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Abdominal masses and distension

➤ History of presenting complaint

When did the lump appear?

SOCRATES

Site

Where is the lump?

Onset

Duration?

How was it noticed and by whom? (suddenly appeared, painful).

Have your clothes become tighter recently?

Character

Is it focal or generalised?

Associated symptoms

Is it producing local symptoms?

Is there pain or discomfort?

Are there any other lumps?

Are there any systemic symptoms (weight loss, malaise, change in bowel habit, anorexia, fever?).
The 7 F’s

Are there any symptoms of bowel obstruction (Flatus)? – colicky abdominal pain, vomiting, absolute constipation, abdominal distension. Are there any changes in bowel habit or rectal bleeding? (think about the causes of bowel obstruction).

Is there any shortness of breath due to Fluid accumulation, or ascites, (causing splintage of the diaphragm)? Are there any features suggesting liver disease and in particular portal hypertension eg jaundice, haematemesis (varices), dilated veins on abdomen, rectal bleeding (haemorrhoids). Are there any signs of jaundice or symptoms of anaemia?

Are you constipated? (Faeces)

Have you put on weight recently? (Fat)

Is there any chance that you could be pregnant? (Fetus)

Are there any symptoms of malabsorption eg steatorrhoea (Are your stools pale, bulky, offensive? Do your stools float? Are they difficult to flush away?) (Food – coeliac disease causes abdominal distension).

Are there any Gynaecological/Genitourinary symptoms? – dysuria, frequency, urgency, urge incontinence, haematuria, vaginal bleeding (Flipping Great Masses). Is there any associated leg swelling/ DVTs/ varicosities (extrinsic venous compression)?

Timing/duration

Is it enlarging/staying the same/getting smaller? Over what time course?

What do you think is wrong?

Is there anything that you are worried this might be due to?

Ask about treatment, if any, already received?
Past medical history

**MITJTHREADS**

Is there any history of previous hospital admissions/operations/illnesses, especially abdominal disorders or operations?

Is so when (year), why, how was the diagnosis made, where (which hospital?), who were you under?

Is there a history of IBD?

Is there a history of any gynaecological problems (flipping great masses) such as fibroids, ovarian cysts etc.

Is there any history of known hernias, maldescended testes, or AAA?

Drug history

What medications are you currently taking?

What dose?

Why are you on that?

Compliance, side-effect(s) of medication, OTC/herbal remedies, allergies. (What happens?)

Social history

To focus on:

- Smoking
- Alcohol
- Recreational drugs
- Overseas travel history such as hydatid cysts
- Occupation (heavy lifting → hernias)

Lifestyle limitations due to disease.

Has patient taken time off work? How much?

What are your hobbies?

How do the symptoms interfere with your life (walking, working, sleeping)?
Family history

Are there any diseases or illnesses that ‘run in the family’?

*Is there a FHx of malignancy, especially bowel carcinoma?*

Has there been any contact with TB or other infections?

*Is there a FHx of polycystic kidney disease?*

Is there any consanguinity? Draw a family tree.

Differential diagnosis

- Fat (Obesity)
- Fetus (Pregnancy)
- Flatus (Air)
  - **Bowel Obstruction**
  - Aerophagy (air swallowing) eg IBS
- Fluid (Ascites)
  - Chronic peritonitis (eg TB, missed appendicitis)
  - Carcinomatosis (malignant deposits especially ovarian, stomach)
  - Chronic liver disease (cirrhosis, secondary deposits, portal or hepatic vein obstruction, parasitic infections)
  - Congestive heart failure (right-sided)
  - Chronic renal failure (nephrotic syndrome)
  - Chyle (lymphatic duct disruption)
  - Constrictive pericarditis
- Faeces
  - Chronic constipation
  - Chronic intestinal obstruction
  - Hirschsprung’s disease
  - Acquired megacolon
- Flipping great masses
  - Uterine fibroids
  - Giant Hepatomegaly/splenomegaly
  - Giant renal cell carcinoma
  - Polycystic kidneys
  - Lymph nodes
  - Abdominal aortic aneurysm
• Abdominal cysts – renal, pancreatic, ovarian, pancreatic pseudocyst, mesenteric, hydatid
• Desmoid tumour
• Bladder (retention)
• Food
  • Malabsorption syndromes eg coeliac disease

