk Factors (always ask about smoking and alcohol)**
Previous abdominal surgery >> intestinal obstruction
Atherosclerosis >> Mesenteric ischemia , AAA

**Red Flags of acute abdominal pain**: Bleeding (upper GI bleed or lowerGI bleed), Severe pain, Signs of shock, Signs of peritonitis.

**Review of systems**

**Past medical and surgical**
• Previous surgeries.
• Hepatitis, or history of blood transfusions, sexual intercourse, contact with jaundiced patient.

**Drug Hx:** NSAIDs, antacids, use of laxatives..

**Family Hx:** Ask about relevant conditions related to the history (IBD, PUD ... etc.), andany chronic diseases.

**Social Hx**: Smoking history (# of pack years), alcohol, travel history

# Bleeding per rectum

Introduce yourself , take permission

Patient profile (name , age , occupation , address, marital status)

Chief complaint + duration

Analysis of the Chief Complaint

**Onset:** - Sudden acute - chronic
**Previous episodes**

**Character:**
- **Color:** Mixed with stool, Streak, at the toilet paper
- **Amount** (In cups).

**Associated bleeding from other sites**

**Time:** Constant or episodic. / **Progression** (Getting worse or better)

**Exacerbating and relieving factors:**
- NSAIDs ⟶ PUD
- Food ⟶ GU
- Trauma to abdomen ⟶ Hematoma

**Severity:**
- **Anemia symptoms** (Fatigue/ SOB/ Palpitations/ Dizziness).
- Assess the **dehydration symptoms** (Feeling thirst/ dry mucous membrane/ oliguria/ altered mental status)

**Associated symptoms**

**I. GI:**

A) Dysphagia and odynophagia.
B) Heartburn and regurgitation
C) Dyspepsia
D) Jaundice / change in urine & stool color / itching/ limb swelling⟶ Cirrhosis
E) Abdominal Pain ⟶ Epigastric ⟶ PUD
F) Abdominal Distention
H) Diarrhea or constipation
G) Hematochezia/ anal **pain or anal lump**.

**II. Blood disorders:**

Bleeding from other site, ecchymosis, purpura, petechial, hematuria.

**III. Constitutional symptoms:** Fever, Weight loss, Anorexia, Night sweat.

| |
|---|
| **Risk Factors (always ask about smoking and alcohol)**<br>**I. PUD** → Smoking, NSAIDS, Alcohol<br>**II. Bleeding disorders** → Drugs {Anti-coagulants (Heparin or Warfarin) / NSAIDS(Aspirin).<br>**III. Chronic constipation** → Straining (diverticulosis), hemorrhoids.<br>**IIII. Family hx of IBD** or colorectal cancer |
| **Review of systems** |
| **Past medical and surgical**: GERD, PUD, liver problems, coagulopathy, IBD, Colorectal cancer,previous GI surgery. |
| **Drug Hx:** NSAIDs, steroid, aspirin, warfarin |
| **Family Hx:** Ask about relevant conditions related to the history (IBD, PUD, colon cancer ... etc.), and any chronic diseases. |
| **Social Hx**: Smoking history (# of pack years), alcohol, travel history, drug abuse, **Type of diet** |

# Breast mass

| |
|---|
| **Introduce yourself , take permission** |
| **Patient profile** (name , age , occupation , marital status, address) |
| **Chief complaint + duration** |
| **HOPI** |
| **I. Site**<br>**II. Onset (duration, progression)**<br>**III. Character 1. MASS (SSSS/ CC/ OOO) 2. Nipple discharge (FCBS A B).**<br>a) Palpable/not<br>b) Size/ site/ surface/ shape.<br>c) Color/ Consistency.<br>d) Other breast/ other masses/ other features (Movement), (Skin changes or nipple changes), (Nipple discharge or blood).<br>**IV. Radiation.**<br>**V. Time (Course = Change in time/ Pattern).**<br>**VI. Severity.** |
| **Associated symptoms**<br>**Malignancy:** Constitutional symptoms (Weight loss/ Loss appetite/ Night sweat/ Low grade fever).<br>**Gynecological SX:** Menarche, Menstrual cycle, Marital status and Breast feeding, Menopause.<br>**Infectious causes:** Fever, rigors, chills, hotness, tenderness (SOCRATES), redness. |
| **Review of systems** |
| **Past medical + Blood transfusion and surgical + Trauma** |
| **Drug HX:** OCPS, HRT, Previous Radiotherapy . |
| **Family HX:** I. Same condition II. Chronic illness (Autoimmune disease) |
| **Social HX**: Smoking history (# of pack years), alcohol, travel history, drug abuse. |

**Nipple discharge DDX:**

**1. Milky: Either physiological (Lactation) or Pathological (Galactocele/ hyperprolactinemia).**
**2. Serous, Brown, Green: Fibroadenosis.**
**3. Green paste: Duct ectasia.**
**4. Purulent: Acute breast abscess.**
**5. Bloody: Duct papilloma, duct carcinoma, duct ectasia, Paget disease, trauma, mastitis.**

**Breast pain DDX:**

**1. Inside the breast: Fibroadenosis, acute inflammatory disease, cancer (advanced or infected).**
**2. Out-side: Angina, pleurisy, rib ostitis … etc.**

**Breast mass DDX:**

**1. Cystic swelling: breast cyst.**
**2. Solid: 1. Firm: Fibroadenosis. 2. Soft mass: Soft fibroadenoma, breast cancer (Mucinous). 3. Hard: Hard fibroadenoma, Breast cancer (scirrhous), Traumatic, Duct ectasia, chronic breast abscess.**

# Intermittent Claudication

| |
|---|
| **Introduce yourself , take permission** |
| **Patient profile** (name , age , occupation , marital status, address) |
| **Chief complaint + duration** |
| **HOPI** |
| **Site (Unilateral or Bilateral)**<br>**Onset** (sudden or gradual)<br>**Character**<br>- Cramps – Numbness/ tingling – Bursting.<br>**Radiation**<br>**Associated symptoms:**<br>- Color of leg (Normal/ Pale/ Cyanosed).<br>- Temperature (Normal/ cool/ increased).<br>- Edema (Absent/ present).<br>**Timing** (Course/ Pattern)<br>**Exacerbating Factors** (Walking/ Rest)<br>**Relieving Factors** (Rest/ Bending forwards/ Leg elevations)<br>**Severity** (from 0-10) (How it affects your life? How many steps do you walk before pain is reproduce?). |
| **Review of systems** |
| **Past medical and surgical**<br>• Chronic illnesses (DM/ HTN/ Hyperlipidemia/ Stroke/ Angina ..etc.)<br>• Previous admission.<br>• Blood transfusion.<br>• Previous surgery/ Cathetarization.<br>• Trauma history. |
| **Drug HX:** Antiplatelet, Anticoagulant, Anti-hyperlipidemia. |
| **Family HX:** Ask about relevant conditions related to the history (HTN/ DM/ Stroke/ MI), Premature coronary artery diseases (♂<55, ♀<65). |
| **Social HX**: Smoking history (# of pack years), alcohol, travel history, Diet, Home environment. |

**4.23 The clinical features of arterial, neurogenic and venous claudication**

| | Arterial | Neurogenic | Venous |
|---|---|---|---|
| Pathology | Stenosis or occlusion of major lower limb arteries | Lumbar nerve root or cauda equina compression (spinal stenosis) | Obstruction to the venous outflow of the leg due to iliofemoral venous occlusion |
| Site of pain | Muscles, usually the calf but may involve thigh and buttocks | Ill-defined<br>Whole leg<br>May be associated with numbness and tingling | Whole leg<br>'Bursting' in nature |
| Laterality | Unilateral or bilateral | Often bilateral | Nearly always unilateral |
| Onset | Gradual after walking the 'claudication distance' | Often immediate on walking or standing up | Gradual, from the moment walking starts |
| Relieving features | On stopping walking, the pain disappears completely in 1–2 minutes | Bending forwards and stopping walking<br>Patient may sit down for full relief | Leg elevation |
| Colour | Normal or pale | Normal | Cyanosed<br>Often visible varicose veins |
| Temperature | Normal or cool | Normal | Normal or increased |
| Oedema | Absent | Absent | Always present |
| Pulses | Reduced or absent | Normal | Present but may be difficult to feel owing to oedema |
| Straight-leg raising | Normal | May be limited | Normal |

# Constipation

Introduce yourself , take permission

Patient profile (name , age , occupation , address,  marital status)

Chief complaint + duration

Analysis of the Chief Complaint

**Onset** ( sudden or gradual, progression, first time) = **OPP**

**Frequency:** Times per day

**Consistency:** (Sausage shape,  separate hard lumps like nuts)

**Blood**:

**Caliber**:  large caliber, narrow or pencil thin stools

**Amount (small/large)**

**Mucous**

**Pain**

**Melena**

**Associated symptoms (finish the CC analysis then ask about them ↓)**

**Associated symptoms**

**Constitutional**:
- Weight Loss
- Anorexia
- fever
- night sweat

**GI: From above to down**
a) Mouth ulcers ⟶ IBD
b) Nausea & Vomiting ⟶ Intestinal obstruction
c) Abdominal pain >> Intestinal obstruction, IBD
d) Abdominal distention → IBS, Intestinal obstruction
e) Alternating diarrhea ⟶ IBS
f) Anal pain or itching ⟶ Hemorrhoid, Perianal fissure

**MSS**
Skin rash, Joint Pain, Eye Symptoms

**Hypothyroidism** : Cold intolerance, Weight Gain , fatigue.

**DM :** Polyuria, Polydipsia, Polyphagia

**Hypercalcemia :** Renal stones , bone pain , polyuria , abdominal pain.

**Dehydration :** feeling thirst , dark urine , oliguria

**Risk factors**
I. IBD → Family hx
II. Colon CA → Low fiber diet, family hx
III. Intestinal obstruction (Adhesions) → Previous surgeries

