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Contributors

Sanders, Bill

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METHOD

OF

EXAMINING AND RECORDING MEDICAL CASES.

BY

WILLIAM R. SANDERS, M.D., ETC.,

PROFESSOR OF PATHOLOGY AND OF CLINICAL MEDICINE IN THE UNIVERSITY OF EDINBURGH.

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ON CASE-TAKING.

AFTER a good many years' experience of clinical work, I have thought it might not be without interest to explain the general method which I have adopted in investigating medical cases, especially in connexion with the teaching of clinical medicine. It is not on the score of novelty, but of usefulness, that I would venture to recommend the procedure I am going to describe, or some modification of it. Though comprehending many details, the plan is simple in its principle, and, at the bedside, I have found it work satisfactorily. It is intended chiefly for students, but I have had evidence to convince me that some such method would be found of service to practitioners, as an aid towards that accurate observation of medical cases which is a leading feature, as it is an undoubted necessity, of the medicine of the present day.

Many methods of examining patients have been proposed, but hitherto none has been universally accepted. Perhaps variety is necessary to suit different minds, or particular circumstances. Generally speaking, however, the plans suggested have been mainly founded either on an anatomical division of the body into Regions, or on a physiological division according to Systems, as the circulatory, respiratory, nervous, etc. The arrangement according to Systems was devised in 1814–1826, and tabulated by M. Rostan, who seems first to have perceived the importance of definite method in clinical work. Rostan's plan was introduced into our Royal Infirmary by Professor Bennett many years ago, and was always employed in his course of clinical instruction. The method which I purpose now to describe, consists mainly of a combination of the regional and the physiological plans of arrangement. For clinical inspection, the body is divided into certain Regions, and the Systems of organs are taken in connexion with the region to which they respectively belong. The successive examination of the various regions, with their included systems, ensures a thorough investigation of the whole organism. A complete account is thus obtained of the "present condition," the "status presens," of the patient, which is the main object, the backbone of any method of case-taking. The other parts of the investigation, viz., the antecedent history of

the patient, and the diagnosis, prognosis, treatment, etc., are arranged in the general scheme in appropriate positions before or after the Regional examination.

The directions for case-taking according to the method now proposed have been drawn up in a tabular form or scheme. The items given under the different headings are intended as examples or hints of the kind of information wanted; they are suggestive, not exhaustive; sufficient for ordinary purposes so far as space would allow. In former years this table was written on a large sheet of paper, and suspended in the side-room of the wards; but lately the plan has been adopted of printing the scheme on cards of convenient size, which are distributed to students of the clinical class. In using this scheme, it is to be remembered that the order of examining the case is the same as the order of recording or reporting it. To some it might seem more convenient to examine in one way, and afterwards adjust the report differently in some more precise form; but the advantages of using the same mode of examination and reporting are so decided, that I think a uniform plan should always be adopted.

I shall now submit the general Scheme or "Method of Case-taking," and shall afterwards subjoin such explanations and remarks as appear necessary.

METHOD OF CASE-TAKING.

*Disease*_____

*Result*_____

I. Preliminary Information.

1. Name, Age, Occupation, Residence, Date of Admission, Number of Ward and Bed.
2. Complaints, (*a.*) as stated by patient, or (*b.*) reported by friends, also (*c.*) obvious morbid appearances, *e.g.*, jaundice.
3. History (*a.*) of present attack, (*b.*) of previous health, (*c.*) history of social condition and habits, (*d.*) family history.

II. Present Condition—Regional Examination.

REGIONS A. EXTERNAL.

1. General condition as to conformation or development, height, weight, muscularity, whether confined to bed, posture, etc.
2. Aspect and expression of face.

3. Integument (*i.e.*, skin and subcutaneous texture, including glands), as to temperature, perspiration, eruptions, tumours, etc.
4. Condition of limbs and joints.

Regions B. Internal.

N.B.—Here commence with the Region and System presumably most diseased, also describe all the systems of one region before going to another.

HEAD.

NERVOUS SYSTEM.