▶ Investigations

Blood tests
• Haematology – FBC, ESR, blood film
  • Anaemia (anaemia of chronic disease)
  • Polycythaemia (RCC)
  • Raised WCC (blood dyscrasias, diverticular disease, renal infections, empyema gall bladder etc)
  • ESR (malignancy, chronic inflammation)
  • Blood film (blood dyscrasias and hepatosplenomegaly)
• Biochemistry
  • U+Es (vomiting and dehydration eg gallbladder and bowel lesions, ureteric obstruction, renal lesions)
  • Ca²⁺ (carcinoma)
  • Glucose (pancreatitis, pancreatic carcinoma)
  • CRP (infection)
  • LFTs (liver lesions, metastases, low albumin in ascites)
  • Amylase (pancreatic pseudocyst)
  • PSA (prostate carcinoma)

Urine (M,C&S)
• Haematuria (RCC, bladder tumours)
• Pus cells
• Organisms
• Malignant cells
• β-hCG (pregnancy)
Radiology

- CXR
  - Congestive cardiac failure
  - Metastases
- AXR
  - Bowel obstruction
  - Constipation
  - Large spleen/liver
  - Renal/ureteric calculi
- Transabdominal/transvaginal USS
  - Organomegaly
  - AAA
  - Cysts/collections
  - Enlarged bladder
  - Ovarian/uterine lesions
- CT abdomen ± guided biopsy
  - Carcinoma
  - Collection/cyst

Further investigations

- OGD (carcinoma stomach, pyloric stenosis)
- Small bowel enema (Crohn’s, carcinoma)
- Barium enema (carcinoma bowel, diverticular)
- Colonoscopy (carcinoma colon, diverticular)
- Cystoscopy (bladder tumour)
- Paracentesis – If ascites for cytology, culture (microbiology) and protein content (biochemistry)
- Diagnostic laparoscopy ± biopsy
Acute abdominal pain

History of presenting complaint

Site
Can you point with a finger to the location of the pain?

Onset
When did the pain start? Where did it start?
Has it moved since?
What were you doing when the pain started?
How quickly did it come on? (Suddenly, over seconds, minutes, gradually)

Character
Where is the pain worst?
What is the pain like – aching, sharp/stabbing/like a knife, burning?
Is it constant or variable? Is it colicky?

Radiation
Does the pain radiate? (To the back – AAA, pancreatitis; down into the groin/genitals – renal/ureteric colic, testicular torsion; to the shoulders – gallbladder; loin – pyelonephritis; chest – MI)

Associations
What else did you notice?

General
• Sweating/fever
• Rigors
• Shortness of breath
• Dizziness on standing (Concealed/covert haemorrhage)
Acute abdominal pain

Gastrointestinal – Have you had any
- Acid reflux, waterbrash?
- Pain during swallowing? (Odynophagia) Difficulty swallowing? (Dysphagia)
- Nausea or vomiting? (Onset, duration, persistence, how much, frequency, composition – blood, bile, small-bowel contents, coffee-grounds)
  - What came first, the vomiting or the pain? (NB: Classically, if pain comes on first, followed by vomiting, this suggests a surgical cause. If vomiting comes on first, followed by pain, this suggests a medical cause for the pain)
  - What effect did vomiting have on the pain?
- *Is there diarrhoea* (frequency, consistency, blood/mucus/pus), *constipation, haematemesis/melaena/PR bleeding, painful defecation? Is there any recent change in bowel habit? Are there any symptoms of indigestion, steatorrhoea, or weight loss?*
- *Are there any features of bowel obstruction?*
  - When were your bowels last open?
  - When was flatus last passed?
  - Are you able to pass flatus at the moment?
  - Is there any distension or vomiting?
- *Are there any current hernias?*

Genitourinary – *Are there urinary symptoms?* (Suggestive of UTI or acute retention: ask about frequency, dysuria, urgency, haematuria, nocturia, hesitancy, poor stream, terminal dribbling, etc)

Gynaecology
- Have you had previous gynaecological problems?
- Do you mind me asking if you are sexually active?
- At what stage are you at in your menstrual cycle at the moment? Are there any problems with menstruation?
- *Is there per vaginal bleeding, PID/inflammation of the tubes, ovarian cysts?*
- When was the first day of your last menstrual period? (Menses – duration, regular, heavy, painful; PV discharge; PV bleeding; IMB, PCB, PMB; fibroids; endometriosis; relation of pain to menstrual cycle (mittelschmerz))
- Is it possible you could be pregnant? (Ectopic)
- Has there been recent trauma? (Delayed rupture of spleen!)
Timing
What is the duration? (> 6 hours of unremitting pain is likely to be surgical rather than medical)
Have you had it before? If so, how was it different?
When does the pain occur and how frequently?