**Review of systems**

**Past medical and surgical**
- Previous attacks
- Previous surgeries ⟶ Intestinal obstruction (Adhesions)
- Chronic illness
- (DM, HTN, Hyperlipidemia) , Hx of trauma (spinal cord)

**Drug Hx:** ⟶Iron and Ca supplement , opioids , thiazides , Antacids

**Family Hx:** Ask about relevant conditions related ( IBD , Colon CA ) and any chronic diseases.

**Social Hx**: Smoking history (# of pack years), alcohol , travel history , Diet and water intake

# Clinical round in surgery

# Clinical Round History

**Dysphagia**

# Dysphagia (Etiology)

- **Subjective sensation of difficulty or abnormal swallowing.**
- **Tow main classes:**

**1. Oropharyngeal:**

**Difficulty in initiating a swallow, associated with chocking, coughing, aspiration and globus sensation.**

**Usually due to Varity of neurological, structural, infectious, and iatrogenic cause.**

**2. Esophageal:**

- **Motality disorders.**
- **Structural lesions.**
- **Esophagitis.**

# Dysphagia ( Clinical presentation)

## 1. Oropharyngeal dysphagia:

- **Difficulty in initiating a swallow, associated with chocking, coughing, aspiration and globus sensation.**

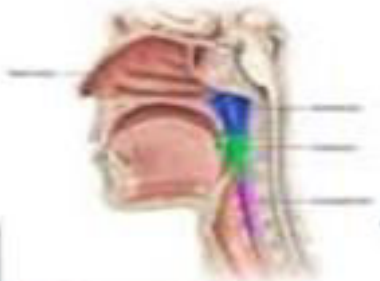
## 2. Esophageal dysphagia:

**Difficulty in swallowing seconds after initial swallow, associated with Sensation of food in esophagus.**

**Solid and liquid { Motality disorders}.**

**Solid more { Structural}**

# Dysphagia



Can't Swallow
Coughing
Hoarseness

## Oropharyngeal

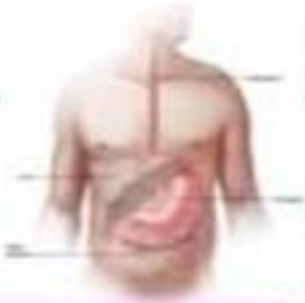
### Structural

- Carcinoma
- Infections of pharynx
- Proximal Esophageal webs
- Thryomegaly
- Zenker Diverticulum

### Neuromuscular

- ALS
- CNS Tumor
- Multiple Sclerosis
- UES Dysfunction
- Myasthenia Gravis
- Stroke
- Parkinson disease

**Barium Swallow Evaluation**



Food getting stuck below sternal notch

## Esophageal

Solids & Liquids

### Neuromuscular Motility

**Manometry**

#### Primary

- Achalasia
- Esophageal Spasm
- Jackhammer esophagus
- Hypertensive LES

#### Secondary

- Chagas
- Reflux related dysmotility
- Scleroderma
- Rheum

Solids >Liquids

### Structural

- Carcinoma
- Diverticula
- Eosinophilic Esophagitis
- Esophageal Rings
- LES Rings
- Strictures

**EGD**

# Dysphagia (Work-up)

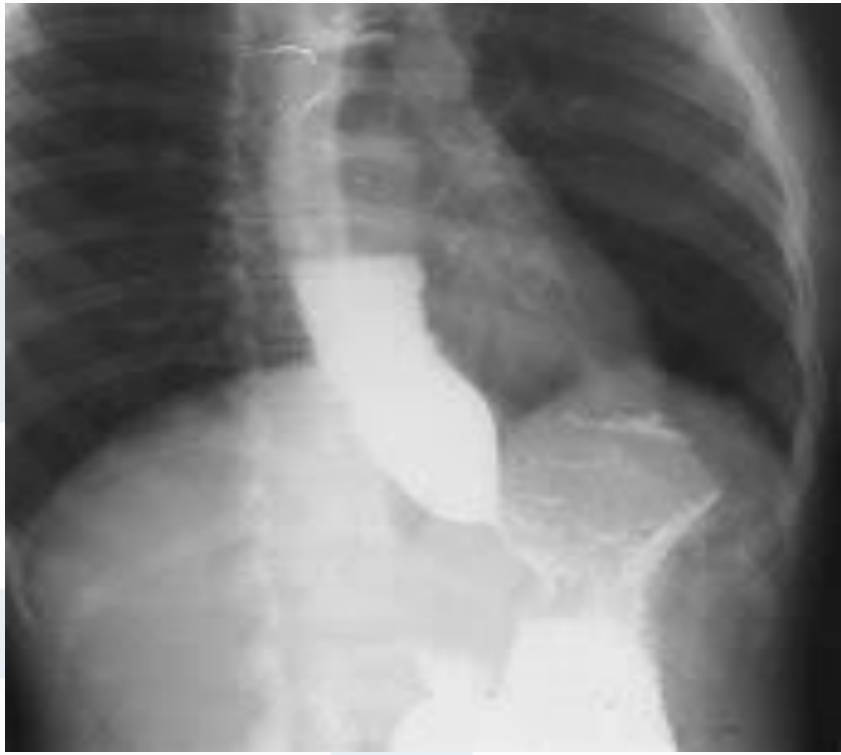
- **Esophageal dysphagia:**

1. **Upper Endoscopy (generally first done to rule out structural lesions).**
2. **Barium swallow.**
3. **Manometry.**

- **Oropharyngeal dysphagia:**

1. **Modified barium swallow (Investigations oral, pharyngeal, and esophageal).**

# Achalasia



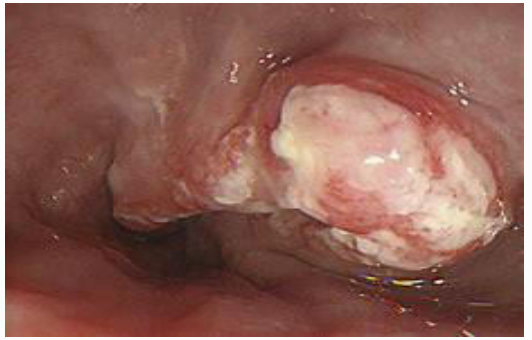
- **Failure of LES to relax:**
- **(idiopathic/ autoimmune/ Chagas/ malignancy).**
- **Diagnosis:**
- **(EGD/ Manometry/ Barium swallow (rate-tail)).**
- **Manometry:**

**Incomplete LES relaxation, Elevated resting pressure (>45 mmHg), Aperistalsis of esophageal body.**

- **Management:**

**(Drugs (CCB/NITRATE), Botox, Pneumatic dilation, Surgical myotomy (95% in first year).**

# Esophageal cancer



**- Two types:**

**1. Squamous cell carcinoma** (upper 2/3, Smoking/ ETOH/ Achalasia/ Strictures/ dietary(N-nitroso), 50%, metastasis to cervical and mediastinal LN).

**2. Adenocarcinoma:** (Distal 1/3, Barret's/ LONGSTANDING GERD/ ETOH, 50%, Metastasis to celiac and gastric LN).

**- CLX:** Progressive dysphagia (Solids then liquids) + Constitutional symptoms + RS symptoms + Horsiness.

**- DX:** EGD with BX, CT(staging), PET.

**- TRX:** Surgery + Chemo-radiotherapy.

**- Poor prognosis because of late presentation**. (5-YR = 5%-30%)

# Thank you

# Epigastric pain

Introduce yourself , take permission

Patient profile (name , age , occupation , address , marital status)

Chief complaint + duration

Analysis of the Chief Complaint **(SOCRATES)**

**Site**

**Onset** (sudden or gradual, progression, first time)

**Character**

- Squeezing - Sharp/stabbing - Burning/pricking - Dull

**Radiation**

- To back
- To Right shoulder, scapula
- Up to chest
- Diffuse

**Associated symptoms (finish the CC analysis then ask about them ↓)**

**Timing** (episodic or continuous)

**Exacerbating:**

- Eating or fasting.
- increased by swallowing.
- fatty foods.
- acidic/spicy foods/coffee.
- Does it increase by movement or breathing?

**Relieving:**

- Eating or fating
- Certain position (lying on one side, or leaning forward)
- Bowel motion.
- Drugs

**Severity** (from 0-10).

**Associated symptoms**

- **GI symptoms**:
- Dysphagia, Regurgitation, heart burn, hoarseness of voice.
- Dyspepsia , N+V
- Bloating/abdominal swelling (generalized/localized)
- Early satiety
- Jaundice/ RUQP/ Steatorrhea, urine & stool changes, itching
- Bowel habit, diarrhea/constipation • Flatulence
- Melena and Hematochezia

•**Heart symptoms:** Chest pain, sweating, SOB, PND, orthopnea, ankle swelling,.

• **Respiratory symptoms:** Cough, SOB, wheeze.

**General**
• Fever, weight loss, loss of appetite, night sweat.

**Risk Factors (always ask about smoking and alcohol)**
I. PUD ⟶ Smoking, NSAIDS, Alcohol
II. Hepatitis ⟶ Alcohol, blood Transfusion, HBV infection, DM, contact with patient having Hepatitis
III. MI ⟶ Smoking, HTN, DM, Hyperlipidemia, Family Hx
IV. Cholecystitis⟶ Family Hx of gall bladder stones

**Review of systems**

**Past medical and surgical**
• Previous surgeries.
• Hepatitis, or history of blood transfusions, sexual intercourse, contact with jaundiced patient.

