Office procedures - Review and Practice Tips

Introduction

The technique of history taking, combined with the art and skill involved in the physical examination, still remains the basis of diagnosis, despite continuing advances in medical technology.

The diagnostic process requires correlation and interpretation of the patient's history, symptoms and signs. The skill arises in placing all these factors in proper perspective.

After arriving at a provisional clinical diagnosis, a decision is then made regarding the need for further investigation or for surgical intervention.

Many factors must be taken into account before deciding to operate. The most important of these is to have arrived at a clinical diagnosis.

This is becoming increasingly important in terms of medical economics, hospital priorities, patient convenience and safety.

The following issues, form the basis of all surgery:

1. Clinical diagnosis
2. Method of anaesthesia, analgesia and pain control; and
3. Surgical technique and post-operative care.

These principles can be applied not only to skin surgery but also to:
· Hernias
· Scrotal and testicular conditions
· Ano-rectal region and pilonidal sinus
· A diverse group including lipomata, ganglia, bursae, lymph nodes, ingrown toenails and varicose veins.

Surgery should only be undertaken by those who have had appropriate training and whose skills have beend eveloped under the supervision of acknowledged teachers and experts in each field, as well as by practice under supervision.

Any surgical condition requires a thorough preoperative and postoperative assessment in addition to evaluation of progress during the operation.

The reasons for the decision to operate, the result expected by the patient, the family and by the treating doctors, depend on thorough assessment and detailed explanation.

A method is presented which in most cases allows for such evaluation. It involves:

1. The history of the presenting problem;
2. A general history of the patient;
3. An analysis of factors which may affect the problem; and
4. The clinical examination.

History

For every clinical case involving the presence of an abnormal lump, tumour or mass, a thorough history is taken.

What questions should be asked?

Think about what questions you would ask prior to proceeding.

There are particular questions that should be asked.

The Lesion -Why has the patient attended?

· How did the lesion occur?
· When did it happen or when was it first noticed?
· What were the associated circumstances?
· What changes have occurred, for example, in size, shape, colour, discharge and when did the changes occur?
· Has there been any pain or discomfort?
· What are the features of the discomfort or pain?
· Has there been any change in the quality or the intensity of the pain or discomfort? When did this happen?
· Has there been any associated features such as fever, loss of weight, swelling, lymph gland enlargement or jaundice?

Present situation - What is happening now?

When, where, how and why did the condition develop?
What are the associated features of other symptoms, which can aid in diagnosis of the lesion?
Are there any family or other contacts who have a similar problem?

General Assessment

Are there any factors which may affect (positively or negatively) the presenting complaint, its treatment or the patient's recovery?

What are the present effect(s) of past activities?
Are there any factors in the past or present social, economic, educational, religious, occupational, family

history, or involvement with sporting clubs or other social networks or people in the patient's life, which may affect (positively or negatively) the cause, treatment or outcome of the presenting problem?

What are present effects of present lifestyle?

What predictions are present which will influence future management and health of the patient?

Are there any factors in the past medical (including surgical and anaesthetic) history, socio-economic or belief systems of the patient which may influence the intended therapy? Is the intended treatment the most appropriate in the circumstances?

The Ethical Issues - What does the patient want, understand and expect?

Is the intended treatment necessary and affordable by the patient or patient's family; is it best performed by the attending doctor at this or a later time?

What is the best and the most appropriate surgical procedure and method of anaesthesia for this patient at this time by this surgeon, in these circumstances?

What can be done?
What should be done?
Who should do it?
Where should it be done?
Who else is present, if anyone?
Can or should treatment be delayed or deferred?

Will the optimal result be achieved (immediately or later) by not doing anything, or by undertaking a definitive procedure?

Written or verbal consent must be given by the patient to the doctor, before any procedure is performed.

The Clinical Examination

What steps should be taken?

This is performed in 4 practical steps:

1. Direct Diagnostic Approach
The examination of the lump or lesion. There should be adequate exposure of the part, and adequate illumination.

2. Extended Direct Examination
For example, examine the rest of the affected limb and compare it with the opposite side.

3. Regional or Systemic Examination
When a lesion is likely to be associated with other relevant findings elsewhere, for example, a malignant melanoma may be associated with enlargement of the liver, or the lymph nodes, regional or elsewhere.

4. Full Generation Examination
To ascertain fitness for the intended anaesthesia, and operation, the extent of disease or co-existent diseases, to help in planning rehabilitation of the part or the whole patient.

Thus it can be seen that when any lump, tumour or mass is discovered, or any illness, a comprehensive approach will lead, not only to the correct diagnosis, but also determine the appropriate decisions regarding management with the best prospects for a successful outcome.

Key Concepts and Practice Tips

Do not consider a lump in isolation from the rest of the body.

Consider the implications of questions and diagnostic decisions for each patient.

Inspect before palpating.

While inspecting, think of active tests which may be appropriate for certain locations (e.g. swallowing for neck lumps and coughing for groin swellings).

Palpate gently in a definite sequence used every time. Do not prod.

If a patient says the lesion is painful, proceed gently while simultaneously watching the patient's facial expression. Locate the lump in terms of its relationship to anatomical landmarks and regions.

Determine the anatomical tissue plane in which the lesion lies.

Test mobility both with and without underlying muscular resistance.

Systematically examine each of the relevant physical characteristics.

Interpret the clinical findings in terms of the pathological process and the most likely diagnosis in relationship to any given site.

Examine for possible causes and effects.

Examine for factors which may affect clinical management.

Do not forget to examine the regional lymph nodes.

If lymph nodes are enlarged, assess whether it is a consequence of the presenting lesion or a consequence of an undetected lesion or a primary lymphoid problem.

Remember to examine the opposite side of the body, for comparison.

A provisional diagnosis should be made.

Histological examination of a biopsy may be required to ensure accurate diagnosis.

Reference

Office procedures. M. Brygel, *medi+WORLD International*