(*a.*) *Peripheral.*—Nerves, as to motion, sensation, special senses (ophthalmoscope).

(*b.*) *Central.*—Brain and spinal cord, as to feeling of well-being or exhaustion, intelligence, sleep, headache, vertigo, nausea, etc.

THORAX.

RESPIRATORY SYSTEM.

1*st*, *Symptoms.*—Number of respirations; dyspnœa, pain, cough, amount and character of expectoration, etc.

2*d*, *Physical Examination.*—Chiefly by inspection, palpation, percussion, auscultation of organs—

(*a.*) *Peripheral.*—Nose, action of alæ nasi, larynx, voice (laryngoscope), trachea, etc.

(*b.*) *Central.*—Lungs and pleura.

CIRCULATORY SYSTEM.

1*st*, *Symptoms.*—Cardiac dyspnœa, palpitation, pain at precordia, syncope, angina pectoris, etc.

2*d*, *Physical* examination by inspection, palpation, percussion, auscultation of organs—

(*a.*) *Peripheral.*—Arteries, especially radial and carotid; pulse as to number, character, variations, etc. Veins.

(*b.*) *Central.*—Heart and large vessels within the thorax.

§ State of the blood; microscopic examination, etc.

§ Intra-thoracic tumours.

N.B.—The lymphatics and lymphatic glands are examined locally in the regions in which they occur.

ABDOMEN.

DIGESTIVE SYSTEM.

Examination as to Symptoms and Physical signs of—

(*a.*) *Intestinal Tube.*—Teeth, tongue; hunger, thirst; deglutition, digestion, vomiting, stools, etc.

(*b.*) *Walls and Solid Viscera of Abdomen.* — Shape, swelling, etc.; condition of peritoneum; liver; spleen; pancreas; lymphatic glands; tumours, etc.

Frequency of micturition; pain; difficulty.
Urine, amount in twenty-four hours; specific gravity; colour and transparency; acidity; odour; deposits; chemical and microscopical examination.
Examination of kidney, bladder, urethra, etc.
Menstruation; condition of vagina and uterus, etc.; pregnancy, etc.; tumours.

III. Diagnosis.

Nature of Disease, as founded on brief summary of the functional disorders and structural lesions made out. These are arranged in the order of their importance or probable succession.

IV. Prognosis.

Immediate and remote.

V. Treatment.

Diet and regimen. Principles and special indications. Copy of prescriptions.

VI. Progress of Case.

Reports daily, or as occasion requires. Condition ascertained according to the order of Regions and Systems above given. Any changes or new phenomena specially noted.

VII. Termination of the Case.

Date and nature of the result. If necessary, patient's address in town or country noted. If fatal, and a post-mortem held, enter the report.

Explanatory Remarks.—It will be observed that, at the head of the case, blank spaces are left for the name of the disease and the result of the case. These, which are to serve as Title, should not be filled in till the case is completed. The case-taking proper is divided into seven sections:—Preliminary Information, Present Condition, Diagnosis, Prognosis, Treatment, and, finally, Progress and Termination of the case. On each of these, but especially on the first and second, I have some remarks to make. Before doing so, however, I should mention a necessary precaution. Either before a case is formally taken, or, at all events, during the initial inquiries, the observer should satisfy himself whether the case is evidently, 1*st*, Febrile or non-febrile (as shown by heat of skin and rapid pulse); 2*d*, Whether the patient is intelligent and able to answer questions; 3*d*, Whether he is in a condition to undergo the fatigue of physical examination. If the patient is apparently affected with fever, or is

delirious (I have known a patient in delirium tremens subjected uselessly to a painstaking interrogatory according to a fixed method), or if he is in a weak or dangerous condition, those circumstances should be reported, and the course of examination modified accordingly. To this precaution the physician or his assistant usually attends, but it is well that beginners should also be aware of it.

I. *Preliminary Information*, which is the first division, comprises :—

1*st*, The designation, *i.e.*, name, age, occupation, etc., date of admission (*giving day of month and year*), etc.