Exacerbating/relieving factors
What brings it on/what made the pain worse?
What relieves the pain (What takes the pain away)? (Rest, posture/movement/lying flat, analgesia, antacids, milk, defecation)
What brings on the pain?
- Does breathing affect the pain?
- Does breathing deeply make it worse?
- How about coughing, movement, hot drinks, alcohol? (Gastritis, pancreatitis)
- Food? (Fatty foods – the pain of gallbladder pathology, acute pancreatitis, mesenteric ischaemia, PUD and GORD can all be precipitated by food)
- Exercise/exertion?

Severity
Is it the worst pain you have ever experienced? Score out of 10 compared with childbirth or 10 being severe enough to take your own life.
Have you taken time off work or been away from school because of the pain?
Is your sleep affected?
RISK FACTORS

**Risk factors for AAA**

- Hypertension
- Smoking
- Advancing age
- Family history of AAA
- COPD
- Cardiac disease
- Previous stroke

**Risk factors for pancreatitis (GET SMASHED)**

- Gallstones and Ethanol – two commonest causes of pancreatitis
- Trauma
- Steroids
- Mumps
- Autoimmune (PAN)
- Scorpion bites
- Hypothermia, Hypercalcaemia, Hypertriglyceridaemia
- ERCP, Emboli
- Drugs – thiazides, azathioprine

What do you think is wrong?

Ask about treatment already received (eg NSAIDs).
Past medical history

Is there history of previous GI disease? (Indigestion, abdominal pain)

Do you suffer from gallstones?

Have you had an AAA, peptic ulcer, diverticular disease or pancreatitis before?

Have you had abdominal surgery previously (adhesions)?

Have you had previous gynaecological problems?

Have you had a previous appendicectomy?

Consider the patient’s fitness for general anaesthesia – Have you had any reactions to general anaesthetics in the past?

Drug history

Are you taking any medications, especially:

- Anti-inflammatories? (Cause PUD)
- Steroids? (Mask abdominal signs)
- The pill or HRT? (Need to be stopped prior to surgery due to increased thromboembolic risk)

Compliance, side-effect(s) of medication, OTC/herbal remedies, allergies.

(What happens?)

Social history

Do you smoke? (Important to stop pre-operatively because of increased risk of thrombosis)

Do you drink alcohol? (Gastritis, acute/chronic pancreatitis)

Do you use recreational drugs?

Sexual history – I need to ask you some important though rather personal questions, if I may, which may or may not relate to the symptoms you’ve been having. Have you had recent unprotected intercourse with a new partner? (PID/salpingitis)

How would you manage at home after a possible operation? Who is at home to look after you on discharge? (The situation at home is very important if considering surgery.)
Family history

Is there a family history of any GI conditions, eg IBD (UC/Crohn’s disease)?

Is there a family history of rare metabolic causes of abdominal pain, eg porphyria, familial Mediterranean fever?

Do any anaesthetic reactions run in the family? (Malignant hyperpyrexia syndrome)
### Differential Diagnosis

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<td>Oesophagitis/gastritis</td>
<td>Basal pneumonia</td>
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<td>Peptic ulcer disease</td>
<td>Ruptured spleen</td>
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<td>Splenic infarction</td>
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<tr>
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<td>Perforated oesophagus</td>
<td>Subphrenic abscess</td>
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<td>(Boerhaave’s)</td>
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<td>aneurysm</td>
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<td>Pyelonephritis</td>
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<td>Left iliac fossa</td>
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<td>degeneration)</td>
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<td>Terminal ileitis</td>
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<td>Ovarian cyst accident</td>
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<td>(rupture, haemorrhage,</td>
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<td><strong>Renal/ureteric colic</strong></td>
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<td>torsion)</td>
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<td>Ovarian cyst accident (rupture, haemorrhage, torsion)</td>
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<td><strong>Testicular torsion</strong></td>
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Medical causes of abdominal pain

