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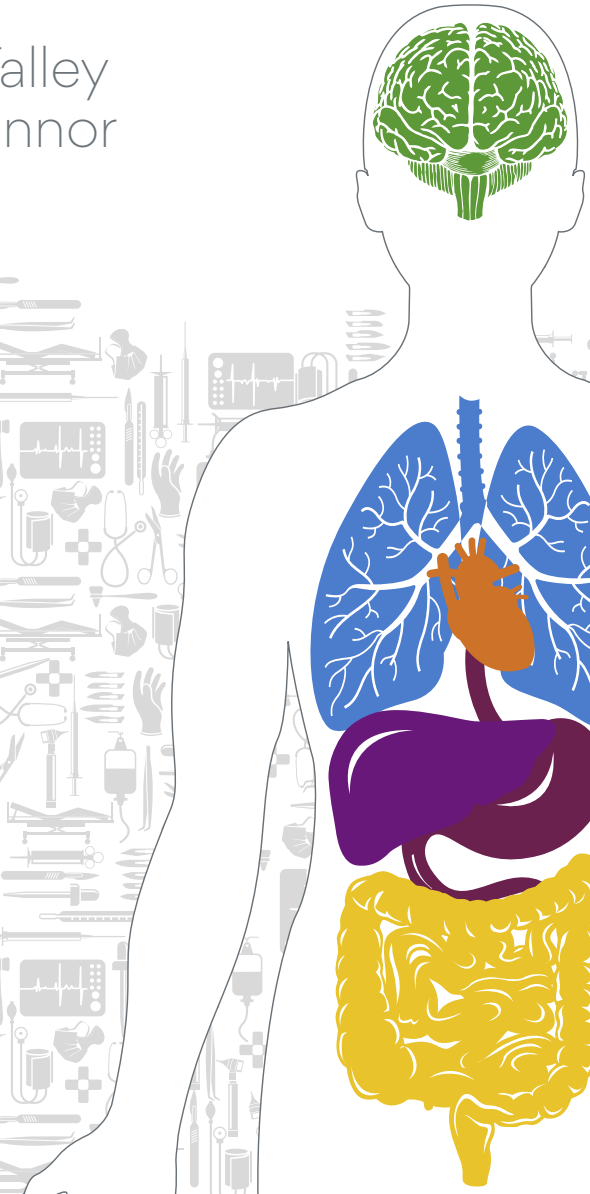
Talley & O'Connor's CLINICAL EXAMINATION 9e

A systematic guide to physical diagnosis

Nicholas J Talley
Simon O'Connor



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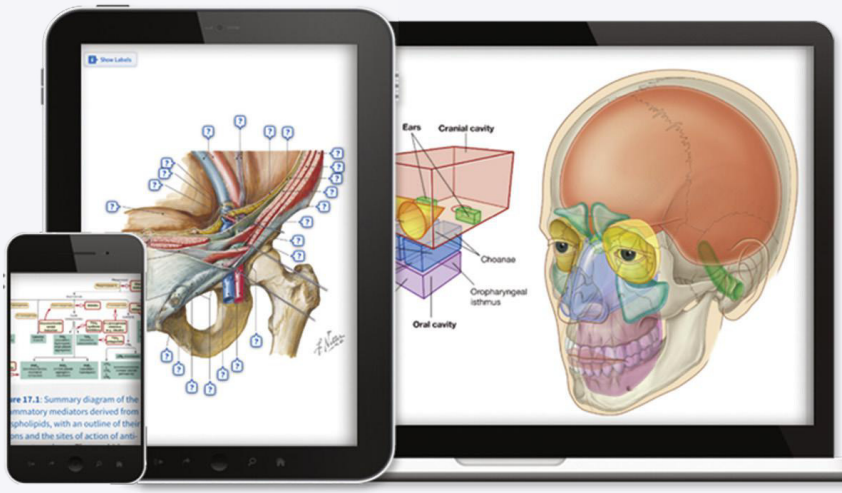

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Talley & O'Connor's Clinical Examination

A systematic guide to physical diagnosis

9th edition

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Foreword

Medical advances are increasing exponentially, and medical knowledge expands at an alarming rate, but the ability to assess a patient by listening to a medical history and examining the body systems in order to formulate a clinical diagnosis is a timeless skill which all doctors value.

Caring for the sick has been a key part of civilised society for many hundreds of years. It became professionalised in England with the endowment of Royal Charters to ensure that only those with an appropriate mix of skills and knowledge could enter the profession, and so membership of a Royal College had the added benefit of keeping the quacks and charlatans out. The Royal College of Physicians was set up on the 23rd of September 1518, in London, by King Henry VIII together with Thomas Linacre, one of his favoured physicians, to do just that. Since that time, the practice of medicine has developed and expanded into what we see today, more than 500 years later. Medical professional regulation was taken over by the UK General Medical Council in 1858, and a respected worldwide professional reputation has been building since then. It was my privilege to be the President of the Royal College of Physicians from 2014 until its quincentennial year in 2018, and so I understand the responsibility we have as physicians today.

The acquisition of the highest standard of clinical and communication skills coupled with sophisticated clinical reasoning is still at the heart of all clinical practice.

Our knowledge of pathology and disease processes continues to move very fast, but it is based on a foundation of expertise in the assessment of the patient that has been consolidated and enhanced over the years. New challenges appear, but the science underpinning medicine helps us to rise to these challenges. The recent global pandemic caused by coronavirus has demonstrated the strength of the partnership between the extraordinary advances in science and high-quality, good old-fashioned medicine.

Medicine continues to be a wonderful career with a wide variety of specialties, and something for everyone who enters the fold. Developing proficiency in the knowledge and skills required to practise high-quality clinical medicine binds us together as a professional group. Wherever I have travelled in the world, I meet doctors who instantly share a set of core values that have become the international language of medicine. As a profession, this is something to be proud of.

The education of doctors has changed over the years to keep pace with current pedagogy and the increasing knowledge base, but continues to emphasise the importance of basic clinical method. The conditions we see have changed from a predominance of infection and communicable disease to a skew towards long-term conditions and the impact of a modern lifestyle. This all needs to be understood by today's health professionals. We now recognise that a focus on prevention is the key to a healthy future, and all this is now included in medical curricula. Ways of learning now embrace the use of modern technology, and instant access to knowledge via a device, but the fundamental basis of medicine has not changed.

The great medical teacher, and arguably the father of modern medicine, William Osler, is quoted as saying:

The good physician treats the disease; the great physician treats the patient who has the disease.

As doctors we are in a privileged position, and benefit from the trust and confidence of our patients. Maintaining our core skills, and our ability to apply robust clinical reasoning allows us to maintain that position of trust, and to take our responsibilities seriously. We aspire to always treat the patient who has the disease, not just the disease.

Professor Dame Jane Dacre DBE, BSc, MD, FRCP, FHEA
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Preface

Listen to your patient, he (she) is telling you the diagnosis.

Sir William Osler (1849–1918)

Diagnosticians are great medical detectives who apply rigorous methodology to uncover the truth, solve a puzzle and commence the healing process.

Nick Talley & Simon O'Connor
Clinical Examination, 2017

Clinical medicine is exciting, and clinical skills continue to form the basis of modern clinical practice in order to make an accurate diagnosis. Thirty-five years ago, encouraged by the success of our first textbook on clinical skills *Examination Medicine,* which was aimed at postgraduate physician trainees sitting their barrier specialist internal medicine examinations, we set out to write *Clinical Examination*. The textbook was written over a year while we were senior registrars at the Royal North Shore Hospital, a major teaching hospital of the University of Sydney, Australia. Our goal was simple but ambitious: to write a new type of clinical skills textbook that would speak (and appeal) to medical students in all their clinical years from first patient exposure to final examinations (and beyond), and to teach a modern, systematic and comprehensive method of history taking and examination including an approach to rigorous clinical thinking and diagnosis.

A number of innovations have aided the success of this textbook and have been employed again here. The text is carefully organised and illustrated to maximise comprehension, including chapter summaries, essential lists and useful tables. Full-colour illustrations provide a visual guide for key signs including ethnic variations so important to recognise in clinical practice. We have included amusing comments and anecdotes with the view that optimal learning must be fun. We've added historical footnotes because these can be an *aide-mémoire*, and we believe students should know medicine is ever changing but we all stand on the shoulders of those who came before us. Videos illustrate how to examine in real time.

The book has extensively evolved over multiple editions and includes all specialty areas taught in undergraduate curriculums. We are pleased that generations of students have responded so positively to each edition, and medical schools around the world have adopted the textbook in their medical degree programs. We were very proud to be awarded First Prize in the Medicine category in the 2018 British Medical Association (BMA) Medical Book Awards, and hope this brand new revised edition will be similarly well received.

Every edition including the current one has undergone rigorous peer review by experts, and we have paid careful attention to the comments and suggestions. The book has received numerous reviews in major journals and readers have sent us many suggestions, and again we have taken the opportunity to try and address all reasonable recommendations with every revision. Before embarking on each revision, we also conduct a thorough literature search to identify new key references that inform the text and, where necessary, new references are added (and old ones replaced) for further reading. A strong emphasis on evidence-based medicine continues to permeate this edition. This is because today it takes only about 3 months for existing medical knowledge to double in size, compared with about 50 years mid last century. Despite rapidly accelerating knowledge, an understanding of the diagnostic value of important symptoms and signs is essential to excellent clinical practice. There remain huge research gaps and we hope readers of this book will aspire to fill many of them in the coming years.

The SARS-CoV-2 pandemic has shaken the globe and emphasised the importance of clinical skills and expertise in frontline care. We want to acknowledge all of the expert contributors to this new edition who willingly assisted us despite the pandemic, and the excellent peer reviewers and everyone who has provided us with feedback and encouragement. Do write to the publisher with any suggestions. We also thank all our colleagues and patients who continue to educate and inspire us on a daily basis.

Nicholas J. Talley, AC
Simon O'Connor
Newcastle and Canberra, 2021

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This book provides an evidence-based account of clinical skills. We are very grateful for the reviews, comments and suggestions from the many outstanding colleagues over the years who have helped us to develop and refine this book. All chapters have again been peer reviewed, a hallmark of our books, and we have taken great care to revise the material based on the detailed reviews obtained. We take responsibility for any errors or omissions.

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Clinical methods: an historical perspective

The best physician is the one who is able to differentiate the possible and the impossible.

