WRITING AND DEFENSE MEDICAL HISTORY

Academic discipline «Pediatric Propedeutics»

Teacher's guide for the 3rd year

English medium students

НАПИСАННЯ ТА ЗАХИСТ ІСТОРІЇ ХВОРОБИ

З дисципліни «Пропедевтика педіатрії»

Методичні розробки для викладачів
до аудиторноїної роботи студентів 3-го курсу
медичного факультету

МІНІСТЕРСТВО ОХОРОНИ ЗДОРОВ'Я УКРАЇНИ
Харківський національний медичний університет

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Amount of educational hours: practical training – 4.

Specific goals:

- to collect and to analyze the data of objective examination of the child.
- to differentiated clinical syndromes.
- to establish syndromatic diagnosis.
- to prescribe and to interpret the results of laboratory and instrumental methods.

Materials needed for methodological support:

1. Scheme of the case history for students.

The technological card of the lesson

№	Stage of the lesson	Study time (min)	Tutorials		Place of the lesson
			Learning tools	Equipment	
1.	Solution for the training tasks of the topic	90	Independent work of a student under the guidance of a teacher - training of practical skills.	Premises and equipment of the hospital	Departments of the hospital
3.	Break	10			
4.	Solution for the training tasks of the topic	60	Independent work of a student under the guidance of a teacher - training of practical skills	Premises and equipment of the hospital	Departments of the hospital
	Break	10			
10.	Summation of the lesson. Assignment to the next lesson.	30	Quiz, discussion		Classroom

Scheme of the case history for students.

Passport part

1. Patient’s name, patronymic, surname.

Имя пациента, отчество, фамилия

2. Patient's age in years, months. Date of birth. Age in months and days of infants.

Возраст пациента в годах, месяцах. Дата рождения. Возраст в месяцах, днях для детей первого года жизни.

3. Sex (male, female).

Пол (мужской, женский)

4. Information about parents, name, patronymic, surname of parents, occupation, place of employment.

Информация о родителях, имя родителей, фамилия, профессия, место работы родителей.

5. Patient's address: province, district, town, village, street, house, flat number, telephone number.

Адрес пациента, город, район, улица, номер дома, номер квартиры, номер телефона.

6. Information about child education. Does the child live in family or in children establishment, orphanage, boarding school. Does the child visit the children collective, kinder garden, school? Address, telephone number of this establishment.

Где воспитывается ребенок: в семье, в детском учреждении. Посещает ли ребенок детский коллектив, детский сад, школу. Адрес, телефон детского учреждения.

7. Information about organization, which sent the patient to the hospital.

Учреждение, которое направило ребенка в больницу.

8. Date of admission to the hospital.

Дата поступления в больницу.

9. Date of discharging from the hospital.

Дат выписки из больницы.

10. The diagnosis of doctor who sent the patient to the hospital.

Диагноз врача, который направил ребенка в больницу.

Anamnesis of the disease

(according mother's information)

Анамнез болезни

(Согласно информации матери)

1.Complains at the moment of examination. If the child stays in the hospital during long time, complains at the time of admission should be indicate.

1.Жалобы на момент обследования. Если пребывание ребенка в больнице в течение долгого времени, указать жалобы на момент поступления.

2. Development of the disease is expounded in chronological order since the moment of the onset of the disease to the moment of examination, the reason of disease, exso - and endogenic, information about medical care, dynamic of symptoms, results of paraclinical investigation, treatment, its effectiveness, side effects of antibiotics and chemical preparations.

2.Развитие болезни в хронологическом порядке, начиная с момента начала болезни к моменту осмотра, причина болезни, экзо - или эндогенный фактор, медицинское обслуживание, динамика симптомов, результаты

параклинических исследований, лечение, его эффективность, побочные эффекты антибиотиков и других препаратов.

Anamnesis of vitae

Анамнез vitae (жизни)

1. The child is first, second, third and so on in the family.
2. The child was born from I, II, ... pregnancy, I, II, ... delivery.
3. Obstetric anamnesis. Mother health during pregnancy. Life, job, nutrition condition during pregnancy. Peculiarity of pregnancy, gestosis.
4. Peculiarity of previous pregnancies, abortions, its reasons, the term of pregnancy when abortion has happened. Information about stillborn, child death in the family, reason of child death.
5. Peculiarity of the delivery, complications, medical assistance.
6. Newborn condition. Physical development, weight, length, head, chest circumferences at birth.
7. Peculiarity of newborn period, physiological loose of weight, the term of the separation of the umbilical cord and healing of umbilical wound, diseases of newborn. The term of newborn discharging from maternity house. Home-nursing.