**Drug Hx:** NSAIDs, Steroids ,antacids, anticoagulant.

**Family Hx:** Ask about relevant conditions related to the history (Gastric cancer, PUD ... etc.), and any chronic diseases.

**Social Hx**: Smoking history (# of pack years), alcohol, travel history

# Hematemesis

Introduce yourself , take permission

Patient profile (name , age , occupation , address, marital status)

Chief complaint + duration

Analysis of the Chief Complaint

**Onset:** - Sudden acute - chronic
- insidious onset of vomiting
**Progression** (Getting worse or better)
**Previous episodes**

**Character:**
**smell**
**Color** (Fresh bright red, Dark color "coffee grounds").
**Amount** (In cups).

**Associated bleeding from other sites**

**Time:** Constant or episodic.

**Exacerbating and relieving factors:**
- NSAIDs → PUD
- Food → GU
- Trauma to abdomen → Esophageal perforation
- Alcohol, Vomiting/retching → Mallory-Weiss tear

**Severity:**

**Associated symptoms**
**I. GI:**
a) Heartburn and regurgitation
B) Dysphagia and odynophagia.
C) Dyspepsia
D) Abdominal Pain → Epigastric → PUD
E) Abdominal Distention
f) Jaundice / change in urine & stool color / itching/ limb swelling→ Cirrhosis
g) Diarrhea or constipation
h) Hematochezia/ anal pain or anal lump.
**II. Blood disorders:** Bleeding from other site, ecchymosis, purpura, petechial, hematuria.
**III. Constitutional symptoms:** Fever, Weight loss, Anorexia, Night sweat.

| |
|---|
| **Risk Factors (always ask about smoking and alcohol)**<br>**I. PUD** → Smoking, NSAIDS, Alcohol<br>**II. Bleeding disorders** → Drugs {Anti-coagulants (Heparin or Warfarin) / NSAIDS (Aspirin).<br>**III. Cirrhosis** → Alcohol, Blood transfusion, HBV infection, sexual intercourse, easy bruising, leg swelling.<br>**III. Mallory –Weiss >>** binge drinking |
| **Review of systems** |
| **Past medical and surgical**: GERD, PUD, liver problems, coagulopathy, IBD, Colorectal cancer, previous GI surgery, AAA repair (Aorto-enteric fistula). |
| **Drug Hx:** NSAIDs, steroid, aspirin, warfarin |
| **Family Hx:** Ask about relevant conditions related to the history (Gastric cancer, PUD, colon cancer ... etc.), and any chronic diseases. |

# NECK MASS

| |
|---|
| Introduce yourself , take permission |
| **Patient profile** (name , age , occupation , marital status, address) |
| **Chief complaint + duration** |
| Analysis of the **Chief Complaint (SOCRATES)** |
| **I. Site**<br>a) Central → Thyroid enlargement, Thyroglossal cyst.<br>b) Lateral → Lymphadenopathy, branchial cyst.<br>**II. Onset (duration, progression)**<br>**III. Character**<br>a) Consistency.<br>b) Tenderness, redness, hotness.<br>c) Mobility.<br>d) Movement with swallowing.<br>**IV. Radiation.** **V. Time (Course/ Pattern).** **VI. Severity.** |
| **Associated symptoms**<br>**I. Lymphadenopathy**<br>a) URTI → Fever & Chills, Sore throat, Cough, Nasal discharge.<br>b) TB → Fever, Hemoptysis, Night sweats, Weight loss.<br>c) Lymphoma or Leukemia → SOB, Fatigue, Bleeding tendency, Recurrent infections, Bone pain.<br>d) Sarcoidosis → SOB, Skin lesions, Joint pain, Uveitis.<br>**II. Thyroid**<br>**a) Hyperthyroidism** (Grave's disease, Toxic Multinodular goiter)<br>Symptoms due to mass effect→ Breathing difficulty, Hoarseness of voice,Dysphagia, Chronic sore throat.<br>Symptoms due to Hyperthyroidism → Fatigue, Sweating, Weight loss, Increased appetite, Headache, Restlessness, Palpitation, Diarrhea, Heatintolerance.<br>**b) Hypothyroidism** (Hashimoto's thyroiditis, Iodine deficiency)<br>Slow speech, Hoarseness of voice, Decreased appetite, Weight gain, Constipation.<br>**C) Malignancy:** Constitutional symptoms, other masses. |
| **Review of systems** |
| **Past medical + Blood transfusion and surgical + Trauma** |
| **Drug HX:** Amiodarone, Previous Radiotherapy . |
| **Family HX:** I. Same condition II. Chronic illness (Autoimmune disease) |
| **Social HX**: Smoking history (# of pack years), alcohol, travel history, drug abuse, contact with sick people or elderly0 |

**(DDX: Lymphadenopathy: (TB / Sarcoidosis / Lymphoma / Metastasis / URTI), Thyroid enlargement: (Multinodular goiter / Grave's disease / Thyroid CA)).**

**Investigations: 1. Biopsy 2. Thyroid function test (TFT) 3. Neck US.**

# DYSPHAGIA

| |
|---|
| Introduce yourself , take permission |
| Patient profile (name , age , occupation , marital status, address) |
| Chief complaint + duration (odynophagia?!!!) |
| Analysis of the Chief Complaint |
| **Site:** At what level does the food stick<br>**Onset:** (sudden or gradual)<br>**Character** Fluids, Solids or both (at the same time!), Stage the dysphagia occurs: initiating swallowing, after initiation swallowing?<br>**Associated symptoms (finish the CC analysis then ask about them ↓)**<br>**Timing** (Progression, episodic (intermittent) or continuous)<br>**Severity** (Is there complete obstruction , regurgitation?) |
| **Associated symptoms**<br>**Constitutional:**<br>- Weight loss<br>- Loss of appetite<br>- Night sweat.<br>- fever<br>**URTI:** Cough, nasal congestion, sore throat.<br>**Neurological:** vision problem, tremor, Recurrent choking (previous strokes).<br>**GI:** Nausea/vomiting, Regurgitation, heart burn, Bloating/abdominal swelling, Early satiety, Jaundice/ RUQP/ Steatorrhea, Bowel habit, Melena and Hematochezia.<br>**Scleroderma:** Skin tightness and discoloration (Raynaud Phenomenon).<br>**Myasthenia gravis:** Ptosis, diplopia, fatigue<br>**Pharyngeal pouch** (zenker diverticulum) Neck bulge , gurgle on drinking or halitosis ? |
| **Review of systems** |
| **Past medical +Blood transfusion and surgical +Trauma.**<br>• Stroke • Thyroid problems (Goiter) • PUD and GERD •Scleroderma •Iron deficiency.<br>• Previous admission.<br>• Previous surgeries. |
| **Drug HX:** → • NSAIDs • Bisphosphonates/Doxycycline •Use of antacids (related to GERD and PUD). |
| **Family HX:** Esophageal cancer, neuromuscular diseases , any chronic illnesses |
| **Social HX**: • Alcohol (peptic ulcer disease, gastritis) • Smoking • Illicit drug use • Diet: spicy foods ( peptic ulcer disease ) |

**(DDX: URTI, Esophageal cancer, Achalasia, Scleroderma, Neurological, GERD, PUD)**

**Investigations:**

1. Manometry, Barium swallow
2. Upper endoscopy
3. 24 PH monitoring
4. Anti Ach antibodies

# Jaundice

Introduce yourself , take permission

Patient profile (name , age , occupation , marital status)

Chief complaint + duration

Analysis of the Chief Complaint

**I.Site**
a) Eyes (Sclera)
b) Skin
**II. Onset** ( sudden or gradual, progression, first time) OPP

**III. Associated symptoms (finish the CC analysis then ask about them ↓)**

**IV. Exacerbating and relieving factors** (Drugs, exercise, fasting, certain foods like fava beans).

**V. Time**: Intermittent (e.g. Gilbert's syndrome), continuous.

**Associated symptoms**

**I.Prehepatic : Hemolytic Anemia** → Fatigue, Dizziness, Pallor, SOB.

**II. Hepatic :**
**a) Hepatitis** → Fever, RUQ pain, Nausea & Vomiting
Autoimmune →Arthralgia, vitiligo, skin rashes
**b) Cirrhosis** → Ascites, Limb swelling, Bleeding tendency , Hematemesis , Anal lump

**III. Post hepatic : - Obstructive Jaundice**→ Itching , Dark urine and pale stool
**- Constitutional (Periampullary tumor):**
- Weight Loss - Anorexia - nigh sweat - steatorrhea – DM

**IV. GI Sx** : from above to below.

**Risk factors: (always ask about smoking and alcohol)**

**1-Pre-hepatic:** Hx of blood diseases (Thalassemia / G6PD)**, Drugs** → PAINS (Primiqune , Aspirin , Isonizid ,Nitrofurantoin, Sulfa drugs)

**2- Hepatic:** , Hx of hepatitis , Hx of bloodTransfusion, or contact w/ jaundiced patient

**3- Post-hepatic:** Hx of gallstones, Hx of cholecystitis**, Hx of** IBD **(Crohn's)**

**Past medical and surgical**
- Previous surgeries
- Chronic illnesses (DM, HTN, Hyperlipidemia)

**Drug Hx:** → PAINS (Primiqune , Aspirin , Isonizid ,Nitrofurantoin, Sulfa drugs) , OCPs

| |
|---|
| **Family Hx:** Hx of blood diseases (Thalassemia / G6PD) , Hepatitis and liver failure . and any chronic diseases. |
| **Social Hx**: Smoking history (# of pack years), alcohol , Drug abuse ,travel history , Sexual history |