Herophilus of Alexandria (335–280BC)

Since classical Greek times interrogation of the patient has been considered most important because disease was, and still is, viewed in terms of the discomfort it causes. However, the current emphasis on the use of history taking and physical examination for diagnosis developed only in the 19th century. Although the terms 'symptoms and signs' have been part of the medical vocabulary since the revival of classical medicine, until relatively recently they were used synonymously. During the 19th century, the distinction between *symptoms* (subjective complaints, which the clinician learns from the patient's account of his or her feelings) and *signs* (objective morbid changes detectable by the clinician) evolved. Until the 19th century, diagnosis was empirical and based on the classical Greek belief that all disease had a single cause: an imbalance of the four humours (yellow bile, black bile, blood and phlegm). Indeed the Royal College of Physicians, founded in London in 1518, believed that clinical experience without classical learning was useless, and physicians who were College members were fined if they ascribed to any other view. At the time of Hippocrates (460?–375BC), observation (inspection) and feeling (palpation) had a place in the examination of patients. The ancient Greeks, for example, noticed that patients with jaundice often had an enlarged liver that was firm and irregular. Shaking a patient and listening for a fluid splash was also recognised by the Greeks. Herophilus of Alexandria (335–280BC) described a method of taking the pulse in the 4th century BC. However, it was Galen of Pergamum (AD130–200) who established the pulse as one of the major physical signs, and it continued to have this important role up to the 18th century, with minute variations being recorded. These variations were erroneously considered to indicate changes in the body's harmony. William Harvey's (1578–1657) studies of the human circulation, published in 1628, had little effect on the general understanding of the value of the pulse as a sign. Sanctorius (1561–1636) was the first to time the pulse using a clock, while John Floyer (1649–1734) invented the pulse watch in 1707 and made regular observations of the pulse rate. Abnormalities in heart rate were described in diabetes mellitus in 1776 and in thyrotoxicosis in 1786. Fever was studied by Hippocrates and was originally regarded as an entity rather than a sign of disease. The thermoscope was devised by Sanctorius in 1625. In association with Gabriel Fahrenheit (1686–1736), Hermann Boerhaave (1668–1738) introduced the thermometer as a research instrument and this was produced commercially in the middle of the 18th century. In the 13th century Johannes Actuarius (d. 1283) used a graduated glass to examine the urine. In Harvey's time a specimen of urine was sometimes looked at (inspected) and even tasted, and was considered to reveal secrets about the body. Harvey recorded that sugar diabetes (mellitus) and dropsy (oedema) could be diagnosed in this way. The detection of protein in the urine, which Frederik Dekkers (1644–1720) first described in 1673, was ignored until Richard Bright (1789–1858) demonstrated its importance in renal disease. Although Celsus described and valued measurements such as weighing and measuring a patient in the 1st century AD, these methods became widely used only in the 20th century. A renaissance in clinical methods began with the concept of Battista Morgagni (1682–1771) that disease was not generalised but rather arose in organs, a conclusion published in 1761. Leopold Auenbrugger invented chest tapping (percussion) to detect disease in the same year. Van Swieten, his teacher, in fact

used percussion to detect ascites. The technique was forgotten for nearly half a century until Jean Corvisart (1755–1821) translated Auenbrugger's work in 1808.

The next big step occurred with René Laënnec (1781–1826), a student of Corvisart. He invented the stethoscope in 1816 (at first merely a roll of stiff paper) as an aid to diagnosing heart and lung disease by listening (auscultation). This revolutionised chest examination, partly because it made the chest accessible in patients too modest to allow a direct application of the examiner's ear to the chest wall, as well as allowing accurate clinicopathological correlations. William Stokes (1804–78) published the first treatise in English on the use of the stethoscope in 1825. Josef Skoda's (1805–81) investigations of the value of these clinical methods led to their widespread and enthusiastic adoption after he published his results in 1839. These advances helped lead to a change in the practice of medicine. Bedside teaching was first introduced in the Renaissance by Montanus (1498–1552) in Padua in 1543. In the 17th century, physicians based their opinion on a history provided by an apothecary (assistant) and rarely saw the patients themselves. Thomas Sydenham (1624–89) began to practise more modern bedside medicine, basing his treatment on experience and not theory, but it was not until a century later that the scientific method brought a systematic approach to clinical diagnosis.

This change began in the hospitals of Paris after the French Revolution, with recognition of the work of Morgagni, Corvisart, Laënnec and others. Influenced by the philosophy of the Enlightenment, which suggested that a rational approach to all problems was possible, the Paris Clinical School combined physical examination with autopsy as the basis of clinical medicine. The methods of this school were first applied abroad in Dublin, where Robert Graves (1796–1853) and William Stokes worked. Later, at Guy's Hospital in London, the famous trio of Richard Bright, Thomas Addison (1793–1860) and Thomas Hodgkin (1798–1866) made their important contributions. In 1869 Samuel Wilks (1824–1911) wrote on the nail changes in disease and the signs he described remain important. Carl Wunderlich's (1815–77) work changed the concept of temperature from a disease in itself to a symptom of disease. Spectacular advances in physiology, pathology, pharmacology and the discovery of microbiology in the latter half of the 19th century led to the development of the new 'clinical and laboratory medicine', which is the rapidly advancing medicine of the present day. The modern systematic approach to diagnosis, with which this book deals, is still, however, based on taking the history and examining the patient by looking (inspecting), feeling (palpating), tapping (percussing) and listening (auscultating).

Suggested reading

Bordage G. Where are the history and the physical? *Can Med Assoc J* 1995; 152:1595–1598.

McDonald C. Medical heuristics: the silent adjudicators of clinical practice. *Ann Intern Med* 1996; 124:56–62.

Reiser SJ. The clinical record in medicine. Part I: Learning from cases. *Ann Intern Med* 1991; 114:902–907.

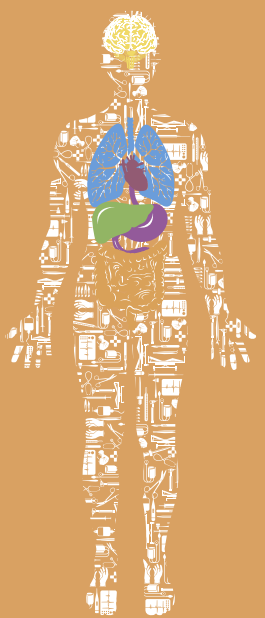
The Hippocratic oath

I swear by Apollo the physician, and Aesculapius, and Hygieia, and Panacea, and all the gods and goddesses that, according to my ability and judgment, I will keep this Oath and this stipulation: To reckon him who taught me this Art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to look upon his offspring in the same footing as my own brother, and to teach them this Art, if they shall wish to learn it, without fee or stipulation, and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any if asked, nor suggest any such counsel; and in like manner I will not give a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practise my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken of abroad I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated may it be granted to me to enjoy life and the practice of the Art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!

Hippocrates, born on the Island of Cos (c.460–357 BC) is agreed by everyone to be the father of medicine. He is said to have lived to the age of 109. Many of the statements in this ancient oath remain relevant today, while others, such as euthanasia and abortion, remain controversial. The seduction of slaves, however, is less of a problem.

SECTION 1

The general principles of history taking and physical examination



CHAPTER 1

The general principles of history taking

Medicine is learned by the bedside and not in the classroom. SIR WILLIAM OSLER (1849–1919)

An extensive knowledge of medical facts is not useful unless a doctor is able to extract accurate and succinct information from a sick person about his or her illness, and then synthesise the data. This is how you make an accurate diagnosis. In all branches of medicine, the development of a rational plan of management depends on a correct diagnosis or a sensible, differential diagnosis (list of possible diagnoses). Except for patients who are extremely ill, taking a careful medical history should precede both examination and treatment.

Taking the medical history is the first step in making a diagnosis; it will be used to direct the physical examination and will usually determine what investigations are appropriate. More often than not, an accurate history suggests the correct diagnosis, whereas the physical examination and subsequent investigations merely serve to confirm this impression.[1,2] Text box 1.1 shows the consultation sequence.

Great diagnosticians have been feted by history and you will see their names live on in this book: Hippocrates, Osler, Mayo, Addison and Cushing, to name a few. History taking involves more than listening: you must observe actively (a part of physical examination). Noting the discomfort of a patient who has abdominal pain, for example, will influence the interpretation of the history. Remember that the history is the least-expensive way of making a diagnosis.

Changes in medical education mean that much student teaching is now conducted away from the traditional hospital ward. Students must learn how to take a medical history in any and every setting, but obviously adjustments to the technique must be made for patients seen in busy surgeries or outpatient departments. Much information about a patient's previous medical history may already be available in hospital or clinic records (some regrettably inaccurately recorded, so be on your guard); the detail needed will vary depending on the complexity of the presenting problem and on whether the visit is a follow-up or a new consultation.

T&O'C ESSENTIALS

All students must have a comprehensive understanding of how to take a complete medical history, which is usually essential for accurate diagnosis.

The consultation sequence

1. History
2. Examination
3. Explanation to patient of findings, differential diagnosis (possible diagnoses) and management plan (further tests and treatment)
4. Ordering of, and explanation of, appropriate tests
5. Commencement of treatment, if indicated

TEXT BOX 1.1

BEDSIDE MANNER AND ESTABLISHING RAPPORT

History taking requires practice and depends very much on the doctor–patient relationship.[3] It is important to learn an approach that helps put patients at ease. This is often best done by watching the way more senior colleagues work with their patients. Students need to develop their own methods of feeling easy with their patients. Once students learn how to establish this rapport with patients, the history taking and indeed all of the consultation is likely to be rewarding.

Successful doctors are able to imagine what it would be like to be in the position of the patient they are treating. Ask yourself the question 'How would I like to be treated if I were this patient?'

It is possible to be understanding and sympathetic about a patient's illness and circumstances but retain objectivity. Doctors who can become overwhelmed by their patients' problems cannot look after them properly.[a]

Hospitals and clinics all have rules and suggestions for students about how they should dress and identify themselves, and whose permission they need to see patients on wards. Make sure you are familiar with these rather than face ejection from the ward by a senior doctor or (more frightening) nurse.[b]

Remember that patients tell doctors and even medical students facts they would tell no one else. It is essential that these matters be kept confidential except when shared for clinical reasons and in accordance with privacy legislation. There should be no problem in discussing a patient with a colleague, but unless the colleague is directly involved in the patient's management the patient should not be identified. This applies to discussion of patients and their results at clinical meetings. In open meetings, the patient's name should be removed from displayed tests and documents.