8.Feeding of a newborn. When a newborn had a first breast feeding, had a newborn any difficulties during first breast feeding? Feeding of an infant at first year of life (breast feeding, mixed feeding, artificial feeding). Type of formula feeding used. The term of introduction of solid food, the ceasing of breast feeding. Feeding of the child at moment of admission to the hospital.

9.Characteristic of physiological development of the child. Weight, height, head, chest circumference dynamics, its data at admission. To mark the time when the child start to keep the head up, to sit, to stand, to walk, the time of cutting child first teeth, teeth formula at admission.

10.Psychological child development. To mark when the child start to fix the subjects by eyes, to smile, to pronounce first words, to speak. Child's behaviour in the family, in children collective, in school, progress in the school.

11.Infection and somatic diseases in past, information has to be done in chronological order. It is necessary to mark the character of the disease, peculiarity of the clinical characteristic, to pay attention to diseases of the allergical cause, to the nutritience and medicine intolerance.

12. Information about the tuberculin sensitivity, Mantu test result, date of performance.

13. Information about contacts with infection patients during last 3 weeks before admission, with tuberculous patient and other infections (occasional, family, flat contact).

14. Information about prophylactic vaccination, reactions on vaccination.

15. Family material values and living condition. The child's hygienic regime, who takes child's care, the term of being on the fresh air, sleep condition, bathing.

16. Parents age, health condition of the parents and other members of family, including children, there age, health condition.

16. Возраст родителей, состояние здоровья родителей и других членов семьи, включая других детей, их возраст, состояние здоровья.

IV. Status praesens at date of curation.

1.General condition and neural system characteristic.

General state of the patient is satisfactory, moderate severity, grave, extremely grave. Patient's position is active, forced patient's attitude position, passive patient's position. State of consciousness. Mental state, estimate of intelligence, memory. speech, sleeping. Estimate reaction to parents, physician, nature of cry and face's expression. State of skull brain innervation, skin and deep tender reflexes, vegetative innervation according the result of dermography investigation. Abnormalities of gait, posture, coordination. Assess the developmental reflexes in newborn – Moro reflex, tonic neck reflex, stepping reflex, Babinsky reflex, planter reflex, palmar grasp, traction response, rooting reflex, suck reflex, swallow and gag reflex (reflex is normal, decreased, absent).

2. Physical development and its assessment.

Weight, length, head and chest circumference of patient. The result of investigation the must be compared with age standards. Assessment of physical development as normal, state the degree and character of deviation from standard.

3. Skin and mucous membranes characteristic, color (cyanosis, jaundice, pallor, erythema), textura, hydratation, turgor and elasticity. Edema, hemorrhagic manifestations, scars, rash, dilated vessels, hemangiomas, nevi, Mongolian (blue-black), coffee-like spots, pigmentation, striae and wrinkling. Character nails and hair distribution, colour of visible mucous membranes.

4. Subcutaneous tissue characteristic, degree and character of development. Thickness of subcutaneous fat fold, turgor, edema and subcutis formation, it`s location and sizes.

5. Lymphatic system characteristic. Palpation groups of lymphatic nodes, there quantity, shape and size, conjunctiion of each with other, with near-by tissues. One should routinely attempt to palpate suboccipital, preauricular, anterior cervical, posterior cervical, submaxillary, sub-linqual, axillary, epitrochlear and inguinal lymph nodes.

6. Muscle system characteristic, development degree, tone, strength. Static and motion development.

7. Bone system characteristic, head size, shape, asymmetry, cephalohematoma, craniotabes, fontaneles (size, tension, number , abnormally late or early close). Sutures, dilated scalp veins. Rachitic and other skeleton deformation (kyphosis, lordosis, scoliosis, X- and O-shape deformation of legs). Joints, there configuration, active and passive movements.

8. State of sensitive organs, vision, hearing, skin sensibility, olphactory, taste characteristic.

9. Respiratory system characteristic. State type of respiration (thoracic, abdominal, mixed). Appreciate respiration rhythm (rhythmic respiration, arrhythmic respiration, Chene-Stoke`s respiration, Biot`s respiration, Kussmaul`s respiration). Respiratory rate, type of dyspnea (inspiratiry, expiratory, mixed dyspnea), participation of additional muscle in respiration. Appreciate the shape and symmetry of thorax, veins, retractions and pulsations, Harrison`s groove, flaring of ribs, pigeon chest, funnel shape of sternum. Voice, cry, cough, sputum.

Palpation of the chest. Elasticity of the chest (the chest is elastic, elasticity of chest is decreased, the chest is rigid). Pain in the chest wall ("surface" pain) (the chest is painless, pain of the chest wall is determined, to indicate location). Vocal fremitus (vocal fremitus of the middle strength, the same on the symmetrical parts, vocal fremitus is decreased, increased on the one half of the chest, local changes of vocal fremitus (decreased or increased), to indicate location.