2*d*, Complaints of patient: *i.e.*, a brief statement of all his alleged ailments. This information is usually derived from the patient himself. If his complaints are definite, *e.g.*, "complains of cough," "looseness of the bowels," etc., these are set down simply: but if his symptoms are vague, we must say so, and endeavour to ascertain cursorily, whether his ailments are general or local, as indicated by pain, etc. Sometimes it is told us on the part of friends, previous medical attendant, or by the patient himself, that his case is one of "heart disease," "diabetes," etc. When thus obtained, the information should be entered upon as "Reported (by——) to be suffering from," etc. Occasionally a patient is admitted, who is seen at once to be affected with "jaundice," etc., which fact may at once be set down, along with his other complaints. Lastly, patients may be brought in comatose,—or in a fit, or delirious, etc. Unusual circumstances like these, require of course modifications in the statement, which are suggested by the events themselves. All that is wanted at this stage, is a first indication as to the probable nature of the case, so as to guide the further examination, on which alone, and not on first impressions, the diagnosis must be founded.

3*d*, Antecedent History (Anamnesis). This includes, first and chiefly, the account of the present attack, its presumed cause, date of commencement, first symptoms, and subsequent course, till the time of admission. Next, the previous state of health, and especially former diseases, are noted. Inquiry may then be made as to the social condition and habits (clothing, lodging, food, intemperance, syphilis, mercury, etc.); and, lastly, any important particulars of family history, as to hereditary diseases and general health or longevity, may be taken down.

In regard to etiology, diagnosis, and prognosis, the history or anamnesis is of great importance. But it is a very difficult part of case-taking, owing to the want of recollection or the deficient powers of observation or description on the part of the patient. Here patience, and especially tact in eliciting reliable facts and dates, with succinctness in narration, are qualities which the observer ought to cultivate.

In the course of careful case-taking, a doubt may sometimes

arise, whether the antecedent history should be taken at this stage of the inquiry, or had better be postponed till after the Regional examination has been made. Much may be said in favour of either view. On the whole, however, after experience of both ways, I think that, when the case is chronic, and time permits, it is best to obtain the history at once, before proceeding to the investigation of regions and systems. But if the patient is very weak, or in cases of acute disease (*e.g.*, pneumonia), or when the information must be got from friends, etc., the history may be meanwhile omitted, or obtained in part now, and left to be completed afterwards.

II. *Present Condition—Regional Examination.*—This constitutes the chief part of the case. Clinical experience has proved, that it is not enough to examine merely the parts or organs which are presumed to be diseased. These should be more specially investigated, but at the same time a general review of the whole organism must also be made. With method and practice this can be done quickly; but by beginners it should always be done carefully. Otherwise, reliable results cannot be obtained, and serious errors and oversights are certain to occur.

As previously stated, the examination is to be conducted according to Regions, the physiological systems being taken in connexion with the regions in which their chief organs lie. The division of the body into regions, when once understood, of itself settles the different subdivisions of the inquiry; no effort of memory is needed to discover what system comes next, or whether all have been examined or not. The whole body is gone over in regular order, and when that is finished, the examination is necessarily complete.

For clinical purposes, the body may be divided into A, the External Regions, viz., the external or integumentary surface, and the limbs; and B, the Internal Regions, viz., the three great visceral cavities, head (cranio-vertebral cavity)—thorax—abdomen.

In the Regional examination, it appears to me essential that the External regions should always be taken *first.* 1*st*, because they are most accessible; 2*d*, because the information they supply is immediately useful—(*e.g.*, temperature of skin as indication of pyrexia or apyrexia; eruptions, dropsy, etc.); 3*d*, because apt to be forgotten if left to the last. This external examination may be done very rapidly, except in cases, *e.g.*, of skin eruption, or acute rheumatism, in which the external regions are often the most important. The external regions should be taken in the order indicated by the numbers 1, 2, 3, 4.