There is no doubt that the treatment of a patient begins the moment one reaches the bedside or the patient enters the consulting rooms. The patient's first impressions of a doctor's professional manner will have a lasting effect. One of the axioms of the medical profession is *primum non nocere* (first, do no harm).[4] An unkind and thoughtless approach to questioning and examining a patient can cause harm before any treatment has had the opportunity to do so. You should aim to leave the patient feeling better for your visit.

Much has been written about the correct way to interview patients, but each doctor has to develop his or her own method, guided by experience gained from clinical teachers and patients themselves.[5–8] To help establish this good relationship, the student or doctor must make a deliberate point of introducing him- or herself and explaining his or her role. A student might say: 'Good afternoon, Mrs Evans. My name is Jane Smith. I am Dr Osler's medical student. She has asked me to come and see you.' A patient seen at a clinic should be asked to come and sit down, and be directed to a chair. The door should be shut or, if the patient is in the ward, the curtains drawn to provide some privacy. The clinician should sit down beside or near the patient so as to be close to eye level and give the impression that the interview will be an unhurried one.[9,10]

It is important here to address the patient respectfully, look at him or her (not the computer) and use his or her name and title (see Fig. 1.1). Some general remarks about the weather, hospital food or the crowded waiting

(a) Interviewing correctly. (b) Interviewing incorrectly

FIGURE 1.1

[a] Remember; 'the patient is the one with the disease', from the infamous *House of God* by Samuel Shem.

[b] Many hospitals have banned ties and long sleeves for their staff so as to prevent the spread of infection. Who knows where this trend for less and less clothing may end?

room may be appropriate to help put the patient at ease, but these must not be patronising.

OBTAINING THE HISTORY

Start with an open-ended question and listen actively—patients will 'tell you the diagnosis' if you take the time to listen to the story in their own words and synthesise what they are saying based on your knowledge of pathophysiology.

Allow the patient to tell the story first and avoid the almost overwhelming urge to interrupt. Encourage the patient to continue telling you about his or her main problem or problems from the beginning. Then ask specific questions to fill in all the gaps.

At the end of the history and examination, a detailed record is made. However, many clinicians find it useful to make rough notes during the interview. Tell patients you will be doing this but will also be listening to them. With practice, note taking can be done without any loss of rapport. Pausing to make a note of a patient's answer to a question and engaging his or her eyes directly can help, and indicates that the story is being taken seriously.

Many clinics and hospitals use computer records, which may be displayed on a computer screen on the desk. Notes are sometimes added to these during the interview via a keyboard. It can be very off-putting for a patient when the interviewing doctor looks entirely at the computer screen rather than at the patient. With practice it is possible to enter data while maintaining eye contact with a patient, but at first it is probably preferable to make written notes and transcribe or dictate them later.

The final record must be a sequential, accurate account of the development and course of the illness or illnesses of the patient (see Ch 50). There are a number of methods of recording this information. Hospitals may have printed forms with spaces for recording specific information. This applies especially to routine admissions (e.g. for minor surgical procedures). Follow-up consultation questions and notes will be briefer than those of the initial consultation; obviously, many questions are relevant only for the initial consultation. When a patient is seen repeatedly at a clinic or in a general practice setting, the current presenting history may be listed as an 'active' problem and the past history as a series of 'inactive' or 'still active' problems.

A sick patient will sometimes emphasise irrelevant facts and forget about very important symptoms. For this reason, a systematic approach to history taking and recording is crucial.[11] List 1.1 outlines a history-taking

HISTORY-TAKING SEQUENCE

1. **Presenting (principal) symptom (PS)**
2. **History of the presenting illness (HPI)**
   - Details of current illnesses
   - Details of previous similar episodes
   - Extent of functional disability
   - Effect of the illness
3. **Drug and treatment history**
   - Current treatment
   - Drug history (dose, duration, indication, side effects): prescription, over-the-counter and alternative therapies
   - Past treatments
   - Drug allergies or reactions
4. **Past history (PH)**
   - Past illnesses
   - Surgical operations (dates, indication, procedure)
   - Menstrual and reproductive history for women
   - Immunisations
   - Blood transfusions (and dates)
5. **Social history (SH)**
   - Upbringing and education level
   - Marital status, social support, living conditions and financial situation
   - Diet and exercise
   - Occupation and hobbies
   - Overseas travel (where and when)
   - Smoking and alcohol use
   - Analgesic and illicit (street) drug use
   - Mood and sexual history
6. **Family history (FH)**
7. **Systems review (SR)**

See Questions box 1.1 on pages 9–12

Also refer to Chapter 50.

LIST 1.1

sequence, but the detail required depends on the complexity of the presenting illness.

INTRODUCTORY QUESTIONS

In order to obtain a thorough history the clinician must establish a **good relationship**, interview in a **logical manner**, **listen** carefully, **interrupt** appropriately and usually only after allowing the patient to tell the initial story, note **non-verbal clues** and **correctly interpret** the information obtained.

The next step after introducing oneself should be to find out the patient's major symptoms or medical problems. Asking the patient 'What brought you here today?' can be unwise, as it often promotes the reply 'an ambulance' or 'a car'. This little joke wears thin after some years in clinical practice. It is best to attempt a conversational approach and ask the patient 'What has been the trouble or problem recently?' or 'When were you last quite well?' or 'What made you come to the hospital (or clinic) today?' For a follow-up consultation some reference to the last visit is appropriate, for example: 'How have things been going since I saw you last?' or 'It's been about … weeks since I saw you last, isn't it? What's been happening since then?' This lets the patient know the clinician hasn't forgotten him or her.

Some have suggested that the clinician begin with questions about more general aspects of the patient's life. There is a danger that this attempt to establish early rapport will seem intrusive to a person who has come for help about a specific problem, albeit one related to other aspects of life. This type of general and personal information may be better approached once the clinician has shown an interest in the presenting problem or as part of the social history—usually intrusive questions should be deferred to a subsequent consultation when the patient and clinician know each other better. The best approach and timing of this part of the interview will vary, depending on the nature of the presenting problem and the patient's and clinician's attitude.

T&O'C ESSENTIALS

Encourage patients to tell their stories in their own words from the onset of the first symptom to the present time. Find out the full details of each problem and document them.

When a patient stops volunteering information, the question '**What else?**' will usually help start the conversation up again, and can be repeated several times if necessary.[8] On the other hand, some direction may be necessary to keep a garrulous patient on track later during the interview.

It is necessary to *ask specific questions to test diagnostic hypotheses*. For example, the patient may not have noticed an association between the occurrence of chest discomfort and exercise (typical of angina) unless asked specifically. It may also be helpful to give a list of possible answers. A patient with suspected angina who is unable to describe the symptom may be asked whether the sensation is sharp, dull, heavy or burning. The reply that it is sharp makes angina less likely.

Appropriate (but not exaggerated) reassuring gestures are of value to maintain the flow of conversation. If the patient stops giving the story spontaneously, it can be useful to provide a short summary of what has already been said and encourage him or her to continue.

The clinician must learn to listen with an open mind.[10] The temptation to leap to a diagnostic decision before the patient has had the chance to describe all the symptoms in his or her own words should be resisted. Avoid using pseudo-medical terms and if the patient uses them then find out exactly what is meant by them, as misinterpretation of medical terms is common.

Patients' descriptions of their symptoms may vary as they are subjected to repeated questioning by increasingly senior medical staff. The patient who has described his chest pain as sharp and left-sided to the medical student may tell the registrar that the pain is dull and in the centre of his chest. These discrepancies come as no surprise to experienced clinicians; they are sometimes the result of the patient having had time to reflect on his or her symptoms. This does mean, however, that very important aspects of the story should be checked by asking follow-up questions, such as: 'Can you show me exactly where the pain is?' and 'What do you mean by sharp?'

Some patients may have medical problems that make the interview difficult for them; these include deafness and problems with speech and memory. These must be recognised by the clinician if the interview is to be successful. See Chapter 2 for more details.

PRESENTING (PRINCIPAL) SYMPTOM

Not uncommonly, a patient has many symptoms. An attempt must be made to decide which symptom led the patient to present. It must be remembered that the patient's and the doctor's ideas of what constitutes a serious problem may differ. A patient with symptoms of a cold who also, in passing, mentions that he has recently coughed up blood (haemoptysis) may need more attention to his chest than to his nose. Find out what problem or symptom most concerns the patient. Patients are unlikely to be satisfied with their consultation if the issue that troubles them the most is not dealt with, even if it is a minor problem for which reassurance is all that is required. Record each presenting symptom or symptoms in the patient's own words, avoiding technical terms at this stage.

Whenever you identify a major complaint or symptom, think of the following as you are trying to unravel the story and ask questions to try to find out:

1. Where is the problem? (Probable anatomical diagnosis)
2. What is the nature of the symptom? (Likely pathological diagnosis)
3. How does it affect the patient? (Physiological and functional diagnosis)
4. Why did the patient develop it? (Aetiological diagnosis)

A diagnosis is not just about a name; you are trying to determine the likely disease process so that you can advise the patient of the prognosis and plan management.

HISTORY OF THE PRESENTING ILLNESS

Each of the presenting problems has to be talked about in detail with the patient, but in the first part of the interview the patient should lead the discussion. In the second part the doctor should take more control and ask specific questions. When writing down the history of the presenting illness, the events should be placed in chronological order; this might have to be done later when the whole history has been obtained. If numerous systems are affected, the events should be placed in chronological order for each system. Remember, patients may have multiple problems, of which some are interdependent and some not. In the older person, multiple problems are the rule, not the exception. Your job is to identify them all accurately and create a full medical picture of the individual.

Current symptoms

Certain information should routinely be sought for each current symptom if this hasn't been volunteered by the patient. The mnemonic **SOCRATES** summarises the questions that should be asked about most symptoms:

- **S** ite
- **O** nset
- **C** haracter
- **R** adiation (if the symptom is pain or discomfort)
- **A** lleviating factors
- **T** iming
- **E** xacerbating factors
- **S** everity.

Site

Ask where the symptom is exactly and whether it is localised or diffuse. Ask the patient to point to the actual site on the body.

Some symptoms are not localised. Patients who complain of dizziness do not localise this to any particular site—but vertigo may sometimes involve a feeling of movement within the head and to that extent is localised. Other symptoms that are not localised include cough, shortness of breath (dyspnoea) and change in weight.