Percussion of lungs. Comparative percussion of the lungs (clear pulmonary sound, dulled pulmonary sound – to indicate location; tympanic sound – on all parts of the chest, on one part of it, local – to indicate location; bandbox sound; cracket-pot sound - to indicate location; metalic sound - to indicate location; dull with tympanic tone - to indicate location).

Topographic percussion. Appreciate the lower border of the lungs (the lower borders of the lungs is displaced downward or upward on the one or on the both sides, the lower border of the lungs is in a form of Damoisean curve), respiratory mobility of pulmonary borders by midaxilary line (cm).

Auscultation of the lungs. The main respiratory sounds (pueril, vesicular breathing, decreased vesicular breathing, to indicate location of weakening of vesicular breathing, increased vesicular breathing, harsh breathing, vesicular breathing with longer expiration, bronchial breathing, amphoric respiration. Adventitious respiration sounds (dry rales-high-pitched-sibilant, low-pitched-sonorous, moist rales (fine bubbling, medium bubbling, coarse bubbling, consonating and non-consonating, crepitation – initial, resolve, pleural friction sound, to indicate location of adventitious respiratory sounds.

10. Cardiovascular system characteristic.

Observation and palpation. Presence of the chest deformation in the heart region(the chest deformation is absent, the chest deformation is present, indicate the cause: pericarditis with effusion, cardiac "humpback"). Presence of the apex beat (the apex heat is not determined, the apex beat is determined (indicate location by attitude to the left medioclavicular line).

Presence of the pathological signs in the heart region (is absent, is present), the cardiac beat (is absent, is present), presence of the pathological pulsation, in the 3^{rd} –4^{th} intercostals spaces to the left of sternum , in the 2^{nd} intercostals spaces to the left and to the right of sternum edge, presence of remote pathological pulsation, in the epigastric region, in the liver region (is absent, is present).

Palpation. The apex beat, location, the width, the height, the strength (middle strength, strong, weak, like a dome, present of the "cat`s purr" symptom (don`t determine, is determine, indicate location). Palpation in the pulsated liver region (the true liver pulsation, the transmitted liver pulsation).

Percussion of the heart. The borders of relative cardiac dullness (the right, the upper, the left).

Auscultation of the heart. Rhythm of the cardiac activity (regular, irregular – to determine the type of rhythm disorder, extrasystolia, fibrillation, etc). The number of beat sounds (two, three reduplication, splitting of the second sound over). The rate of cardiac contraction (RCC) per minute. Appreciate RCC according age norm, tachycardia, bradicardia. Character of the heart sounds (the

heart sounds intensity is sufficient, the heart sounds are dulled, the heart sounds are voiceless, the heart sounds are loud, the first heart sound at the apex is increased, snapping or diminished, the 2^{nd} sound over the aorta is increased or diminished, the 2^{nd} sound over the pulmonary artery is increased or diminished, the 2^{nd} sound over the pulmonary artery is rreduplicated (splitted).

Cardiac murmurs don`t heard, is heard (to indicate location and its transmission, systolic, diastolic murmur, at the heart apex, 2^{nd} interspace, over the aorta, over the pulmonary artery, in the 5^{th} point).

Examination of the vessels. Aortic pulsation (invisible, visible, to indicate location). Periphery arteries (temporal, carotids, subclavian, brachial, intercostal, invisible, visible). The subcutaneous veins (jugular, veins of the upper and lower extremities, veins on the front surface of the chest and abdomen are invisible, visible (to describe), general swelling of the veins, local swelling of the veins (is present, is absent).

Palpation. Examination of pulse on radial artery. Comparison pulse size on both hands (pulse is same on the both hands , is different on different hands). Rhythm of the pulse waves (the rhythm is rhythmic, arrhythmic), pulse rate per minute, pulse deficit, pulse pressure (of satisfactory tension, the pulse is hard, soft), volume of pulse (of satisfactory volume, the pulse is full, the pulse is empty, pulse size (of middle size, the pulse is large, the pulse is small, the pulse is thread), pulse speed (the pulse of middle speed, the pulse is quick, the pulse is slow), pulse character (quick, and high, slow and small).

Examination of the arterial pressure.

1. Systolic (SAP)
2. Diastolic (DAP)
3. Pulse pressure (PP)

Assessment of AP: norm, pathology.

11. Digestive organs and abdominal cavity characteristic.

Observation. Condition of mucous membrane of oral cavity, throat, tonsils (colour – normal, pink, hyperaemia, dry or moist, coated tongue, follicules, fissures, geographical tongue). Teeth condition (dicideous, permanent, teeth quantity, teeth formula, caries presence). Shape and size of the abdomen (distended abdomen, scaphoid abdomen, board-like abdomen, frog abdomen), visible peristalsis, respiratory movement, veins, umbilicus, hernia. Examination of the perianal area (gaping anus, mucosal prolapse of the rectum, fissures of the anus).