# Clinical round in surgery

# Clinical Round History

**Neck masses**

# Neck mass (Etiology)

**1. What is the usual etiology in infants?**

**Congenital** (branchial cleft cysts, thyroglossal duct cysts)

**2. What is the usual etiology in adolescents?**

**Inflammatory** (cervical adenitis is #1), with congenital also possible

**3. What is the usual etiology in adults?**

**Malignancy** (squamous is #1), especially if painless and immobile

**4. What is the "80% rule"?**

In general, **80% of neck masses are benign in children**; **80% are malignant in adults >40 years of age.**

# Neck mass( Clinical presentation)

- **What are the seven cardinal symptoms of neck masses?**

1. **Dysphagia.**
2. **Odynophagia.**
3. **Hoarseness.**
4. **Stridor (signifies upper airway obstruction).**
5. **Globus.**
6. **Speech disorder.**
7. **Referred ear pain (via CN V, IX, or X).**

# Neck mass (Work-up)

- **What comprises the workup?**

**Full head and neck examination, indirect laryngoscopy, CT scan and MRI, FNA for tissue diagnosis; biopsy contraindicated because it may adversely affect survival if malignant.**

- **What is the workup of node-positive squamous cell carcinoma and no primary site?**

**Triple endoscopy (laryngoscopy, esophagoscopy, bronchoscopy) and biopsies of likely sites, PET scan.**

# Neck mass (DDX)

- **What is the differential diagnosis?**

**Inflammatory: cervical lymphadenitis, cat-scratch disease, infectious mononucleosis, infection in neck spaces.**

**Congenital: thyroglossal duct cyst (midline, elevates with tongue protrusion), branchial cleft cysts (lateral), dermoid cysts (midline submental), hemangioma, cystic hygroma.**

**Neoplastic: primary or metastatic.**

# Neck mass (DDX)

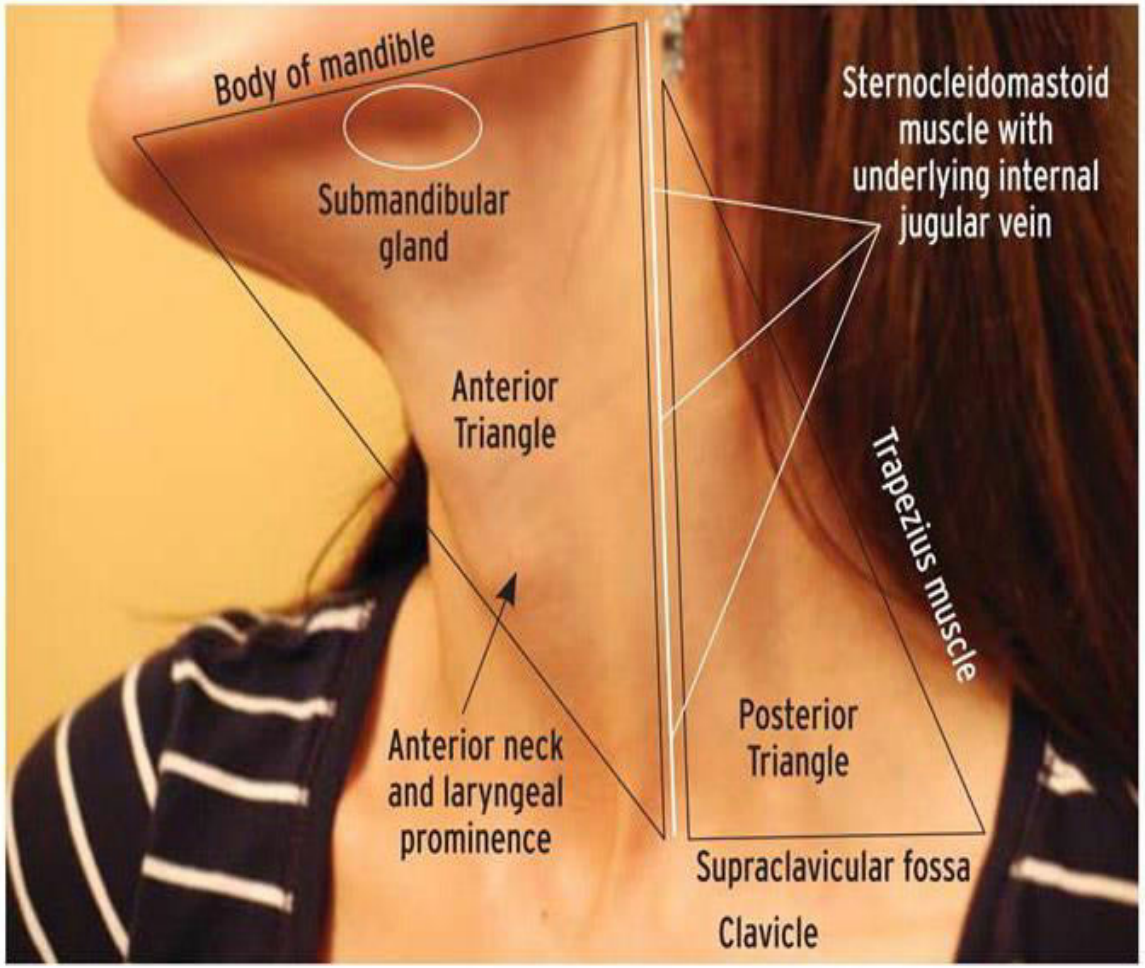



**FIGURE 1.** The anatomic divisions of the lateral neck

| Location | | |
|---|---|---|
| Mid line | Ant. Triangle | Post. Triangle |
| **Congenital**<br>-thyroglossal duct cyst<br>-dermoid cyst<br>-laryngocele | **Congenital**<br>-brachial cleft cyst<br>-thymic cyst<br>-sialadenopathy (parotid,submandibular) | **Congenital**<br>-lymphangioma |
| **Inflammation**<br>-adenditis | **Inflammation**<br>-adenitis(viral,bact., glanulomatous)<br>-sialadenitis | **Inflammation**<br>-adenitis(viral,bact., glanulomatous) |
| **Tumor**<br>-thyroid<br>-lymphoma | **Tumor**<br>-metastasic<br>-upper jugular<br>-submandibular<br>-middle jugular<br>-lymphoma<br>-vascular(carotid tumor, hemangioma) | **Tumor**<br>-lymphoma<br>-metastatic<br>-supraclavicular |
| **Other**<br>-sternocleidomastoid hematoma/fibroma | **Other**<br>- False aneurysm | **Other**<br>Neuroma |

# Neck mass (Management)

- **Surgical excision for congenital or neoplastic; two most important procedures for cancer treatment are selective and modified neck dissection.**
- **What is the role of adjuvant treatment in head and neck cancer?**

**Postoperative chemotherapy/XRT.**

# Thank you

# Diarrhea

**QMA Team**

# Etiology

- Pass of **more than three times per-day of loose stool.**
- The definition is **relative** to each patient normal habits.
- It could be **three types** according to onset:

1. **Acute**: 2 weeks or less.
2. **Subacute**: 2-4 weeks.
3. **Chronic**: more than 4 weeks.

# DDX

- **GI causes:**

1. **Tract abnormality:** Infectious, inflammation (allergy), IBS??.
2. **Food:** High fiber diet.
3. **Enzymatic causes:** when we loss enzyme such as 1. Steatorrhea (Loss of pancreatic/ liver enzymes). 2. lactase deficiency.

- **Non GI causes:**

1. Hyperthyroidism.
2. DM.
3. Drugs.

# History evaluation

- Diarrhea must be distinguished from **fecal incontinence, change in stool caliber, rectal bleeding, and small, frequent**, but otherwise normal stools.
- **Careful medication history is essential.**
- **Alternating diarrhea and constipation** suggests **fixed colonic obstruction (e.g., from carcinoma) or irritable bowel syndrome**.

- A sudden, **acute course, often with nausea, vomiting, and fever**, is typical of **viral and bacterial infections**, **diverticulitis, ischemia, radiation enterocolitis, or drug induced diarrhea** and may be the **initial presentation of inflammatory bowel disease**.
- **More than 90% of acute diarrheal illnesses are infectious in etiology.**

# History evaluation

- **A longer (>4 weeks),** more insidious course suggests **malabsorption, inflammatory bowel disease, metabolic or endocrine disturbance, pancreatic insufficiency, laxative abuse, ischemia, neoplasm** (hypersecretory state or partial obstruction), or **irritable bowel syndrome. Parasitic and certain forms of bacterial enteritis can cause chronic diarrhea**.
- Particularly **foul-smelling or oily stool suggests fat malabsorption**. **Fecal impaction may cause apparent diarrhea** because only liquids pass partial obstruction.
- Several infectious causes of diarrhea are associated with **an immunocompromised state**.