Onset (mode of onset and pattern)

Find out whether the symptom came on rapidly, gradually or instantaneously. Some cardiac arrhythmias are of instantaneous onset and offset. Sudden loss of consciousness (syncope) with immediate recovery occurs with cardiac but not neurological disease. Ask whether the symptom has been present continuously or intermittently. Find out whether the symptom is getting worse or better, and, if so, when the change occurred. For example, the exertional breathlessness of chronic obstructive pulmonary disease (COPD) may come on with less and less activity as it worsens. Find out what the patient was doing at the time the symptom

began. For example, severe breathlessness that wakes a patient from sleep is very suggestive of cardiac failure.

Character

Here it is necessary to ask the patient what is meant by the symptom, to describe its character. If the patient complains of dizziness, does this mean the room spins around (vertigo) or is it more a feeling of impending loss of consciousness? Does indigestion mean abdominal pain, heartburn, fullness after eating, excess wind or a change in bowel habit? If there is pain, is it sharp, dull, stabbing, boring, burning or cramp-like?

Radiation of pain or discomfort

Determine whether the symptom, if localised, radiates; this mainly applies if the symptom is pain. Certain patterns of radiation are typical of a condition or even diagnostic, for example the nerve root distribution of pain associated with herpes zoster (shingles).

Alleviating factors

Ask whether anything makes the symptom better. For example, the pain of pericarditis may be relieved when a patient sits up, whereas heartburn from acid reflux may be relieved by drinking milk or taking an antacid. Have analgesic medications been used to control the pain? Have narcotics been required?

Timing

Find out when the symptom first began and try to date this as accurately as possible. For example, ask the patient what the first thing was that he or she noticed was 'unusual' or 'wrong'. Ask whether the patient has had a similar illness in the past. It is often helpful to ask patients when they last felt entirely well. In a patient with long-standing symptoms, ask why he or she decided to see the doctor at this time.

Exacerbating factors

Ask whether anything makes the symptom worse. The slightest movement may exacerbate the abdominal pain of peritonitis or the pain in the big toe caused by gout.

Severity

This is subjective. The best way to assess severity is to ask the patient whether the symptom interferes with normal activities or sleep. Severity can be graded from mild to very severe. A mild symptom can be ignored by the patient, whereas a moderate symptom cannot be ignored but does not interfere with daily activities. A severe symptom interferes with daily activities, whereas a very severe symptom markedly interferes with most activities. Alternatively, pain or discomfort can be graded on a 10-point scale from 0 (no discomfort) to 10 (unbearable). (However, asking patients who are in severe pain to provide a number out of 10 seems at best a distraction and at worst rather unkind.) A face scale using pictures of different faces to represent pain severity from no pain (0) to very much pain (10) can be useful in practice.[12]

A number of other methods of quantifying pain are available (e.g. the visual analogue scale, whereby the patient is asked to mark the severity of pain on a 10-centimetre horizontal line). Note that all of these scales are more useful for comparing the subjective severity of pain over time than for absolute severity—for example, comparing before and after a certain treatment has been started.

The severity of some symptoms can be quantified more precisely; for example, shortness of breath on exertion occurring after walking 10 metres on flat ground is more severe than shortness of breath occurring after walking 90 metres up a hill. Central chest pain from angina occurring at rest is more significant than angina occurring while running 90 metres to catch a bus.

It is relevant to quantify the severity of each symptom—but also to remember that symptoms that a patient considers mild may be very significant.

Associated symptoms

Here an attempt is made to uncover in a systematic way those symptoms that might be expected to be associated with disease of a particular area. Initial and most thorough attention must be given to the system that includes the presenting problem (see Questions box 1.1). Remember that, although a single symptom may provide the clue that leads to the correct diagnosis, usually it is the combination of characteristic symptoms that most reliably suggests the diagnosis.

QUESTIONS BOX

The systems review

Enquire about common symptoms and three or four of the common disorders in each major system listed below. Not all of these questions should be asked of every patient. Adjust the detail of questions based on the presenting problem, the patient's age and the answers to the preliminary questions.

! denotes symptoms for the possible diagnosis of an urgent or dangerous (alarm) problem.

General

1. Have you had problems with tiredness? (Many physical and psychological causes)
2. Do you sleep well? (Insomnia and poor 'sleep hygiene', sleep apnoea)

Cardiovascular system

1. Have you had any pain or pressure in your chest, neck or arm? (Myocardial ischaemia)
2. Are you short of breath on exertion? How much exertion is necessary?
3. Have you ever woken up at night short of breath? (Cardiac failure)
4. Can you lie flat without feeling breathless?
5. Have you had swelling of your ankles?
6. Have you noticed your heart racing or beating irregularly?
7. ! Have you had blackouts without warning? (Stokes–Adams attacks)
8. ! Have you felt dizzy or blacked out when exercising? (Severe aortic stenosis or hypertrophic cardiomyopathy)
9. Do you have pain in your legs on exercise?
10. Do you have cold or blue hands or feet?
11. Have you ever had rheumatic fever, a heart attack or high blood pressure?

Respiratory system

1. Are you ever short of breath? Has this come on suddenly? (Pulmonary embolism)
2. Have you had any cough?
3. Is your cough associated with shivers and shakes (rigors) and breathlessness and chest pain? (Pneumonia)
4. Do you cough up anything?
5. ! Have you coughed up blood? (Bronchial carcinoma)
6. What type of work have you done? (Occupational lung disease)
7. Do you snore loudly? Do you fall asleep easily during the day? When? Have you fallen asleep while driving? Obtain a sleep history.
8. Do you ever have wheezing when you are short of breath?
9. Have you had fevers?
10. Do you have night sweats?
11. Have you ever had pneumonia or tuberculosis?
12. Have you had a recent chest X-ray?

Continued

QUESTIONS BOX *continued*

Gastrointestinal system

1. Are you troubled by indigestion? What do you mean by indigestion?
2. Do you have heartburn?
3. ! Have you had any difficulty swallowing? (Oesophageal cancer)
4. ! Have you had vomiting, or vomited blood? (Gastrointestinal bleeding)
5. Have you had pain or discomfort in your abdomen?
6. Have you had any abdominal bloating or distension?
7. Has your bowel habit changed recently? (Carcinoma of the colon)
8. How many bowel motions a week do you usually pass?
9. Have you lost control of your bowels or had accidents? (Faecal incontinence)
10. ! Have you seen blood in your motions? (Gastrointestinal bleeding)
11. ! Have your bowel motions been black? (Gastrointestinal bleeding)
12. ! Have you lost weight recently without dieting? (Malignancy)
13. Have your eyes or skin ever been yellow?
14. Have you ever had hepatitis, peptic ulceration, colitis or bowel cancer?
15. Tell me (briefly) about your diet recently.

Genitourinary system

1. Do you have difficulty or pain on passing urine?
2. How often do you pass urine?
3. Do you leak urine?
4. Is your urine stream as good as it used to be?
5. Is there a delay before you start to pass urine? (Applies mostly to men)
6. Is there dribbling at the end?
7. Do you have to get up at night to pass urine?
8. Are you passing larger or smaller amounts of urine?
9. Has the urine colour changed?
10. ! Have you seen blood in your urine? (Urinary tract malignancy)
11. Have you any problems with your sex life? Difficulty obtaining or maintaining an erection?
12. Have you noticed any rashes or lumps on your genitals?
13. Have you ever had a sexually transmitted disease?
14. Have you ever had a urinary tract infection or kidney stone?

Haematological system

1. Do you bruise easily?
2. Have you had fevers, or shivers and shakes (rigors)?
3. ! Do you have difficulty stopping a small cut from bleeding? (Bleeding disorder)
4. ! Have you noticed any lumps under your arms, or in your neck or groin? (Haematological malignancy)
5. Have you ever had blood clots in your legs or in the lungs?

QUESTIONS BOX *continued*

Musculoskeletal system

1. Do you have painful or stiff joints?
2. Are any of your joints red, swollen and painful?
3. Do you have any muscle pain around your shoulder?
4. Have you had a skin rash recently?
5. Do you have any back or neck pain?
6. Have your eyes been dry or red?
7. Have you ever had a dry mouth or mouth ulcers?
8. Have you been diagnosed as having rheumatoid arthritis or gout?
9. Do your fingers ever become painful and become white and blue in the cold? (Raynaud's)

Endocrine system

1. Have you noticed any swelling in your neck?
2. Do your hands tremble?
3. Do you prefer hot or cold weather?
4. Have you had a thyroid problem or diabetes?
5. Have you noticed increased sweating?
6. Have you been troubled by fatigue?
7. Have you noticed any change in your appearance, hair, skin or voice?
8. Have you been unusually thirsty lately? Or lost weight? (New onset of diabetes)

Reproductive and breast history (women)

1. Are your periods regular?
2. Do you have excessive pain or bleeding with your periods?
3. How many pregnancies have you had?
4. Have you had any miscarriages?
5. Have you had high blood pressure or diabetes in pregnancy?
6. Were there any other complications during your pregnancies or deliveries?
7. Have you had a Caesarean section?
8. ! Have you had any bleeding or discharge from your breasts or felt any lumps there? (Carcinoma of the breast)

Neurological system and mental state

1. Do you get headaches?
2. ! Is your headache very severe and did it begin very suddenly? (Subarachnoid haemorrhage)
3. Have you had fainting episodes, fits or blackouts?
4. Do you have trouble seeing or hearing?
5. Are you dizzy?
6. Have you had weakness, numbness or clumsiness in your arms or legs?
7. Have you ever had a stroke or head injury?
8. Do you feel sad or depressed, or have problems with your 'nerves'?
9. Have you ever been sexually or physically abused?

Continued

QUESTIONS BOX *continued*

The elderly patient

1. Have you had problems with falls or loss of balance? (High fracture risk)
2. Do you walk with a frame or stick?
3. Do you take sleeping tablets or sedatives? (Falls risk)
4. Do you take blood pressure tablets? (Postural hypotension and falls risk)
5. Have you been tested for osteoporosis?
6. Can you manage at home without help?
7. Are you affected by arthritis?
8. Have you had problems with your memory or with managing things like paying bills? (Cognitive decline)
9. How do you manage your various tablets? (Risk of polypharmacy and confusion of doses)

Concluding the interview

Is there anything else you would like to talk about?

BOX 1.1

The effect of the illness

A serious illness can change a person's life—for example, a chronic illness may prevent work or further education. The psychological and physical effects of a serious health problem may be devastating and, of course, people respond differently to similar problems. Even after full recovery from a life-threatening illness, some people may be permanently affected by loss of confidence or self-esteem. There may be continuing anxieties about the capability of supporting a family. Try to find out how the patient and his or her family have been affected. How has the patient coped so far, and what are the expectations and hopes for the future with regard to health? What explanations of the condition has the patient been given or obtained (e.g. from the internet)?