Cardiovascular
- Myocardial infarction
- Aortic dissection
- Bornholm’s disease (Coxsackie B)

Respiratory
- Basal pneumonia

Metabolic
- Diabetic ketoacidosis
- Addisonian crisis
- Sickle cell crisis
- Hypercalcaemia
- Uraemia
- Phaeochromocytoma
- Acute intermittent porphyria
- Lead poisoning

Infections
- Gastroenteritis
- Tuberculosis
- Typhoid fever
- Malaria
- Cholera
- Yersinia enterocolitica
- Urinary tract infection

Neurological
- Herpes zoster/shingles (NB: dermatomal)
- Tabes dorsalis
Inflammatory
- Vasculitis
  - HSP
  - PAN
- Familial Mediterranean fever

Psychogenic
- Narcotic addiction
- Irritable bowel syndrome

Investigations

Blood tests
- Haematology – FBC, ESR, clotting, cross-match/G+S
  - Anaemia (bleeding, anaemia of chronic disease)
  - Raised WCC (infection, inflammation)
  - ESR (infection, inflammation, malignancy)
  - Clotting (pre-op prep)
  - Cross-match/G+S (AAA, ectopic, pre-op prep)
- Biochemistry
  - U+Es (vomiting and diarrhoea, renal lesions)
  - CRP (infection)
  - Glucose (DKA, pancreatitis)
  - LFTs (hepatitis, gallstones)
  - Ca\(^{2+}\) (pancreatitis, renal colic, hypercalcaemia as a primary cause)
  - Amylase (pancreatitis, ischaemic bowel)
  - Lipids (pancreatitis)
  - β-hCG (ectopic)
- Microbiology
  - Blood cultures (Gram-negative sepsis)
  - Arterial blood gases (pancreatitis, metabolic acidosis)
**Urinalysis (M,C+S)**
- Pus cells, nitrites, protein, organisms (pyelonephritis, UTI)
- Blood (renal colic)
- β-hCG (ectopic)
- Glucose, ketones (DKA)

**ECG**
- Exclude MI
- Pre-op preparation for anaesthetic
- Arrhythmias (eg AF) leading to emboli (acutely ischaemic bowel)

**Radiology**
- Erect CXR
  - Perforated viscus
  - Basal pneumonia
  - Pneumomediastinum (Boerhaave’s syndrome)
- AXR (± lateral decubitus)
  - Bowel obstruction
  - Constipation
  - AAA
  - Renal calculi
  - Thumbprinting of bowel wall (bowel ischaemia)
- Transabdominal/transvaginal USS
  - Exclude gynaecological pathology
  - Collection/cyst
  - Free fluid (peritonitis, ascites)
  - AAA
  - Gallstones
  - Renal stones
- CT abdomen/pelvis
  - Collections
  - Anastomotic leak
  - Diverticulitis
  - Renal colic (CTU)
  - Tumours
Further investigations

- OGD ± biopsy and *Helicobacter pylori* testing (peptic ulcer, malignancy)
- Large-bowel enema/Gastrografin (‘instant’) enema (cause for large-bowel obstruction)
- Small-bowel enema/follow-through (Crohn’s disease)
- Duplex Doppler/angiography (mesenteric thrombosis)
- Diagnostic laparoscopy
- Vaginal/endocervical swabs (PID)
- Blood film/Hb electrophoresis (sickle cell crisis)
- VDRL (tabes dorsalis)
- Urinary porphobilinogens (acute intermittent porphyria)
- Short synacthen test (Addison’s disease)
Alcohol-related problems

➢ History of presenting complaint

How much do you drink? How much do you drink on each occasion?
How often do you drink?
What do you drink?

How many units do you drink in a week? (1 unit = 1 small (125-ml) glass wine, 1 shot (25 ml) whisky, 0.5 pint beer (standard 3.5%))

How long does it take you to finish a bottle of whisky/vodka?