# Thank you

# DIARRHEA

| |
|---|
| Introduce yourself , take permission |
| Patient profile (name , age , occupation , marital status) |
| Chief complaint + duration |
| Analysis of the Chief Complaint (FCBCAO) |
| **Frequency how many times a day?**<br>**Character (mucus (greasy) or watery)**<br>**Blood (fresh blood ( hematochezia) , melena )**<br>**Color (fatty . pale)**<br>**Amount**<br>**Odor (foul smelling)**<br>**Onset** (duration, sudden or gradual, progression, first time) = **OPP**<br>**Associated symptoms (finish the CC analysis then ask about them ↓)**<br>**Timing** (episodic (at night) or continuous)<br>**Exacerbating:**<br>- Dietary factors, fatty foods (gallstones), (Gastric ulcer disease).<br>**Relieving:**<br>Bowel motion (defecation)<br>Drugs.<br>**Severity** → dehydration symptoms ( thirst . oliguria , dark urine, Dry mucous membranes ) |
| **Associated symptoms**<br>• **GI symptoms**<br>a) Mouth ulcers → IBD, Celiac Disease<br>b) Nausea & Vomiting → GE, PUD (if bloody vomit)<br>c) Abdominal pain → GE, IBD (Crohn's), Celiac disease, CA<br>d) Abdominal distention + Alternating constipation → IBS<br>• **Constitutional**<br>Fever , wt loss , night sweat , loss of appetite<br>• **MSS** Skin rash , Joint Pain , Eye Symptoms. |
| **Risk Factors (always ask about smoking and alcohol)**<br>I. GE → Eating anything spoiled<br>II. Bacillary dysentery / ameba → Recent travel to endemic area<br>III. IBD → Family hx<br>IV. Colon CA → Low fiber diet, family hx<br>V. Celiac → Family hx and hx of allergy |
| **Review of systems** |
| **Past medical and surgical**<br>• Previous surgeries.<br>• Previous attacks<br>• Chronic illnesses (DM, HTN, Hyperlipidemia) ,contact with jaundiced patient. |
| **Drug Hx:** → Antibiotics, NSAID, Laxatives |
| **Family Hx:** Ask about relevant conditions related to the history (Gastric cancer, PUD … etc.), and any chronic diseases. |
| **Social Hx**: Smoking history (# of pack years), alcohol, travel history |

**(DDx: Gastroenteritis, Bacillary dysentery or Ameba, IBD, Colon CA, PUD, IBS, Celiac disease)**

**Investigations:**

1. Stool Culture → Infectious Colitis
2. Endoscope → Colon CA, IBD, Celiac disease.

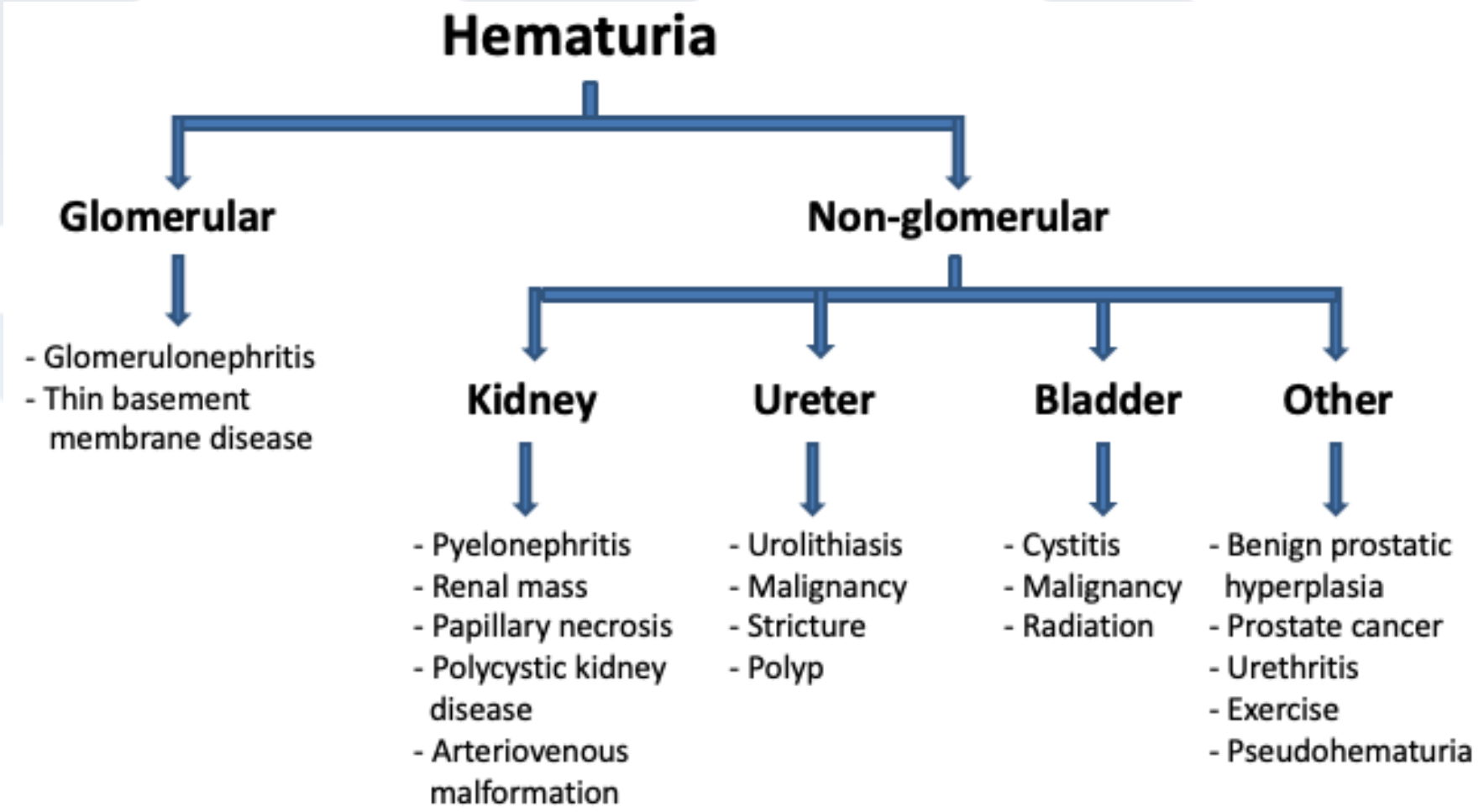
# Hematuria

**QMA Team**

# Hematuria

- The presence of the RBC'S in the urine >5.
- Can be classified according to **quantity**, **occurrence during voiding**, and **origin of bleeding**.
- **Microhematuria** (GN/ UTI/BPH/ Urolithiasis/ Menstruation/ malignanacies) Vs **Macrohematuria** (Non-glomerular).
- **Glomerular VS non-glomerular**.
- **Initial hematuria:** Occur at the beginning and end by the end, typically suggests ureteral damage.
- **Terminal hematuria:** During the last of micturition, suggest the damage to the bladder neck, prostate, or trigonal area (BPH, Prostatitis).
- **Total hematuria:** Kidney cause (Urolithiasis/ UTI/ Polycystic kidney disease).

# Hematuria


Hematuria
Glomerular
- Glomerulonephritis
- Thin basement membrane disease
Non-glomerular
Kidney
- Pyelonephritis
- Renal mass
- Papillary necrosis
- Polycystic kidney disease
- Arteriovenous malformation
Ureter
- Urolithiasis
- Malignancy
- Stricture
- Polyp
Bladder
- Cystitis
- Malignancy
- Radiation
Other
- Benign prostatic hyperplasia
- Prostate cancer
- Urethritis
- Exercise
- Pseudohematuria

# Hematuria

## Table 1. Glomerular Versus Extraglomerular Hematuria

| Factor | Glomerular | Extraglomerular |
|---|---|---|
| Color | Smoky, tea- or cola-colored, red | Red or pink |
| RBC Morphology | Dysmorphic | Normal |
| Casts | RBC, WBC | None |
| Clots | Absent | Present (+/−) |
| Proteinuria | ≥2+ | <2+ |

RBC=red blood cell, WBC=white blood cell

# Painful VS Painless

| Painful hematuria | Painless hematuria |
| --- | --- |
| Stones (MCC), UTI'S, Trauma, Prostatitis | Local causes: Tumors (most important is bladder ca, RCC, prostatic ca), GNs.<br>Note bladder cancer patient mainly complaining of painless gross intermittent hematuria. |
| You have to be sure if it's a hematuria or changed urine color like a patient uses 1- Rifampicin 2- NSAIDS 3- Flagyl (metronidazole). 4. Foods. | Systemic causes: SLE, Paget's, anticoagulant, warfarin toxicity. |

# Investigations

- **Lab:**

- (CBC), UA, Urine culture, KFT, Cytology, PSA.

- **Imaging:** US, KUB, CT.

# Treatment

- **Bladder cancer:** ….. Non invasive : TURBT, BSG.

  Invasive: male (cystoprostatectomy)

  female (Anterior pelvic exenteration).

- **Renal cancer:** complete or partial nephrectomy + Immunotherapy for metastasis (VEGF Inhibitors).
- **UTI :** antibiotics (ciprofloxacin).

# Treatment (Renal stones )

- **First with analgesia and fluid resuscitation**

1) **if <0.5 cm + Distal part of UT** --> Conservative ->

more hydration + drugs to dilate ureter and urethra ( **alpha 1 blockers**).

2) **0.5cm < stone < 2cm proximal** --> ESWL تفتيت

**Distal -**--> flexible uretroscope ,If not working --- > PCNL.

3) **Radiolucent ( Uric acid ) or Large Stones** --> PCNL, if not working ----> **open surgery** (not common ).

# History

- **Introduces self , takes permission and brief patient profile.**
- **HOPI :**

1. **Color.**
2. **Onset.**
3. **Duration.**
4. **When in the stream.**
5. **Colicky pain (Painful VS painless).**
6. **Odor.**
7. **Amount.**
8. **Clots.**
9. **Is it first time?**

**Associated symptoms: 2 marks each (Constitutional/ UTI/ LUTS+ Stones/ Urethritis)**

- Weight loss, Appetite.
- Adequate fluid intake.
- Fever, Chills, Rigor.
- Flank pain >>> SOCRATES.
- Fatigue.
- Nausea, Vomiting.
- Frequency.
- Urgency.
- Incontinence.
- Nocturia.
- Dysuria.
- Hesitancy.
- Poor stream.
- Intermittency.
- Incomplete voiding
- Urine color.
- Urine odor.
- Back / pelvic pain.
- Sexual activity normal

- **Medication**: Rifampin, NSAID, Warfarin, Aspirin, Heparin
- **Type of food:** beetroot ,black berry, food coloring
- **Systematic Review:**

1. CVS
2. RS
3. MSS
4. CNS
5. ES
6. GIT.

- **Past Medical History: ½ mark each /6.5**

1. History of **UTI** 2. Previous episode 3. **Trauma** 4. **Previous surgery** recent foly's cath insertion ? 5. **Chronic diseases** (HTN, DM ).