Helping a patient to manage ill-health is a large part of the clinician's duty. This depends on sympathetic and realistic explanations of the probable future course of the disease and the effects of treatment.

DRUG AND TREATMENT HISTORY

Ask the patient whether he or she is currently taking any tablets or medicines (the use of the word 'drug' may cause alarm); the patient will often describe these by colour or size rather than by name and dose.[c] Then ask the patient to show you all his or her medications (see Fig. 1.2), if possible, and list them. Note the dose, length of use, indication for each drug and any side effects.

This drug list may provide a useful clue to chronic or past illnesses, otherwise forgotten. For example, a patient who denies a history of high blood pressure may remember when asked why he or she is taking an antihypertensive drug having an elevated blood pressure in the past. Remember that some drugs are prescribed as transdermal patches or subcutaneous implants (e.g. contraceptives and hormonal treatment of carcinoma of the prostate). Ask whether the drugs were taken as prescribed. Always ask specifically whether a woman is taking the contraceptive pill, because many who take it do not consider it a medicine or tablet. The same is true of inhalers, or what many patients call their 'puffers'.

To remind the patient, it is often worthwhile to ask about the use of classes of drugs. A basic list should include questions about treatment for:

- blood pressure
- high cholesterol

[c] If you ask a patient what size a tablet is (meaning how many milligrams) a common answer will be, 'Oh it is quite small'.

(a) Medications packed for hospital discharge. (b) A Webster packet; medications packed for the patient by the pharmacy by time and day of the week

FIGURE 1.2

- diabetes
- arthritis
- anxiety or depression
- erectile dysfunction (no longer called impotence)
- contraception
- hormone replacement
- epilepsy
- anticoagulation
- antibiotics.

Also ask whether the patient is taking any over-the-counter preparations (e.g. aspirin, antihistamines, vitamins). Aspirin and standard non-steroidal anti-inflammatory drugs (NSAIDs), but not paracetamol (acetaminophen), can cause gastrointestinal bleeding. Patients with chronic pain may consume large amounts of analgesics, including drugs containing opioids such as codeine and morphine. These may be used in the form of skin patches. A careful history of the period of use of opioids and the quantities used is important, because they are drugs of dependence.

Many patients have printed copies of parts of their electronic records with lists of drugs. Unless these are updated regularly, they tend to contain names of drugs the patient may no longer be using. Ask about each drug on the list—whether it is still being taken, what dose and what it is for. It is very common for patients to say they have not used certain drugs on their list for years. Update the list for the patient if you are in charge of his or her care.

There may be some medications or treatments the patient has had in the past that remain relevant. These include corticosteroids, chemotherapeutic agents (anticancer drugs) and radiotherapy. Often patients, especially those with a chronic disease, are very well informed about their condition and their treatment. However, some allowance must be made for patients' non-medical interpretation of what happened.[10]

Note any **adverse reactions** in the past. Also ask specifically about any **allergy to drugs** (often a skin reaction or episode of bronchospasm) and what the allergic reaction actually involved, to help decide whether it was really an allergic reaction.[13] Patients often confuse an allergy with a side effect of a drug.

Approximately 50% of people now use 'natural remedies' of various types.[14] They may not feel that

these are a relevant part of their medical history, but these chemicals, like any drug, may have adverse effects. Indeed, some have been found to be adulterated with drugs such as steroids and NSAIDs. More information about these substances and their effects is becoming available and there is an increasing responsibility for clinicians to be aware of them and to ask about them directly.

Ask (where relevant—not the 90-year-old nursing home resident) about 'recreational' or street drug use (*vide infra*). The use of intravenous drugs has many implications for the patient's health. Ask whether any attempt has been made to avoid sharing needles. This may protect against the injection of viruses, but not against bacterial infection from the use of impure substances. Cocaine use has become a common cause of myocardial infarction in young people in some countries. Acutely ill patients may have taken overdoses of drugs whose purity has been underestimated (especially narcotics) or taken drugs without knowing what they are. The use of amphetamine-like drugs at parties can be associated with dehydration with electrolyte abnormalities and psychotic symptoms. Here an attempt to find out more detail from the patient or other party-goers is essential.

Not all medical problems are treated with drugs. Ask about courses of physiotherapy or rehabilitation for musculoskeletal problems or injuries, or to help recovery following surgery or a severe illness. Certain gastrointestinal conditions are treated with dietary supplements (e.g. pancreatic enzymes for chronic pancreatitis) or restrictions (e.g. avoidance of gluten for coeliac disease).

PAST HISTORY

Some patients may feel that questions about past problems and the more general questions asked in the systems review (p 19) are somewhat intrusive. It may be best to preface these questions by saying something like, 'I need to ask you some questions about your past medical problems and general health. These may affect your current investigations and treatment.'

Ask the patient whether he or she has had any serious illnesses, operations or admissions to hospital in the past, including any obstetric or gynaecological problems. Where relevant obtain the details. Do not forget to enquire about childhood illnesses. Ask about past blood transfusion (including when and what for). Serious or chronic childhood illnesses may have interfered with a child's education and social activities like sport. Ask what the patient remembers and thinks about this.

Previous illnesses or operations may have a direct bearing on current health. It is worth asking specifically about certain operations that have a continuing effect on the patient—for example, operations for malignancy, bowel surgery or cardiac surgery, especially valve surgery. Implanted prostheses are common in surgical, orthopaedic and cardiac procedures. These may involve a risk of infection of the foreign body, whereas magnetic metals—especially most cardiac pacemakers—are a contraindication to magnetic resonance imaging (MRI). Chronic kidney disease (CKD) may be a contraindication to X-rays using iodine contrast materials and MRI scanning using gadolinium contrast. Pregnancy is usually a contraindication to radiation exposure (X-rays and nuclear scans—remember that computed tomography [CT] scans cause hundreds of times the radiation exposure of simple X-rays).

The patient may believe that he or she has had a particular diagnosis made in the past, but careful questioning may reveal this as unlikely. For example, the patient may mention a previous duodenal ulcer, but not have had any investigations or treatment for it, which makes the diagnosis less certain. Therefore, it is important to obtain the particulars of each relevant past illness, including the symptoms experienced, tests performed and treatments prescribed. The mature clinician needs to maintain an *objective scepticism* about the information that is obtained from the patient.

Patients with chronic illnesses may have had their condition managed with the help of various doctors and at specialised clinics. For example, patients with diabetes mellitus are often managed by a team of health professionals including diabetic educators, nurses and dietitians. Find out what supervision and treatment these have provided. For example, who does the patient contact if there is a problem with the insulin dose, and does the patient know what to do (an **action plan**) if there is an urgent or a dangerous complication? Patients with chronic diseases are often very much involved in their own care and are very well informed about aspects of their treatment. For example, diabetics should keep records of their home-measured blood sugar levels,

heart failure patients should monitor their weight daily and so on. These patients will often make their own adjustments to their medication doses. Assessing a patient's understanding of and confidence in making these changes should be part of the history taking.

It should be routine to find out whether the adult patient is up to date with the recommended immunisations (e.g. mumps, measles, rubella, tetanus, etc.) as well as other recent immunisations (e.g. for human papilloma virus [HPV], hepatitis B, pneumococcal disease, *Haemophilus influenzae* or influenza) (p 32).

Ask what other medical practitioners the patient sees and whether he or she wants copies of your report sent to them. Patients have the right not to have information sent to other doctors if they choose.

Additional history for the female patient

For women, a menstrual history should be obtained; it is particularly relevant for a woman with abdominal pain, a suspected endocrine disease or genitourinary symptoms. Write down the date of the last menstrual period. Ask about the age at which menstruation began, whether the periods are regular or whether menopause has occurred. Ask whether the symptoms occur at a particular time in the menstrual cycle. Do not forget to ask a woman of childbearing age if there is a possibility of pregnancy; this, for example, may preclude the use of certain investigations or drugs.[15] Observing the well-known axiom that 'every woman of childbearing years is pregnant until proven otherwise' can prevent unnecessary danger to the unborn child and avoid embarrassment for the unwary clinician. Ask about any miscarriages. Record *gravida* (the number of pregnancies) and *para* (the number of births of babies over 20 weeks' gestation).

SOCIAL HISTORY

This is the time to find out more about the patient as a person. The questions should be asked in an interested and conversational way and should not sound like a routine learned by rote. For example, chronic pain can affect relationships, employment, income and leisure activities, and it is your job to understand these matters in order to provide the best possible care plan.

T&O'C ESSENTIALS

The social history includes the patient's economic, social, domestic and work situations.

Upbringing and education level

Ask first about the places of birth and residence, and the level of education obtained (including problems with schooling caused by childhood illnesses). This can influence the way things need to be explained to the patient. Recent migrants may have been exposed to infectious diseases like tuberculosis; ethnic background is important in some diseases, such as thalassaemia and sickle cell anaemia.

Marital or stable relationship status, social support and living conditions

Ask who is at home with the patient. Is this a stable relationship? Who else is living at home with the patient. Find out about the health of the spouse and any children. Check whether there are any other household members. If the patient is not able to look after him- or herself unaided, establish who the patient's main 'caregiver' is. 'Matter of fact' questions about sexual activity may be very relevant. For example, erectile dysfunction may have important effects on the patient's partner and on the relationship. It can be a result of vascular disease, diabetes mellitus, chronic kidney disease, medications or depression. Questions about living arrangements are particularly important for chronic or disabling illnesses, where it is necessary to know what social support is available and whether the patient is able to manage at home (e.g. the number of steps required to get into the house, or the location of the toilet).

Ask whether the patient considers him- or herself to be a spiritual person. Spirituality is an important factor, especially in the care of dying patients, in the creation of living wills and in understanding the support network available for the patient.

The presence of pets in the home may be important if infections or allergies are suspected.

Ask about mobility (e.g. if an adult patient is still driving and how he or she gets to the shops and appointments).

Diet and exercise

Ask about the adequacy of the patient's diet, who does the cooking, the availability of 'meals on wheels' and other services such as house cleaning. Also ask how physically active the patient is.

Occupation and hobbies

Ask the patient about present occupation;[16] the **WHACS** mnemonic is useful here:[17]

W hat do you do?
H ow do you do it?
A re you concerned about any of your exposures or experiences?
C olleagues or others exposed?
S atisfied with your job?