➢ CAGE questionnaire

Have you ever thought that you ought to cut down on your drinking?
Have people annoyed you by criticising your drinking?
Have you ever felt guilty about your drinking?
Have you ever had a drink first thing in the morning to overcome a hangover? (An eye opener)

Two or more positive replies identifies problem drinkers; one is an indication for further enquiry about the person’s drinking.

Do you find that you tend to drink more than your friends around you when you are out socialising? Do they ever comment on how much you drink, or ask you to reduce your intake?

How often during the past year have you been unable to remember what happened the night before because you had been drinking?

History

If intake is low risk, ask about any previous history of heavy drinking or dependence.

Age of onset of regular drinking/alcohol misuse/harmful drinking.
Amount
Are you a binge drinker, or do you drink consistently? (If the former is true, ask for how long, how much consumed, how long in between binges and precipitating factors for binges)
How much money do you spend on alcohol?

Place of drinking
Do you drink alone or with other people?

Other
What is the purpose of your drinking?
What is your attitude towards alcohol?
Do you take any drugs as well?

Conditions associated with drinking
- CNS: Wernicke–Korsakoff syndrome, polyneuropathy
- Gastrointestinal: gastritis, pancreatitis, liver disease, carcinoma of oesophagus
- Endocrine: cushingoid face
- Cardiovascular: hypertension, cardiac arrhythmias, cardiomyopathy
- Metabolism: gout
- Musculoskeletal: myopathies

Dependency
What happens when you go without alcohol for long periods of time? (Manifestations of dependency)
Are you aware of your compulsion to drink?

Tolerance
Is your tolerance increasing? Are you able to drink more now than you used to before getting drunk?
Withdrawal symptoms

Do you get withdrawal symptoms if you go without a drink for a long period of time?

When – first thing in the morning?

Do you get shaking, agitation, nausea, retching, sweating?

Are your symptoms relieved by drinking alcohol?

Do you get hallucinations, or altered perceptions?

Counselling/advice/treatments

Ask about previous advice, counselling and treatments received for alcohol problems.

➢ Past medical history

Have you ever had to detoxify?

Were you admitted to hospital or managed at home?

Establish the history and current situation with regard to the following systems:

Gastrointestinal

- Liver disease
- Jaundice
- Pancreatitis
- Abdominal pain
- Gastritis
- Gl haemorrhage
- Carcinoma of mouth, oesophagus, liver

Cardiovascular

- Hypertension
- Cardiomyopathy
- Arrhythmias
Alcohol-related problems

Neurological
- Neuropathy
- Psychosis
- Memory difficulties
- Hallucinations
- Cognitive impairment
- Blackouts
- Fits
- Accidents
- Anxiety

Respiratory
- Chest infections

Metabolic
- Gout

Reproductive
- Sexual dysfunction
- Fetal alcohol syndrome (in women of reproductive age)

Drug history
Do you take any medications?
Do you take any drugs that may interact with alcohol, eg warfarin, anticonvulsants, disulfiram, metronidazole?

Social history
Do you smoke? (Reinforces drinking behaviour and vice versa)
Do you use recreational drugs?
Have there been any requests for medical certificates?
Has there been any absenteeism at work?
Do you have any marital or family problems and has there been any domestic violence?
Has alcohol ever led you to neglect yourself, your family or work?
Do you have any financial difficulties?
Have you had any prosecutions for violent behaviour or driving offences? Have you ever been done for drink/drunk driving? Have you or someone else been injured as a result of your drinking?
Have you ever had your driving licence taken away or penalty points awarded relating to alcohol misuse?
*Family, housing, social and employment situations and the effect of alcohol misuse on these.*
Do you receive any state benefits – unemployment, incapacity, disability?
Have you made any attempts to stop drinking? What? When was the last time? How? Why did you fail?
Do you presently attend or have you ever been to Alcoholics Anonymous? Have you heard of it? Have you thought before about going?