Palpation superficial and deep. Muscular tenderness and rigidity, painful points, local infiltration (soft abdomen, abdominal distension, tympany, meteorism, tense abdomen, "acute"/surgical abdomen, location of painful points).

Liver palpation (liver is not palpated, palpated for 2,0 and more sm below rib`s arches, its consistency – soft, firm; shape, type of margin – rounded, sharp, tenderness. Percussion of the liver (the upper margin of liver is defined, along the mammillary line in the fifth intercostal space).

Percussion of the abdomen, to detect ascites (fluid wave, fluctuation).

Palpation of large and small intestines. Auscultation of the abdomen (intestinal peristalsis, intestinal tones – is marked, is not marked).

Stool, its character, color, consistence, pathological admixture, frequency of stool (orange-yellow, homogenous, sourish stool, shaped, pale grey, pale yellow, dryish, foul, starvation stool, dyspeptic stool – loose, watery, green, in form of discrete flakes, admixture of mucus and blood, bulky, greyish, dark-brown stool).

12. Urorenal system characteristic.

Observation of lumbal region, bimanual palpation of kidneys (kidneys are palpated, are not palpated), palpation and percussion of urinary bladder (a smooth, elongated fluctuating organ is palpated above the symphysis pubis, percussion produces a flat sound above it). Painful points (pain in the lower abdomen, pain in the urethra, bladder pain, low back pain), renal colic. Pasternacky`s symptom. Urination rate. Painful difficult urination. Involuntary urination. Diurnal urine excretion. Correlation of daily urine flow and nocturnal urination.

13. Endocrine system characteristic.

Disorder of growth (gigantism, nanism), and body mass (malnutrition, obesity), allocation of subcutaneous adipose tissue. Condition of thyroid gland (lobatar and isthmus size).

Observation of genital organs (development of genitals genitals are corresponded with age, degree of development of secondary sexual characteristic).

14. Results of paraclinical methods of investigation (general blood analysis, urinalysis, coprogramma, bacteriologic tests, biochemical examination, X-ray examination). Assessment of results of laboratory and instrumental investigation, comparison with age standards. Conclusion, assessment of pathological deviation.

15. Summery diagnostic conclusion according results of patient complains, anamnesis morbi, status praesens, results of paraclinical investigation, to state the main pathological symptoms and syndromes.

The concluding may be done in such form: Taking into consideration (point complains, anamnesis, results of clinical and paraclinical investigation) it is possible to diagnose (point pathological syndromes and the disease).

16. Substantiate feeding of a child.

The estimated basis of the action in performance of the learning objectives of the topic (sections 4, 6):

1. Self classroom work in the departments for children of different age - medical history, characteristics of clinical methods of the respiratory system examination, interrogation, examination, palpation, percussion, auscultation.

2. Determination of the pathological changes of the respiratory system.

The **maximum number of points** which may be consequently obtained by students is 200 points; this includes 120 points for current educational activity and 80 points for the final lesson.

Current educational activity of students is controlled during practical classes according to specific goals in the course of each practical class as well as during self-training in the hospital department. It is recommended to apply the following

means of diagnostics of the students' level of readiness: control of practical skills, solving cases and test control of theoretical knowledge.

The current assessment of students on respective topics is conducted in the traditional 4-point grade scale ("excellent", "good", "satisfactory" and "unsatisfactory") with further conversion into a multiscore scale.

The grade "Excellent" is given when the student knows the program in toto, illustrating the answers with various examples; gives clear and comprehensive answers without any hints; delivers the material without any inaccuracies or errors; performs practical tasks of a different degree of complexity.

The grade "Good" is given when the student knows the whole program and understands it well, gives correct, consistent and structured but not completely comprehensive answers to questions, although he is able to answer additional questions without mistakes; solves all cases and performs practical tasks experiencing difficulties only in the most complex situations.

The grade "Satisfactory" is given to the student based on his satisfactory level of knowledge and understanding of the entire subject. The student is able to solve modified tasks with the help of hints; solves cases and applies practical skills experiencing difficulties in simple cases; is unable to deliver a consistent answer, but answers direct questions correctly.

The mark "Unsatisfactory" is given when the student's knowledge and skills do not meet the requirements of the grade "satisfactory".

Given the number of practical classes the grades are converted into the multiscore scale as follows:

The mark "Excellent" – 72-80 scores
The mark "Good" – 60-71 scores
The mark "Satisfactory" – 50-59 scores
The mark "Unsatisfactory" – 0 scores

Навчальне видання

Написання та захист історії хвороби

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Комп'ютерна верстка

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