Finding out exactly what the patient does at work can be helpful, as some occupations (and hobbies) are linked to disease (see Text box 1.2). Note particularly any work exposure to dusts, chemicals or disease; for example, mine and industrial workers may have the disease asbestosis. Find out whether any similar problems have affected fellow workers. Checking on hobbies can also be informative (e.g. bird fanciers and lung disease, use of solvents).

Occupations and hobbies linked to disease

1. Farmers: mouldy hay—hypersensitivity pneumonitis
2. Bird fanciers: birds—hypersensitivity pneumonitis, psittacosis
3. Welders: eye flash burns, pacemaker malfunction
4. Stone masons: silicosis
5. Shipyard workers, builders, emergency workers: asbestosis
6. Coal miners: pneumoconiosis and silicosis
7. Timber workers: asthma
8. Electronic workers: berylliosis
9. Healthcare workers: needle-stick HIV, hepatitis B, TB

HIV=human immunodeficiency virus; TB=tuberculosis.

TEXT BOX 1.2

Overseas travel

If an infectious disease is a possibility, ask about recent overseas travel, destinations visited and how the patient lived when away (e.g. did he or she drink unbottled water and eat local foods, or dine at expensive international hotels?). Note any hospitalisations or procedures overseas. Travel overseas, if hospitalised, may be associated with acquiring antibiotic-resistant bacteria. Ask about the patient's immunisation status (see Ch 2). Determine whether any prophylactic drugs (e.g. for malaria) were taken during the travel period.

Smoking

The patient may claim to be a non-smoker if he or she stopped smoking that morning. Therefore, ask whether the patient has ever smoked and, if so, how many cigarettes (or cigars or pipes) were smoked a day and for how many years. Find out whether the patient has stopped smoking and, if so, when this was. It is necessary to ask how many packets of cigarettes per day the patient has smoked and for how many years the patient has smoked. An estimate should be made of the number of packet-years of smoking. Remember that this estimate is based on 20-cigarette packets[d] and that packets of cigarettes are getting larger; curiously, most manufacturers now make packets of 30 or 35. More recently, giant packets of 50 have appeared: these are too large to fit into a pocket and must be carried in the hands as a constant reminder to the patient of his or her addiction.

Cigarette smoking is a risk factor for vascular disease, chronic lung disease, several cancers and peptic ulceration, and may damage the fetus (see List 1.2). The more recent the exposure and the greater the number of packet-years, the greater the risk of these problems becomes. Cigar and pipe smokers typically inhale less smoke than cigarette smokers and overall mortality rates are correspondingly lower in this group, except from carcinoma of the oral cavity, larynx and oesophagus.

As a routine this may be a good time to give a gentle reminder about smoking cessation. Suggesting 'This might be a good time to think about becoming a non-smoker' avoids giving the impression that the

[d] 20 cigarettes a day for a year=1 packet-year.

SMOKING AND CLINICAL ASSOCIATIONS*

Cardiovascular disease

Premature coronary artery disease

Peripheral vascular disease, erectile dysfunction

Cerebrovascular disease

Respiratory disease

Lung cancer

Chronic obstructive pulmonary disease (chronic airflow limitation)

Increased incidence of respiratory infection

Increased incidence of postoperative respiratory complications

Other cancers

Larynx, oral cavity, oesophagus, nasopharynx, bladder, kidney, pancreas, stomach, uterine, cervix

Gastrointestinal disease

Peptic ulceration, Crohn's disease

Pregnancy

Increased risk of spontaneous abortion, fetal death, neonatal death, sudden infant death syndrome

Drug interactions

Induces hepatic microsomal enzyme systems, e.g. increased metabolism of propranolol, theophylline

*Individual risk is influenced by the duration, intensity and type of smoke exposure, as well as by genetic and other environmental factors. Passive smoking is also associated with respiratory disease

LIST 1.2

habit is condoned and the patient's thinking 'Smoking can't be a problem for me; the doctor hasn't suggested I stop.'

Alcohol use

Ask whether the patient drinks alcohol.[18] If so, ask what type, how much and how often. Excessive use of alcohol is common in the community; if the patient claims to be a social drinker, find out exactly what this means. Again a conversational approach may help keep the patient onside and seem less censorious—for example: 'Do you drink beer or wine or spirits?' and 'How many glasses of … would you have on most days?' In a glass of wine, a nip (or shot) of spirits, a glass of port or sherry or a 200 mL (7 oz) glass of beer there are approximately 8–10 g of alcohol (1 unit=8 g).

Guidelines for safe drinking levels vary around the world.[19] The National Health and Medical Research Council (NHMRC) in Australia recommends a maximum alcohol intake of no more than 2 standard drinks per day on average and no more than 4 standard drinks on a single day with 2 alcohol-free days per week for men and women.[20] In the United Kingdom, the current recommended safe limits are 21 units (168 g of ethanol) per week for men and 14 units (112 g of ethanol) for women; weekly consumption of more than 50 units for men and 35 units for women is considered to place the user in a high-risk group. In the United States, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) suggests that the following alcohol levels are harmful: for men under the age of 65, an average of more than 14 standard drinks per week (or more than 4 drinks on any day); and for women and all adults 65 years and older an average of more than 7 standard drinks per week. Alcohol becomes a major risk factor for liver disease in men who consume more than 80 g daily and women who consume more than 40 g daily for 5 years or longer.

Alcoholics are notoriously unreliable about describing their alcohol intake, so it may be important to suspend belief and sometimes (with the patient's permission) talk to relatives.

Certain questions can be helpful in making a diagnosis of alcoholism; these are referred to as the **CAGE** questions:[21]

- Have you ever felt you ought to ***C****ut* down on your drinking?
- Have people ***A****nnoyed* you by criticising your drinking?
- Have you ever felt bad or ***G****uilty* about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (***E****ye opener*)

If the patient answers 'yes' to any two of these questions, this suggests that he or she has a serious alcohol dependence problem (77% sensitivity, 79%

specificity), but the screening often misses unhealthy alcohol use.

A more useful screening test to identify unhealthy drinking comprises three simple questions (AUDIT-C):

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking alcohol?
3. How often do you have 6 or more alcoholic drinks on one occasion?

Each question is scored from 0 (never) to 4 (4 or more times per week). Positive scores for unhealthy (excess) drinking are:

- 3 or more for women (73% sensitivity, 91% specificity)
- 4 or more for men (86% sensitivity, 89% specificity).[22]

An even simpler screening question is to ask, 'How many times in the past year have you had 5 (for men; 4 for women) or more drinks in a day?' A score of *over* 0 (or 'I don't remember') suggests alcohol use in the unhealthy range. This question performs almost as well as the AUDIT-C screening.[23]

The complications of alcohol abuse are summarised in List 1.3.

Analgesics and street drugs

Over-the-counter analgesics can cause harm—for example, if an alcoholic has just a bit too much paracetamol it may lead to acute liver failure.

ALCOHOL (ETHANOL) ABUSE: COMPLICATIONS

Gastrointestinal system

- Acute gastric erosions
- Gastrointestinal bleeding from varices, erosions, Mallory–Weiss tear, peptic ulceration
- Pancreatitis (acute, recurrent or chronic)
- Diarrhoea (watery, due to alcohol itself, or steatorrhoea from chronic alcoholic pancreatitis or, rarely, liver disease)
- Hepatomegaly (fatty liver, chronic liver disease)
- Chronic liver disease (alcoholic hepatitis, cirrhosis) and associated complications
- Cancer (oesophagus, cardia of stomach, liver, pancreas)

Cardiovascular system

- Cardiomyopathy
- Cardiac arrhythmias
- Hypertension

Nervous system

- 'Blackouts'
- Nutrition-related conditions, e.g. Wernicke's encephalopathy, Korsakoff's psychosis, peripheral neuropathy (thiamine deficiency), pellagra (dementia, dermatitis and diarrhoea from niacin deficiency)
- Withdrawal syndromes, e.g. tremor, hallucinations, 'rum fits', delirium tremens
- Cerebellar degeneration
- Alcoholic dementia
- Alcoholic myopathy
- Autonomic neuropathy

Haematopoietic system

- Anaemia (dietary folate deficiency, iron deficiency from blood loss, direct toxic suppression of the bone marrow, rarely B_{12} deficiency with chronic pancreatitis, or sideroblastic anaemia)
- Thrombocytopenia (from bone marrow suppression or hypersplenism)

Genitourinary system

- Erectile dysfunction (impotence), testicular atrophy in men
- Amenorrhoea, infertility, spontaneous abortion, fetal alcohol syndrome in women

Other effects

- Increased risk of fractures and osteonecrosis of the femoral head

LIST 1.3

Ask whether the patient has ever used marijuana, has tried other street drugs or has ever shot up. An excellent screening question that is 100% sensitive (and 74% specific) is to ask, 'How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?'[24] Asking about 'recreational' or street drug use, if not already known, is important.

Mood

Depression severe enough to cause distress to a patient is common: it has a prevalence of up to 8%.[25] Depression can be the result of any significant medical illness; in fact, the incidence of depression increases threefold for these patients. Patients with underlying depression may find illness more difficult to cope with. Questioning patients about depression can be difficult. A common approach is to ask first, 'How are things going at home and at work at the moment?' Questions about depressed mood (see p 25, Questions box 2.2) and *anhedonia* (loss of interest or pleasure in activities previously enjoyed) can be helpful. Major depression is unlikely if the answer to these questions is 'no'.

Certain medical conditions such as hypothyroidism or Cushing disease can be direct causes of depression.

If depression seems likely, questions about suicide risk should be asked. There is no evidence that asking such questions increases the risk of suicide (see Ch 46, Volume 2).[26]

Sexual history

The sexual history may be relevant; if so, specific questions should be asked. Good judgement is necessary about the right time to ask very personal questions (see p 27).

FAMILY HISTORY

Many diseases run in families. For example, ischaemic heart disease that has developed at a young age in parents or siblings is a major risk factor for ischaemic heart disease in their offspring. Various malignancies, such as breast and large-bowel carcinoma, are more common in certain families. Both genetic and common environmental exposures may explain these familial associations. Some diseases (e.g. haemophilia) are directly inherited.[27] Patient reporting of a family history of malignancy is not always accurate. However, two important cancers—bowel and breast—are accurately reported by patients.