When the External examination is completed, we next proceed to the three Internal cavities, for the purpose of observing the state of the walls of these cavities; their contained organs; and, in connexion with these organs, the physiological systems of which they are the centres. In relation to the Head, we have only one system

to investigate—viz., the nervous system. The Thorax comprehends two systems—the respiratory and the circulatory; while the Abdomen includes three systems—viz., the digestive, the urinary, and the generative. It is made a rule that, in the course of the examination, the systems contained in the same cavity should always be taken immediately one after the other, before we pass to the systems in another cavity. Thus, the respiratory and circulatory systems being both thoracic, must be examined in immediate sequence; and, in the abdominal region, the digestive, urinary, and generative systems must be kept in close relation to each other. This rule does not forbid that in the thoracic region the circulatory may, if thought fit, be taken before the respiratory system, or *vice versâ;* or that in the abdominal region the genito-urinary system may take precedence and be followed by the digestive or *vice versâ.* But it requires that the systems belonging to different regions shall not be intermixed. We must not go at random from the urinary to the respiratory, and from that to the nervous system, next to the digestive, and finally to the circulatory system, etc. To do so would risk confusion and omissions. It would violate the principle of Regional division, the advantage of which consists partly in associating together those systems whose chief organs are in anatomical proximity, and partly in securing that when a region has been examined, the included systems have necessarily been examined with it.

On commencing the investigation of the Internal regions or cavities, and their relative systems, the question occurs, Which region should be first examined? and which system in that region should have precedence? In the Table, the head happens to be placed first, then the thorax, and lastly the abdomen. But no necessary precedence is intended by this order. On the contrary, as it is a matter of indifference, *per se,* which internal region is taken first, the rule is given to begin with that region and system which the previous inquiries have indicated as the chief seat of disease. Thus, in cases of paralysis, we should, after finishing the external regions, begin the internal examination with the nervous system (it would be absurd to begin with the digestive organs); in heart disease, with the circulatory organs; in phthisis pulmonalis, with the respiratory system, etc. After finishing the systems in one internal region or cavity, we take next the cavity which has most connexion with the one examined, either anatomically (*i.e.,* the adjoining cavity) or in relation to the disease.

In associating the Systems with the Internal Regions or cavities, the consideration must be specially kept in view, that only the central organs of a system are contained within a given cavity, while the other parts of the apparatus are distributed throughout the body. Thus, while the brain and spinal cord are lodged in the cranio-vertebral cavity, the various nerves take their course throughout the organism. Similarly, the heart is lodged in the

thorax, but the arteries and veins ramify in the trunk and limbs. The chief digestive organs are situated in the abdomen; but the mouth and œsophagus are extra-abdominal; just as the nose, larynx, and trachea are extra-thoracic, though really belonging to the lungs, which fill the lateral portions of the chest. Hence arises the necessity (as indicated in the scheme) of dividing each System into two sets of parts. 1*st*, The peripheral parts, which are placed external to the region or cavity; and 2*d*, The central parts lodged within that cavity. The examination of the peripheral parts is most conveniently taken first, as usually few particulars require notice; and this quite naturally leads up to the more careful and extended investigation of the central organs. Thus, in heart disease, it is the most convenient order to note the radial pulse, and the state of the veins, before investigating the præcordial region and in hemiplegia, *e.g.*, after completing the external regions, it follows, in a kind of regular sequence, to examine the motor and sensory phenomena in the affected limbs before proceeding to investigate the condition of the brain, etc. In practice, this will be found to present no difficulty. The region suggests the physiological system; the central organs of the system suggest its peripheral extensions, while the convenience of readier access will usually indicate the propriety of taking the peripheral before the central parts. Of course, if the central organs exhibit striking phenomena, we may proceed at once to their investigation, and take the peripheral parts afterwards, but this is exceptional.

Another distinction remains to be pointed out. In investigating every System of organs we have to observe two orders of phenomena, viz., symptoms (functional changes), and physical signs (material changes). These must always, if possible, be kept separate. Generally, it is most convenient to take the symptoms first, and the physical examination subsequently; and, accordingly, this is the order indicated in the Table. A careless mixture of symptoms and signs leads inevitably to confusion and inaccuracy.

With these general explanations, the directions in this part of the Table are, I trust, sufficiently intelligible and explicit.