- **Family History: ½ mark each /3**

**Stone, Cancers (Bladder/ Kidney), similar condition**.

- **Social History: 1 mark each /3**

**Smoking** , **Alcohol use, recent travel, menstrual cycle in women**.

- **Patient concerns, ideas, what suspected to do.**

# Kidney stone

| A 30 year old male is complaining of bloody urine . | Mark |
|---|---|
| Introduces self , takes permission and brief patient profile. | /2 |
| **HOPI** | /16 |
| **Details about CC**: each ½ mark<br>Color red<br>Onset 2 days ago<br>Duration every micturation<br>When in the stream the whole stream<br>Coliky pain yes<br>Odor normal<br>Amount a lot<br>Clots no<br>Is it first time ? no | /4 |
| **Associated symptoms**: 2 marks each<br>Fever mild<br>Chills no<br>Rigor no<br>Flank pain yes >>> SOCRATES<br>Weight loss no<br>Appetite normal<br>Adequate fluid intake no<br>Fatigue yes<br>Nausea yes<br>Vomiting no<br>Frequency yes<br>Urgency no<br>Incontinence no | /12 |

Nocturia no
Dysuria yes
Hesitancy no
Poor stream no
Intermittency no

Incomplete voiding no
Urine color red
Urine odor normal
Back / pelvic pain no
Sexual activity normal

Medication Rifampin,
Type of food beetroot ,black berry, food coloring

**Systematic Review:-**

**CVS**
**RS**
**MSS**
**CNS**
**ES**

| | |
|---|---|
| ES<br>GIT | |
| **Past Medical History:** ½ mark each | /6.5 |
| 1. History of UTI no<br>2. Previous episode no<br>3. Trauma no<br>4. Previous surgery recent foly's cath insertion ?<br>5. Chronic diseases (HTN, DM ) yes | |
| **Family History:** ½ mark each | /3 |
| Stone no<br>Cancers no | |
| **Social History:** 1 mark each | /3 |
| Smoking - yes<br>Alcohol use no | |

**What is your DDX ?**

**If Renal stone was the most likely diagnosis; how would you treat this patient? (Lines of management)**

bladder CA
or
renal CA

**During Hx taking don't forget to ask about **I.C.E** : Idea , Concern , Expectation >> the examiner will be glade to here that ! ☺

** IN case of female pt. >> ask about current menstrual cycle .

** Painless hematuria >>don't forget bladder Ca.

# Bladder Cancer

| 55 year old male his complaining of bloody urine | Mark |
|---|---|
| Introduces self and takes permission | /2 |
| **HOPI** | /16 |
| **Details about CC**: each ½ mark<br>Onset week ago<br>Duration every micturation<br>When in the stream the whole stream<br>Coliky pain ? no<br>Odor normal<br>Amount a lot<br>Clots yes<br>Color red | /4 |
| **Associated symptoms**: 2 marks each<br>Fever yes<br>Chills no<br>Rigor no<br>Weight loss yes<br>Appetite low<br>Fatigue yes<br>Nausea yes<br>Vomiting yes<br>Frequency yes<br>Urgency no<br>Incontinence no<br>Nocturia no<br>Dysuria no<br>Hesitancy no | /12 |

Poor stream no
Intermittency no
Incomplete voiding no
Urine color red
Urine odor normal

Back / pelvic pain
Sexual activity normal

Excessive excersise no
Medication Rifampin, Ibuprofen no
Type of food black berry, food coloring no

**Systematic Review:-**

**CVS**
**RS**
**MSS**
**CNS**
**ES**
**GIT**

| | |
|---|---|
| **GIT** | |
| **Past Medical History:** ½ mark each | /6.5 |
| 1. History of UTI no<br>2. Previous episode no<br>3. Trauma no<br>4. Previous surgery no<br>5. Chronic diseases (HTN, DM ) yes | |
| **Family History:** ½ mark each | /3 |
| Stone no<br>UTI no<br>Cancers yes | |
| **Social History:** 1 mark each | /3 |
| Smoking - yes<br>Alcohol use no | |

**What is your DDX ?**

**What is the most common cause of bladder cancer ?**

# Thank You

# (Flank/ Suprapubic) Pain

**QMA Team**

# UTI

- It is a very common urinary tract problem, more common in **females** (**shorter 5cm and wider urethra**).
- The etiology explained by: **Ascending infection**, instrumentation, coitus in females, Hematogenous.
- The most common microorganism is:**E.Coli (90%)/ Proteus/ Klibsiella/ SA**.
- Predisposing factors: **Stones**, **obstruction**, **reflux**, **DM**, **pregnancy**, indwelling **catheter**/ **stent**.
- Clinical picture:

1. **Lower UTI:** Frequency, urgency, dysuria, nocturia, **suprapubic pain**, hematuria.
2. **Upper UTI** (Pyelonephritis): Back/ flank pain, **fever, chills, rigors, nausea, vomiting**, hematuria, **costovertebral angle tenderness**.

# UTI

- **Diagnosis:**

1. **Cystitis**: made by clinical picture + urinalysis (>10 WBC'S/ HPF> 105 CFU).
2. **Pyelonephritis**: clinical picture + CBC + KFT + U.A + Urine culture.

- **Complications of pyelonephritis:**

1. Renal / perinephric abscess.
2. Recurrent infections (chronic pyelonephritis).
3. Sepsis.

# UTI types

- **Complicated VS. Uncomplicated.**
- **Uncomplicated**: Infection in healthy patient with **structurally and functionally normal** urinary tract.
- **Complicated**: **abnormal** structure or function, and **may have factors** that increase the risk to acquire an infection and decrease the efficacy of management.
- **Factors that suggest complicated UTI:**

1. Male gender.
2. Pregnancy.
3. Elderly patient.
4. DM.
5. Immune suppression.
6. Childhood UTI.
7. Recent ABX use.
8. Indwelling catheter.
9. Hospital acquired infections.
10. Symptoms for more than 10 Days.

# Treatment:

- **Lower**:

1. Uncomplicated: 3 days of antibiotics orally in women (TMP-SMX/ Nitrofurantin 5 days and Single dose Fosfomycin), in men 7 days therapy.

2. Complicated: 10-14 days either oral ciprofloxacin or IV.

- **Upper**: 7 days of antibiotics ciprofloxacin orally or give IM 1g Ceftriaxone followed by oral for 7 days.

# Indication of hospitalization

- In **uncomplicated**: High fever, high WBCS, vomiting, dehydration, evidence of sepsis.
- **In complicated pyelonephritis.**
- **Failure to improve on ABX initially** so you should admit and do CT-Scan (obstruction/ complications).

# History

- **Introduces self , takes permission and brief patient profile.**
- **HOPI : SOCRATES**

1. **Site.**
2. **Onset.**
3. **Character.**
4. **Radiation.**
5. **Exacerbating factors.**
6. **Relieving factors.**
7. **Severity.**

**Associated symptoms: 2 marks each (Constitutional/ UTI/ LUTS+ Stones/ Urethritis)**

- Fever, Chills, Rigor
- Weight change, Appetite.
- Fatigue.
- Nausea, Vomiting.
- Frequency.
- Urgency.
- Incontinence.
- Nocturia.
- Dysuria.
- Hesitancy.
- Poor stream.
- Intermittency.
- Incomplete voiding
- Urine color.
- Urine odor.
- Back / pelvic pain.
- Sexual activity normal

- **Medication**: Rifampin, NSAID, Warfarin, Aspirin, Heparin
- **Type of food:** beetroot ,black berry, food coloring
- **Systematic Review:**

1. CVS
2. RS
3. MSS
4. CNS
5. ES
6. GIT -->Anorexia (appendicitis) , change in stool (Diverticulitis), with fatty food (cholecystitis ).

- **Past Medical History: ½ mark each /6.5**

1. History of **UTI** 2. Previous episode 3. **Trauma** 4. **Previous surgery** recent folly's cath insertion ? 5. **Chronic diseases** (HTN, DM ).

- **Family History: ½ mark each /3**

**Stone, Cancers (Bladder/ Kidney), UTI**.

- **Social History: 1 mark each /3**

**Smoking** , **Alcohol use, recent travel, menstrual cycle in women**.

- **Patient concerns, ideas, what suspected to do.**

# UTI

| 30 year old male complaining of flank pain, take a relevant history | Mark |
|---|---|
| Introduces self and takes permission | /2 |
| **HOPI** | /16 |
| **Details about CC**: each ½ mark<br>1. Onset 1 week ago<br>2. Character Tearing in nature<br>3. Radiation No Radiation<br>4. Exacerbating factors No<br>5. Relieving factors No<br>6. Severity increase gradually, Very severe | /4 |
| **Associated symptoms**: 2 marks each<br>Fever yes<br>Chills yes<br>Rigor yes<br>Weight change no<br>Appetite no<br>Fatigue yes<br>Nausea yes<br>Vomiting yes<br>Frequency yes<br>Urgency yes<br>Incontinence no<br>Nocturia no<br>Dysuria no<br>Hesitancy yes, minimal<br>Poor stream no<br>Intermittency no<br>Incomplete voiding no<br>Urine color normal<br>Urine odor normal<br>Sexual activity normal | /12 |