FACTORS SUGGESTING AN INCREASED RISK TO A PATIENT BECAUSE OF GENETIC FACTORS

- Family history of numerous relatives affected by the disorder, e.g. three family members with bowel cancer
- Disease occurring in less-often-affected sex, e.g. thyroid disease in male relatives
- Earlier onset of disease than usual in relatives, e.g. premature coronary artery disease
- Disease occurring despite absence in patient of the usual risk factors, e.g. hyperlipidaemia despite normal weight and excellent diet
- Racial predisposition to a disease, e.g. haemochromatosis in people of Irish descent
- Consanguinity of parents, e.g. cystic fibrosis

LIST 1.4

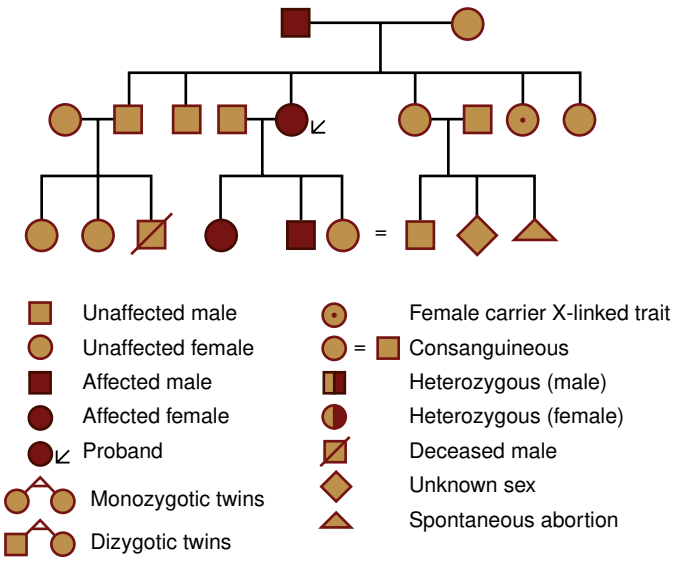
Ask about any history of a similar illness in the family. Certain factors suggest an increased genetic risk (List 1.4).

Enquire about the health and, if relevant, the causes of death and ages of death of the parents and siblings. If there is any suggestion of a hereditary disease, a complete family tree should be compiled showing all members affected (see Fig. 1.3). Patients can be reluctant to mention that they have relatives with mental illness, epilepsy or cancer, so ask tactfully about these diseases. Consanguinity (usually first cousins marrying) increases the probability of autosomal recessive abnormalities in the children; ask about this if the pedigree is suggestive.

SYSTEMS REVIEW

As well as detailed questioning about the system likely to be diseased, it is essential to ask about important symptoms and disorders in other systems (see Questions box 1.1), as otherwise important diseases may be missed.[28,29] An experienced clinician will perform a targeted systems review, based on information already obtained from the patient; clearly it is not realistic to ask anyone all of the listed questions.

When recording the systems review, list important negative answers ('relevant negatives'). Remember: if



Preparing a family tree: note the symbols used for the documentation

FIGURE 1.3

other recent symptoms are unmasked, more details must be sought; relevant information is then added to the history of the presenting illness.

Before completing the history, it is often valuable to ask what the patient thinks is wrong and what he or she is most concerned about. General and sympathetic questions about the effect of a chronic or severe illness on the patient's life are important for establishing rapport and for finding out what else might be needed (both medical and non-medical) to help the patient.

Major presenting symptoms for each system are described in the following chapters. Examples of supplementary important questions to ask about past history, social history and family history are also given there for each system.

SKILLS IN HISTORY TAKING

T&O'C ESSENTIALS

1. *Several skills are important in obtaining a useful and accurate history.*
   a. *Establish rapport and understanding.*
   b. *Ask questions in a logical sequence. Start with open-ended questions. Listen to the answers and adjust your interview accordingly.*
   c. *Observe and provide non-verbal clues carefully. Encouraging, sympathetic gestures and concentration on the patient that make it clear he or she has your undivided attention are most important and helpful, but are really a form of normal politeness.*
   d. *Proper interpretation of the history is crucial.*
2. *A good grounding in history taking will stand you in good stead for the rest of your career in medicine.*
3. *A successful consultation with a patient, based on a good history-taking manner, is satisfying and even enjoyable for both parties.*
4. *Repeated practice in history taking makes it an accurate and quite rapid process (usually).*
5. *Not taking a proper history (a regrettably common event) can lead to an incorrect differential diagnosis, the wrong tests and often the wrong treatment.*
6. *No test is accurate enough (sensitive and specific enough) to be useful if it is ordered for the wrong reason (e.g. as a result of poor history taking).*
7. *Screen for alcohol and drug use using standard questions.*

Your aim should be to obtain information that will help establish the likely anatomical and physiological disturbances present, the aetiology of the presenting symptoms and the impact of the symptoms on the patient's ability to function.[30] (In Ch 2, some advice on how to take the history in more challenging circumstances is considered.) This type of information will help you plan the diagnostic investigations and treatment, and to discuss the findings with, or present them to, a colleague if necessary. First, however, a comprehensive and systematic physical examination is required.

These skills can be obtained and maintained only by practice.[31]

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CHAPTER 2

Taking the history: advanced history taking

First the doctor told me the good news: I was going to have a disease named after me.[a] STEVE MARTIN

I remind my fellows, residents and medical students that what we do is a privilege. People let us into the most intimate aspects of their lives, and they look to us to help guide them through very complex and delicate situations. SHIKHA JAIN, MD

Most complaints about doctors relate to the failure of adequate communication.[1,2] Encouraging patients to discuss their major concerns without interruption enhances satisfaction and yet takes little time (on average only 90 seconds).[3,4] Giving premature advice or reassurance, or inappropriate use of closed questions, badly affects the interview.

Giving a patient the impression that you disapprove of some aspect of his or her life can put up a major barrier to the success of the interview. Avoid what might be seen as a judgemental attitude to anything you hear. This should not prevent you from giving sensible advice about activities that are dangerous to the patient's health. Expressing sympathy about the patient's problems (medical or otherwise) should be a normal human reaction on the part of the clinician.

TAKING A GOOD HISTORY

Communication and history-taking skills can be learned but require constant practice. Watch for signs that the patient is uncomfortable. For example, the sudden breaking off of eye contact or the crossing of arms or legs: this body language suggests that the patient is not comfortable with the questioning and you need to redirect or change tack.[5] Factors that improve communication include using appropriate open-ended questions, giving frequent summaries, and using clarification and negotiation.[3,4,6] (See List 2.1.)

[a] This does not happen often but **Christmas disease** is an example of a disease named after the patient rather than the clinician.

THE DIFFERENTIAL DIAGNOSIS

As the interview proceeds, you will need to begin to consider the possible diagnosis or diagnoses—the **differential diagnosis**. This usually starts as a long and ill-defined mental list in your mind. As more detail of the symptoms emerges, the list becomes more defined. This mental list must be used as a guide to further questioning in the latter part of the interview. Specific questions should then be used to help confirm or eliminate various possibilities. The physical examination and investigations may then be directed to help further narrow the differential. At the end of the history and examination, a likely diagnosis and list of differential diagnoses should be drawn up. This will often be modified as results of tests emerge.

This method of history taking is called, rather grandly, the *hyopthetico-deductive approach*. It is in fact used by most experienced clinicians. History taking does not mean asking a series of set questions of every patient, but rather knowing what questions to ask as the differential diagnosis begins to become clearer.

FUNDAMENTAL CONSIDERATIONS WHEN TAKING THE HISTORY

As the medical interview proceeds, keep in mind four underlying principles:

1. *What is the probable diagnosis so far?* This is a basic differential diagnosis. As you complete the

TAKING A BETTER HISTORY

- Ask open questions to start with (and resist the urge to interrupt), but finish with specific questions to narrow the differential diagnosis.
- Do not hurry (or at least do not appear to be in a hurry, even if you have only limited time).
- Ask the patient 'What else?' after he or she has finished speaking, to ensure that all problems have been identified. Repeat the 'What else?' question as often as required.
- Maintain comfortable eye contact and an open posture. Do not cross your legs, and do not lean backwards.
- Use the head nod appropriately, and use silences to encourage the patient to express him- or herself.
- When there are breaks in the narrative, provide a summary for the patient by briefly restating the facts or feelings identified, to maximise accuracy and demonstrate active listening.
- Clarify the list of chief or presenting complaints with the patient, rather than assuming that you know them.
- If you are confused about the chronology of events or other issues, admit it and ask the patient to clarify.
- Make sure the patient's story is internally consistent and, if not, ask more questions to verify the facts.
- If emotions are uncovered, name the patient's emotion and indicate that you understand (e.g. 'You seem sad'). Show respect and express your support (e.g. 'It's understandable that you would feel upset').
- Ask about any other concerns the patient may have, and address specific fears.
- Express your support and willingness to cooperate with the patient to help solve the problems together.

LIST 2.1

history of the presenting illness, ask yourself: 'For *this* patient based on *these* symptoms and what I know so far, what are the most likely diagnoses?' Think about the anatomical location, then the likely pathology or pathophysiology, then the possible causes, then direct additional questions accordingly.

2. *Could any of these symptoms represent an urgent or dangerous diagnosis—**red-flag** (alarm) symptoms?* Such diagnoses may have to be considered and acted upon even though they are not the most likely diagnosis for this patient. For example, the sudden occurrence of breathlessness in an asthmatic who has had surgery this week is more likely to be due to a worsening of asthma than to a pulmonary embolism, but an embolism must be considered because of its urgent seriousness. Ask yourself: 'What diagnoses must not be missed?'
3. *Could these symptoms be due to one of the mimicking diseases that can present with a great variety of symptoms in different parts of the body?* Tuberculosis used to be the great example of this, but HIV infection, syphilis, sarcoidosis and vasculitis are also important disease 'mimickers'. Anxiety and depression commonly present with many bodily (somatic) symptoms.
4. *Is the patient trying to tell me about something more than these symptoms alone?* Apparently trivial symptoms may be worrying to the patient because of an underlying anxiety about something else. Asking 'What is it that has made you concerned about these problems now?' or 'Is there anything else you want to talk about?' may help clarify this aspect. Ask the patient 'What else?' as natural breaks occur in the conversation.

PERSONAL HISTORY TAKING

Certain aspects of history taking go beyond routine questioning about symptoms. This part of the art needs to be learned by taking a lot of histories; practice is absolutely essential. With time you will gain confidence in dealing with patients whose medical, psychiatric or cultural situations make standard questioning difficult or impossible.[7,8]

Most illnesses are upsetting and can induce feelings of anxiety or depression. On the other hand, patients with primary psychiatric illnesses often present with physical rather than psychological symptoms. This brain–body interaction is bidirectional, and this must be understood as you obtain the story.