➤ Complications of alcohol misuse

**Gastrointestinal**
- Oesophagus
  - Gastro-oesophageal reflux
  - Oesophageal carcinoma
  - **Oesophageal varices**
  - Mallory–Weiss syndrome
- Stomach
  - Gastritis
  - **Peptic ulcer disease**
- Small intestine
  - Malabsorption and malnutrition
  - Altered motor activity (diarrhoea)
Liver
- Fatty liver (steatosis)
- Alcoholic hepatitis
- Liver cirrhosis and its complications
  - Ascites
  - Spontaneous bacterial peritonitis
  - Portal hypertension
  - Hepatocellular carcinoma
Spleen
- Splenomegaly (portal hypertension)
Pancreas
- Pancreatitis (acute and chronic)
- Pancreatic carcinoma

Cardiovascular
- Coronary heart disease
- Dilated cardiomyopathy
- Hypertension
- Cardiac arrhythmias

Respiratory
- Aspiration pneumonia

Neurological
- Seizures/uncontrolled epilepsy
- Cerebrovascular accidents
- Cerebellar degeneration (ataxia)
- Wernicke–Korsakoff syndrome (thiamine deficiency)
- Peripheral polyneuropathy (mainly sensory)
- Hypoglycaemic coma
- Hepatic encephalopathy
- Alcoholic dementia
- Marchiafava–Bignami syndrome (corpus callosum atrophy)
- Central pontine myelinolysis
- Myopathy (acute/chronic)
- Rhabdomyolysis
- Neuropraxia
Alcohol-related problems

Haematological
- Haemolysis (Zieve’s syndrome)
- Impaired erythropoiesis
- Macrocytosis
- Alcoholism-associated folate deficiency
- Sideroblastic anaemia
- Neutropenia
- **Thrombocytopenia**
- **Clotting factor deficiency (liver failure)**
- Warfarin and other drug interactions (liver failure)

Endocrine/metabolic
- Hypoalbuminaemic state
- **Hypoglycaemia**
- Hypogonadism/infertility
- Hyperoestrogenaemia/gynaecomastia
- Pseudo-Cushing’s syndrome
- Ketoacidosis
- Gout
- Osteopenia/osteoporosis/fractures

Dermatological
- Facial flushing
- Palmar erythema
- Spider naevi
- Linear telangiectasia
- Dupuytren’s contracture
- Caput medusae (portal hypertension)
- Parotid enlargement

Pregnancy
- Infertility
- Fetal alcohol syndrome
- Intrauterine growth retardation
- Increased risk of abortion/stillbirth
**Psychiatric**
- Alcohol dependency/addiction/misuse
- Alcohol withdrawal
- Acute confusional state
- **Alcohol intoxication** (falls/blackouts/accidents/injuries, dangerous driving, violence, criminal behaviour)
- Alcoholic hallucinosis
- **Delirium tremens**
- Depression and anxiety
- Suicide
- Alcoholic dementia

**Social**
- Job loss
- Marital/relationship difficulties
- Criminal activity
- Violence
- Driving offences and RTAs

**Investigations**

**Blood tests**
- Haematology – FBC, clotting, haematinics
  - Anaemia (multifactorial)
  - Thrombocytopenia (multifactorial)
  - MCV (macrocytosis)
  - Clotting (liver disease)
  - Haematinics (vitamin $B_{12}$, red cell folate)
- Biochemistry
  - LFTs including GGT (cirrhosis)
  - U+Es (hepatorenal syndrome)
  - Glucose (liver disease, pancreatic failure)
  - Albumin (liver failure)
  - Lipids (secondary hyperlipidaemia)
  - Blood ethanol levels (intoxication)
**Radiology**

- CXR
  - Large heart (dilated cardiomyopathy)
  - Aspiration
- USS
  - Fatty liver
  - Hepatitis
  - Cirrhosis
  - Evidence of portal hypertension

**Further investigations**

- Carbohydrate-deficient transferrin (alcoholism)
- Red cell transketolase (Wernicke’s)
- Echocardiography (dilated cardiomyopathy)
- OGD (varices, PUD)
- Liver biopsy (liver disease)
- EEG (hepatic encephalopathy)
- Nerve conduction studies (neuropathy)
Ano-rectal pain

History of presenting complaint

Site
Where do you feel the pain? (in the skin or deep inside?)

Onset
Sudden vs gradual
Is it there the whole time or precipitated by something, eg passing stool?
Duration?

Character
Is the pain spasmodic? (proctalgia)
Is it worse during or after defecation (anal fissure)?
Does it persist after defecation?