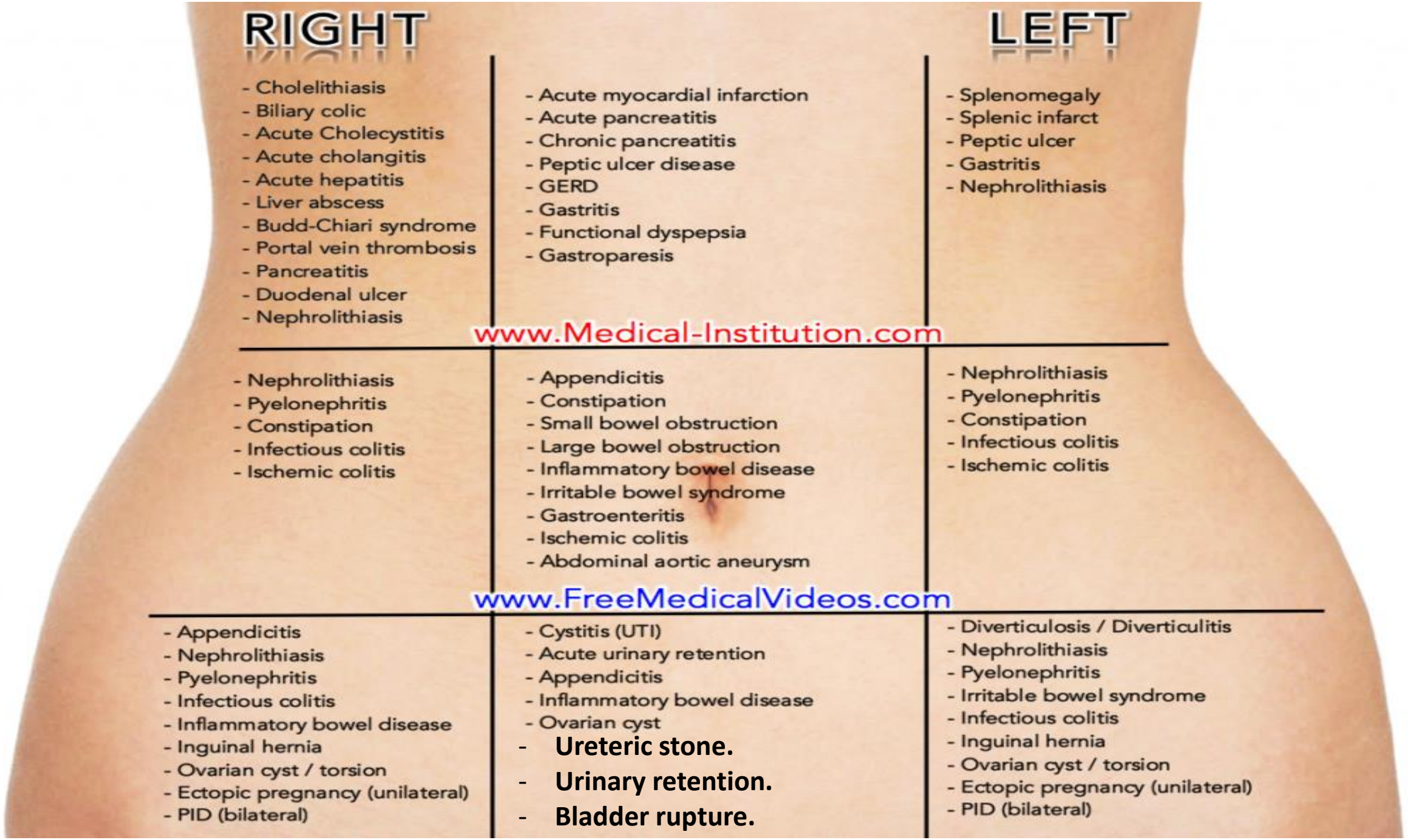
| | |
|---|---|
| **Systematic Review:-**<br>**CVS**<br>**RS**<br>**MSS**<br>**CNS**<br>**ES**<br>**GIT** -->Anorexia (appendicitis) , change in stool (Diverticulitis), with fatty food (cholecystitis ) | |
| **Past Medical History:** ½ mark each | /6.5 |
| 1. History of UTI no<br>2. Previous episode no<br>3. Trauma<br>4. Previous surgery | |

| | |
|---|---|
| 3. Trauma<br>4. Previous surgery<br>5. Chronic diseases (HTN, DM ) | |
| **Family History:** ½ mark each | /3 |
| Stone yes<br>UTI yes | |
| **Social History:** 1 mark each | /3 |
| Smoking - no<br>Alcohol use no | |

**What is your DDX ?**

**Urinary cayuses: 1. UTI. 2. Stone 3. Trauma. 4. Tumor.**
**Non-Urinary: Appendicitis, cholecystitis, bowel obstruction, muscle spasm.**

| Flank Pain Differential | |
|---|---|
| **Pathophysiology** | **Differential** |
| Renal | Nephrolithiasis, urolithiasis, retroperitoneal hematoma, ruptured renal cyst, ureteral stricture |
| Infectious | Pyelonephritis, perinephric abscess, psoas abscess, pneumonia, discitis, vertebral osteomyelitis, epidural abscess |
| Vascular | Ruptured AAA, renal infarct, renal vein thrombosis, PE |
| GI | Biliary dz |
| Other | PCKD (ruptured cyst), renal malignancy, varicella-zoster |
| Trauma | Lumbar spasm, radiculopathy |


RIGHT
LEFT
- Cholelithiasis
- Biliary colic
- Acute Cholecystitis
- Acute cholangitis
- Acute hepatitis
- Liver abscess
- Budd-Chiari syndrome
- Portal vein thrombosis
- Pancreatitis
- Duodenal ulcer
- Nephrolithiasis
- Acute myocardial infarction
- Acute pancreatitis
- Chronic pancreatitis
- Peptic ulcer disease
- GERD
- Gastritis
- Functional dyspepsia
- Gastroparesis
- Splenomegaly
- Splenic infarct
- Peptic ulcer
- Gastritis
- Nephrolithiasis
www.Medical-Institution.com
- Nephrolithiasis
- Pyelonephritis
- Constipation
- Infectious colitis
- Ischemic colitis
- Appendicitis
- Constipation
- Small bowel obstruction
- Large bowel obstruction
- Inflammatory bowel disease
- Irritable bowel syndrome
- Gastroenteritis
- Ischemic colitis
- Abdominal aortic aneurysm
- Nephrolithiasis
- Pyelonephritis
- Constipation
- Infectious colitis
- Ischemic colitis
www.FreeMedicalVideos.com
- Appendicitis
- Nephrolithiasis
- Pyelonephritis
- Infectious colitis
- Inflammatory bowel disease
- Inguinal hernia
- Ovarian cyst / torsion
- Ectopic pregnancy (unilateral)
- PID (bilateral)
- Cystitis (UTI)
- Acute urinary retention
- Appendicitis
- Inflammatory bowel disease
- Ovarian cyst
- Ureteric stone.
- Urinary retention.
- Bladder rupture.
- Diverticulosis / Diverticulitis
- Nephrolithiasis
- Pyelonephritis
- Irritable bowel syndrome
- Infectious colitis
- Inguinal hernia
- Ovarian cyst / torsion
- Ectopic pregnancy (unilateral)
- PID (bilateral)