Discussion of *sensitive matters* may actually be therapeutic in some cases. *Sympathetic confrontation* can be helpful in some situations. For example, if the patient appears sad, angry or frightened, referring to

Emotion-handling skills—NURS

Name the emotion

Show **U**nderstanding

Deal with the issue with great **R**espect

Show **S**upport (e.g. 'It makes sense you were angry after your husband left you. This must have been very difficult to deal with. Can I be of any help to you now?')

TEXT BOX 2.1

this in a tactful way may lead to the patient volunteering appropriate information.

If you obtain an emotional response, use **emotion-handling skills** (**NURS**) to deal with this during the interview (see Text box 2.1).

The patient may be reluctant or initially unable to discuss sensitive problems with a stranger. Here, gaining the patient's confidence is critical. Although this type of history taking can be difficult, it can also be the most satisfying of all interviews, since interviewing can be directly therapeutic for the patient.

It is important for the history taker to maintain an objective demeanour, particularly when asking about delicate subjects such as sexual problems, grief reactions or abuse. It is not the clinician's role to appear to judge patients or their lives.

Any medical illness may affect the psychological status of a patient. Moreover, pre-existing psychological factors may influence the way a medical problem presents. Psychiatric disease can also present with medical symptoms. Therefore, an essential part of the history-taking process is to obtain information about psychological distress and the patient's mental state. A sympathetic, unhurried approach using open-ended questions will provide much information that can then be systematically recorded after the interview. If depression is a concern, it is safe to ask about suicidal ideation.[9]

The formal psychological or psychiatric interview differs from general medical history taking. It takes considerable time for patients to develop rapport with, and confidence in, the interviewer. There are certain standard questions that may give valuable insights into the patient's state of mind (see Questions boxes 2.1–2.3). It may be important to obtain much more detailed information about each of these problems, depending on the clinical circumstances (see Ch 46).

PERSONAL QUESTIONS TO CONSIDER ASKING A PATIENT

1. Where do you live (e.g. a house, flat or hostel)?
2. What work do you do now, and what have you done in the past?
3. Do you get on well with people at home?
4. Do you get on well with people at work?
5. Do you have any money problems?
6. Are you married, or have a partner, or have you been married?
7. Could you tell me about your close relationships?
8. Would you describe your marriage (or living arrangements) as happy?
9. Has your partner ever hurt you?
10. Have you been hit, kicked or physically hurt by someone (physical abuse)?
11. Have you been forced to have sex (sexual abuse)?
12. Would you say you have a large number of friends?
13. Are you religious?
14. Do you feel you are too fat or too thin?
15. Has anyone in the family had problems with psychiatric illness?
16. Have you ever had a nervous breakdown?
17. Have you ever had any psychiatric problem?

QUESTIONS BOX 2.1

Common general symptoms

Fatigue

Up to 30% of people will report that they are often or always tired. Many patients will volunteer this information. Fatigue needs to be distinguished from sleepiness, muscle weakness and dyspnoea. Questions about the numerous possible causes uncover the underlying problem (List 2.2).

QUESTIONS TO ASK THE PATIENT WHO MAY HAVE DEPRESSION

1. Have you been feeling sad, down or blue?
2. Have you felt depressed or lost interest in things daily for two or more weeks in the past?
3. Have you ever felt like taking your own life? (Risk of self-harm)
4. Do you find you wake very early in the morning?
5. Has your appetite been poor recently?
6. Have you lost weight recently?
7. How do you feel about the future?
8. Have you had trouble concentrating on things?
9. Have you had guilty thoughts?
10. Have you lost interest in things you usually enjoy?

QUESTIONS BOX 2.2

QUESTIONS TO ASK THE PATIENT WHO MAY HAVE ANXIETY

1. Do you worry excessively about things?
2. Do you have trouble relaxing?
3. Do you have problems getting to sleep at night?
4. Do you feel uncomfortable in crowded places?
5. Do you worry excessively about minor things?
6. Do you feel suddenly frightened, or anxious or panicky, for no reason in situations in which most people would not be afraid?
7. Do you find you have to do things repetitively, such as washing your hands multiple times?
8. Do you have any rituals (such as checking things) that you feel you have to do, even though you know it may be silly?
9. Do you have recurrent thoughts that you have trouble controlling?

QUESTIONS BOX 2.3

Chronic fatigue

Chronic fatigue syndrome is in the process of being renamed *systemic exertion intolerance disease* (SEID).[b]

By definition these patients:[10]

1. have an inability to carry out normal activities because of severe fatigue that does not improve with rest
2. feel worse after any exertion (physical, cognitive or emotional)
3. find sleep unrefreshing
4. have symptoms that have lasted more than 6 months
5. have symptoms that worsen when they stand up (orthostatic intolerance)
6. often have associated symptoms such as pain syndromes, slow recovery from infections, sore throat, tender lymph nodes and food sensitivities
7. commonly have associated conditions including irritable bowel syndrome and fibromyalgia.

[b] New names do not always catch on.

Insomnia

The inability to fall asleep or stay asleep for long enough to feel refreshed is common especially as people age—up to 30% of older adults are affected.[11]

Ask about:

1. the patient's current sleep pattern—regular or irregular bedtime
2. distractions—using computer or telephone in bed
3. alcohol, caffeine use before bed
4. large meal late at night
5. recent emotional upsets
6. Does the need to use the bathroom cause you to wake during the night? How often does that happen?
7. use of sedatives
8. shift work
9. daytime sleepiness—especially when driving or at work
10. symptoms suggesting sleep apnoea
11. arthritis causing pain at night

CAUSES OF FATIGUE

Way of living

- Not enough sleep
- Too much alcohol
- Too much activity
- Drug use e.g. alcohol

Psychological

- Anxiety
- Worries
- Depression

Medical

- Thyroid disease
- Heart failure
- Obesity
- Obstructive sleep apnoea
- Uncontrolled diabetes mellitus
- Coeliac disease
- Malignancy
- Hypoxia (e.g. chronic lung disease)
- Anaemia
- HIV infection
- Medications (e.g. beta-blockers, antidepressants, benzodiazepines)

LIST 2.2

12. restless legs
13. history of depression or main problem of early morning waking.

Medically unexplained symptoms (MUS)

It is quite common for patients to present with symptoms that cannot be explained. These people have often had years of distressing problems that have led to numerous investigations and visits to doctors.[12] Common symptoms of this sort include:

1. chest pain
2. fatigue
3. dizziness
4. abdominal pain
5. paraesthesiae and numbness
6. headache
7. back pain
8. dyspnoea.

SOMATIC SYMPTOM DISORDER AND ILLNESS ANXIETY DISORDER

Somatic symptom disorder

1. At least one somatic symptom, present for over 6 months and interfering with normal life. The nature of the disorder may change within this time
2. Excessive thoughts, behaviours and feelings related to the symptoms
3. Disproportionate concern about seriousness of symptoms
4. Persistent anxiety about health
5. Excessive time and energy spent on health worries

Illness anxiety disorder

1. Preoccupation about having or acquiring an illness
2. Somatic symptoms are absent or mild

LIST 2.3

Some of these patients meet the criteria for the diagnosis of *somatic symptom disorder* or *illness anxiety disorder* (List 2.3). These terms are replacing the previous terms: hypochondriasis, conversion disorder or functional disorder. This is because, although psychological problems can play a part in the development of these symptoms, psychological distress alone is not the cause of the problem.

Patients with MUS are more often women, have less education and have reported lower quality of life. A systematic approach to patients with suspected MUS can help both the patient and clinician with this frustrating problem (Questions box 2.4).

Patients with these chronic and often disabling symptoms need sympathetic medical help, but in many cases the patient's desire to have more investigations should be resisted and management moved towards reducing the symptoms with regular review of the patient as required.

Non-specific dizziness

Dizziness can be the result of a number of neurological, cardiac and ear abnormalities. These are described in the appropriate sections of the book. Sometimes, however, no specific cause can be found. These patients often describe light-headedness, a feeling of swimming or floating, being 'spaced out' or having a heavy head.

QUESTIONS TO ASK THE PATIENT WITH POSSIBLE MUS

1. What are your main problems (symptoms) at the moment?
2. How long have they been going on? What seems to make them better or worse? (Exacerbating and relieving factors, etc.)
3. How badly do the symptoms affect you? What happens on a typical day?
4. What is your main worry about this symptom?
5. What made you come in today in particular?
6. Was there something you thought I could do in particular to help?
7. Consider asking about depression and mood.
8. What tests and treatment have you had for these symptoms in the past?

QUESTIONS BOX 2.4

When the sensation has been present for most days during a period of 3 months or more and the symptoms cannot be explained by an identifiable abnormality, a diagnosis of *chronic subjective dizziness (CSD)* might be considered (List 2.4). Conditions of this sort are not diagnoses of exclusion but should be diagnosed on the basis of their distinctive symptoms and signs.

FEATURES OF CHRONIC SUBJECTIVE DIZZINESS

1. Symptoms of dizziness or light-headedness for more than 3 months
2. No other diagnosis to explain the symptoms
3. Severity varies but worse when standing or walking and better when patient lies down
4. Worse with motion or moving environment e.g. in train or car
5. Worse when light is dim
6. Often associated with depression, anxiety, obsessive–compulsive traits

LIST 2.4

Sexual history

It is important to obtain information about gender identity as a part of the routine history (see Questions box 2.5). These questions may not be asked at the first visit until the patient has had time to develop confidence and trust. The patient's permission should be sought before questions of this sort are asked, but it is important to *normalise* these questions. This request should include some explanation as to why the questions are necessary.[13] It may be useful to say 'I need to ask you some quite personal questions which are important for your health.'

QUESTIONS TO ASK ABOUT SEXUAL HISTORY

Sexual history should address sexual behaviour, sexual orientation identity and gender identity. You could ask:

1. Do you have a partner? OR Are you in a relationship?
2. Have you had female partners, male partners or both? *OR* When you have had sex, what are the genders of your partners? *OR* Do you have sex with men, women or both?
3. Do you have any concerns or questions about your sexuality, sexual orientation or sexual health?
4. Do you identify as transgender or have gender-related concerns?
5. Many people are affected by gender issues; do you have any concerns about this? If this topic is not relevant to you, tell me and I will move on.

Questions obtained from: Ufomata E, Eckstrand KL, Spagnoletti C, et al. Comprehensive curriculum for internal medicine residents on primary care of patients identifying as lesbian, gay, bisexual, or transgender. *MedEdPORTAL* 2020;16:10875.

QUESTIONS BOX 2.5