III. *Diagnosis.*—Under this division are to be entered, not merely the name of the disease or diseases as far as made out, but the chief groups of symptoms (nosological diagnosis), and their lesions (pathological diagnosis) are to be briefly enumerated. In short, the results of the whole previous inquiry are summed up in a few brief technical expressions. The relation of succession or dependence of the various disorders or lesions may also be indicated; and the degree of certainty of each item of the diagnosis may, when necessary, be expressed. When, in the subsequent progress of the case, new facts arise, modifying or altering the diagnosis, or when new diseases supervene, a new entry as to diagnosis will require to be made.

The advantage of obtaining a brief *résumé* of the case, under the

head of diagnosis, is very great. It obviates the vagueness which often arises from the number of details brought out in the Regional examination, and it concentrates the attention on the leading points of the case.

IV. Under *Prognosis*, the immediate result, and the probable remote effects—*e.g.*, tendency to relapse, etc.—of the disease should both be considered.

V. The principles according to which the *Treatment* is to be conducted, and the particular indications, should be noted here; the direction as to diet and regimen, and a copy of the particular prescriptions ordered, must also be duly entered.

VI. *Progress of Case.*—The preceding subdivisions include all that can be done at the commencement of a case. So long as a patient continues under treatment, however, renewed observations require to be made. These should be conducted on the same plan —*i.e.*, of regions and systems—recommended for the first examination of the case. Particular attention must be directed to the important morbid phenomena summarized under the diagnosis; but, at the same time, a careful lookout should be kept for any important changes or new phenomena which may arise. If well kept, these reports of progress form the most instructive part of the case.

VII. *Termination of Case.*—Before a case is concluded, the previous entries should, if time permits, be revised, and any omissions supplied. A careful entry should be made of the state of the patient at the time of dismissal. If the case proves fatal, and an autopsy is held, the report of this should be entered. If the report of the case is kept in a hospital journal or case-book, the reference in the index should be attended to. If the report is a private one, reflections and comments may be added at the end of the case, or may be inserted within brackets under any of the dates, when special phenomena have been observed. Throughout the whole course of the investigation, the results of the observer's experience, reflection, or reading should be brought to bear on the various incidents as they arise; and although these reflections need not always be explicitly stated, their effect will be apparent in the examination of particular phenomena, or in the modifications made in diagnosis or treatment.

Such is an outline of the mode of procedure in the detailed investigation of medical cases. The full examination is especially required in, and adapted for, chronic cases; and as considerable time is required to do it thoroughly, discretion must be used by beginners to avoid vague and irrelevant matter and useless minutiæ. It is important that the medical observer should be early trained to be expeditious and punctual; to put plain questions, asking one thing at a time; to be expert in manipulation; to be brief, precise, and simple in narration; so as not only to save his own time, but

especially to spare the patient the fatigue and possible injury of a prolonged examination. If all the important points of the case cannot conveniently be overtaken at once, some of them may be postponed to a subsequent occasion. In obscure or important cases, renewed examinations are always required at proper intervals. In acute or urgent cases, on the other hand, only the most accessible facts can with propriety be obtained; and in regard to the *status presens*, a brief record of the general aspect, temperature, and state of skin, number of respirations, aud rate of pulse, together with particular prominent symptoms and indications of treatment, is all that should be attempted. For fevers or other epidemic diseases, special schemes or charts may easily be constructed. But the abbreviations of the method of examination required for urgent cases on the one hand, and, on the other hand, the more extended directions for the examination of particular regions in cases of obscure disease, need not be entered on now. When the general plan is understood, the necessary variations may easily be made. Perhaps, at some future period, I may recur to that part of the subject. For the present, omitting all discussion of the advantages and disadvantages of "systems" or "methods" in general—omitting also any discussion as to the possibility of substituting a nosological method in place of anatomical or physiological arrangements,—I have aimed only at giving an account of an anatomico-physiological method, which, simpler in use than it appears in description, has seemed to me, as a whole, well adapted to beginners, and, in whole or in part, capable of useful application in the investigation of important cases in private practice.

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