# Thank You

# Testicular Pain/ Swelling

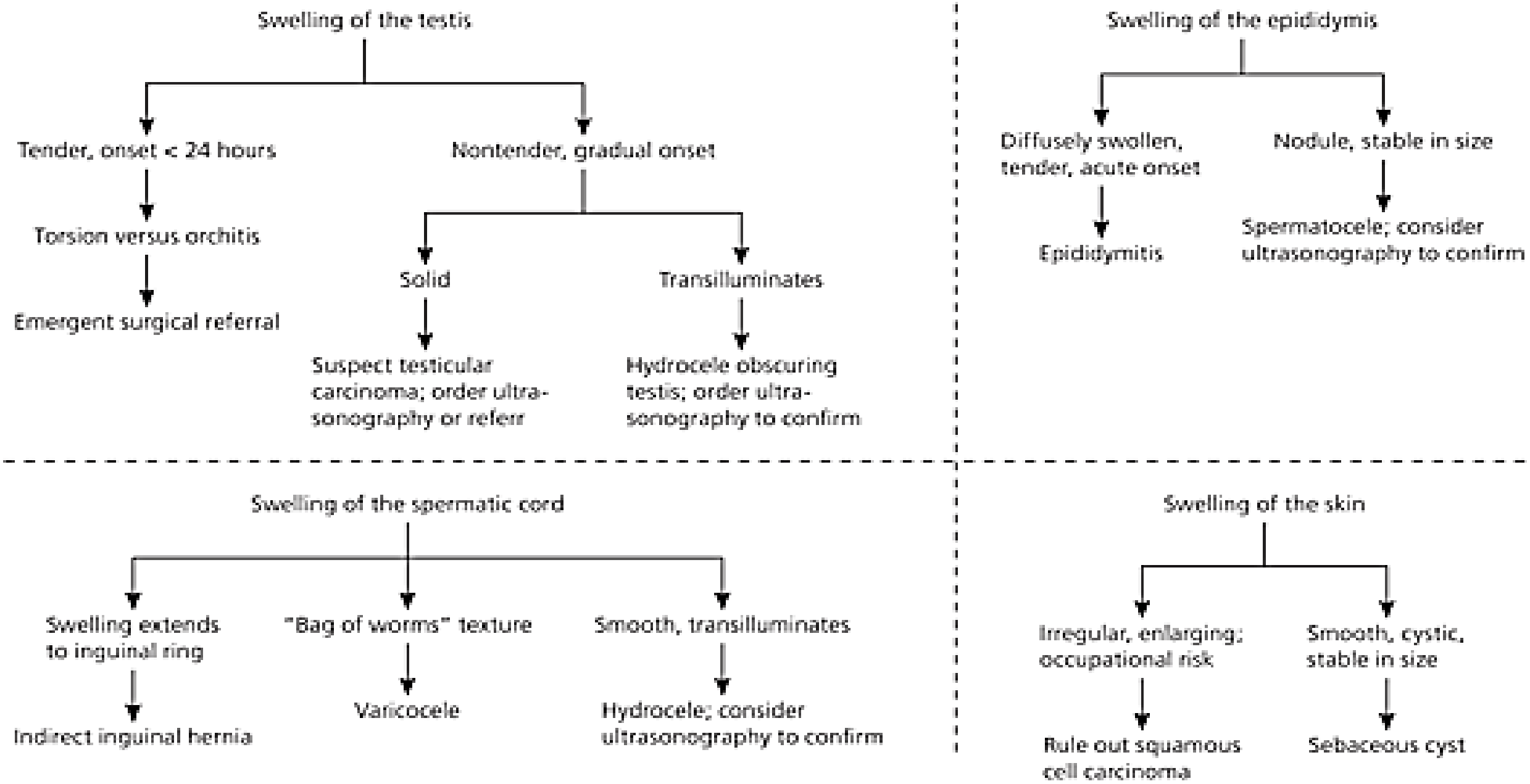
**QMA Team**

# Painful scrotal conditions

1. **Torsion of the testis.**
2. Torsion of the **appendage**: Pain in the **upper pole of the testis**, **not diffuse**, **gradually starts**, with **no systemic symptoms**, on PE **Blue dot sign**, the treatment **conservative** (pain killers, ice and scrotal support).
3. Epididymitis.
4. Orchitis.
5. Trauma.

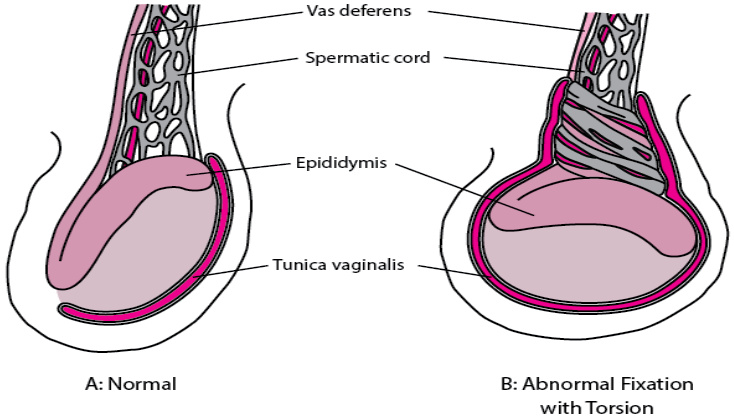
# Painless swelling

- Testicular cancer.
- Hydrocele.
- **Varicocele**: Abnormal dilation of pumpiniform plexus, either **painful/ painless** (infertility), can occur more in the **left side**, gradual in onset, **bag-warm like mass**, associated with **pain** that **decrease with support**. On PE **Valsva/ cough/ stand can increase the mass**. Lab: Do seminal fluid analysis to assess the infertility. Managed by: **Varicocelectomy**.
- Hematocele.




NOTE: *Emergent surgical referral should be strongly considered for any acutely painful scrotum when testicular torsion is a possibility. If testicular torsion is not suspected, ultrasonography may be performed to confirm the diagnosis.*

# Testicular torsion

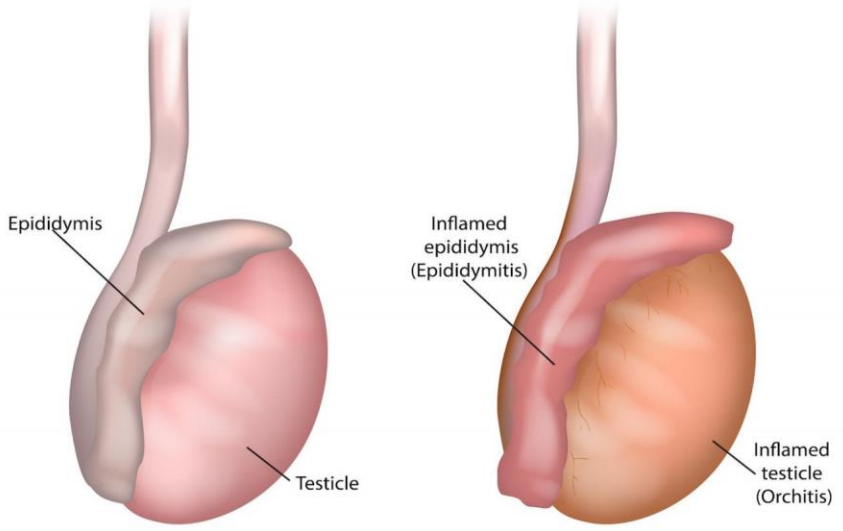



- **Most common cause of testicular pain.**
- Torsion will lead to decrease the blood supply and **ischemia**.
- **Acute** condition.
- Golden time: **6 hours (viable testis), if >24hr (<10% salvage).**
- Age: **10-20** years typical age of torsion, but may occur at any age.
- Associated symptoms: **Vomiting, severe diffuse pain, not relieved by elevation of testis, the testicle may be horizontal and high**.
- **Diagnosed** by: **Surgical exploration**, U/S (Solid mass), Doppler.
- Treatment: **Surgical exploration, detorsion, orchidopexy all**.

# Epididymo-orchitis

- Subacute **inflammatory** condition, **more gradual**.
- Associated with **fever**.
- Caused by 1. **STI**. 2. **Gonorrhea** (MCC). 3. **E.coli** (Middle east).
- DX: UA, Culture, Swab for STD, US+-Doppler
- Treatment:

1. **IV/ Oral antibiotics**.
2. **Analgesic.**
3. **Support**.



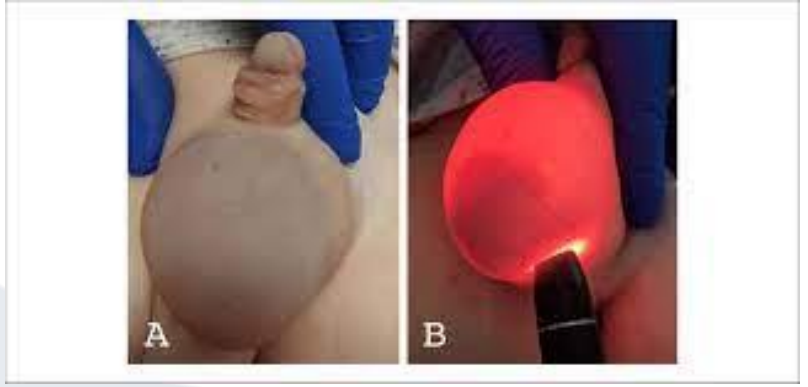
* Differences between Testicular torsion and Epididymo orchitis :

| | Testicular torsion | Epididymo Orchitis |
|---|---|---|
| Onset | Acute | Subacute |
| Doppler U/S | Decreased / Absent blood supply | Increased blood supply |
| Age | 10–20 year (most common) | Rarely between 10-20 year. |
| Management | mentioned above | mentioned above |
| physical Exam | - Redness, swelling, hotness<br>- Negative prehn's sign<br>- Absent Cremasteric reflex | - Redness, swelling, hotness<br>- positive prehn's sign<br>- normal Cremasteric reflex |

* prehn's sign : when you elevate the scrotum, the pain will relieve ( ↓ pain , ↓ edema )

* Cremasteric reflex : stroking/scratching the upper medial thigh, so the scrotum will be contracted

# Hydrocele




- The **accumulation of fluid in the processes vaginalis membrane**.
- Usually **unilateral**.
- Types: **Isolated hydrocele, communicating hydrocele**.
- How to differentiate? (**supine** position = Disappear (communicating)).
- It starts **gradually** and **transillumation** test positive.
- It can be associated with inguinal hernia (vomiting/ pain).
- The management is **hydrocelectomy**.

# History

- **Introduces self , takes permission and brief patient profile.**
- **HOPI : SOCRATES**

1. **Site (Right/ left .. Unilateral/bilateral … localized/diffused) .**
2. **Onset.**
3. **Character (nature of pain/ if swelling redness .. Hotness .. Reducible .. Bag of warms).**
4. **Radiation.**
5. **Exacerbating factors (Standing/ lying/ day VS night/ cough).**
6. **Time (continuous/ intermittent/ previous episodes).**
7. **Relieving factors (Elevation/ pain killers).**
8. **Severity.**

**Associated symptoms: 2 marks each (Constitutional/ LUTS+ Stones/ Urethritis)**

- Fever, Chills, Rigor
- Weight change, Appetite.
- Fatigue.
- Nausea, Vomiting.
- Frequency.
- Urgency.
- Incontinence.
- Nocturia.
- Dysuria.
- Hesitancy.
- Poor stream.
- Intermittency.
- Incomplete voiding
- Urine color.
- Urine odor.
- Back / pelvic pain.
- Sexual activity normal

- **Medication**: Rifampin, NSAID, Warfarin, Aspirin, Heparin
- **Type of food:** beetroot ,black berry, food coloring
- **Systematic Review:**

1. CVS
2. RS
3. MSS
4. CNS
5. ES
6. GIT --> constipation.

- **Past Medical History: ½ mark each /6.5**

1. History of **UTI** 2. Previous episode 3. **Trauma** 4. **Previous surgery** recent folly's cath insertion ? 5. **Crptochidism**. 6. **Chronic diseases** (HTN, DM ).

- **Family History: ½ mark each /3**

**Stone, Cancers (Bladder/ Kidney), UTI**.

- **Social History: 1 mark each /3**

**Smoking** , **Alcohol use, recent travel, menstrual cycle in women**.

- **Patient concerns, ideas, what suspected to do.**

# Thank You