Associated symptoms
- Are there any other pains, such as abdominal pain?
- Is there any bleeding from the back passage?
- Are there any changes in bowel habit? Is there tenesmus?
- Is there passage of mucus/pus/blood?
- Are there any lumps, or the sensation of something coming down when you pass stools?
- Are you still able to reduce your piles?
- Is there a history of trauma?
- Are you able to pass urine, or is there any back pain or weakness of your legs? (rarely cauda equina lesions present this way).
- Are there any systemic features – weight loss, fever, malaise, anorexia, rigors?
Case scenarios

Case 1

You are the surgical SHO on call. It is midnight. You have accepted a referral from a GP for a 35-year-old woman who has pain in the right iliac fossa.

Please take a detailed history from her to determine the cause of her problem.

What questions would you like to ask the patient?

PC

When you ask the patient what is wrong, she explains that she has had right iliac fossa pain since lunchtime that day. She was out at a restaurant with her best friend and just as she got up from her chair at lunch the pain came on. But she tells you nothing much else until direct questions are asked.

HPC

ODQ the pain came on suddenly.
ODQ the pain has been constant and severe.
ODQ about radiation – The location of the pain is vague and she is unsure whether the pain initially started around the umbilicus but she thinks it may well have. There is no radiation down to the groin. However, ODQ about shoulder-tip pain she agrees that there is radiation to the right shoulder, although she puts this down to a recent shoulder injury that she sustained while playing netball.
ODQ there is no history of trauma to the abdomen.

Associated symptoms:
- Bit of nausea, no vomiting
- No fever
- No distension
- Loss of appetite
- No urinary symptoms (dysuria, urgency, frequency)
- ODQ she has noticed she has passed some vaginal discharge which is dark red and possibly blood but she suspects this is a withdrawal bleed/breakthrough bleeding from the OCP.

**Exacerbating factors** – Walking around makes the pain worse.

**Relieving factors** – Lying/sitting still relieves it.

She took ibuprofen earlier but that has not helped.

**Severity** – The worst pain she has ever had, 9/10. She could never sleep with this pain.

ODQ about her LMP, her last withdrawal bleed (from being on the OCP) was 6 weeks ago.

**PMH**

Nil. Has not had her appendix out. No past operations.

No gynaecological history apart from suffering from painful heavy periods as a teenager.

**DH**

OCP – No allergies.

ODQ about compliance, she admits that a few weeks ago while on holiday and because of the excitement of being away from home she forgot to take her pill for two consecutive days.

**SH**

Functionally independent. Has no children. Shares a flat with a woman friend.

ODQ about travel she recently went on holiday to Ibiza with six other friends, including her boyfriend.

ODQ – Nothing significant about her holiday but she did have a D+V illness from sampling the local delicacies.

Smokes 10 a day and has done since the age of 15.

Drinks about 10 units alcohol a week (ODQ five large glasses of wine a week on average).

ODQ sexual history – She has been going out with her boyfriend for 3 years now. No other sexual partners. ODQ no ‘one night stands’ on holiday in Ibiza.
**FHx**

Grandmother diagnosed with bowel cancer at age of 80. Grandfather died of MI at age of 72.

Mother diabetic (insulin-controlled). Father alive and well.

One brother and one sister, alive and well.

**SE**

Nil. No weight loss.

**What is your differential diagnosis?**

**What investigations would you like to carry out?**

**Case discussion**

This case illustrates well the importance of taking a structured and accurate history in any patient presenting with acute abdominal pain. In this case it would be easy to assume, early on, that the diagnosis is acute appendicitis.

However, further questioning revealed that the patient forgot to take her pill while on holiday in Ibiza with her friends (who included her boyfriend). This, together with the fact that she has also noticed some dark-red vaginal discharge and her last withdrawal bleed is late, puts a **ruptured ectopic pregnancy** at the top of the differential diagnosis. The inefficacy of the OCP due to patient non-compliance was compounded further by a D+V illness while on holiday, which reduces absorption of the drug.

Other diagnoses that would also feature in the differential diagnosis are PID, an ovarian accident (rupture, torsion, haemorrhage), appendicitis, miscarriage, Crohn’s disease, etc. However, these are all less likely and this case is an ectopic pregnancy until proved otherwise because of its severity and the consequences of missing such a diagnosis.

This young lady indeed turned out to have an ectopic pregnancy which had ruptured into the peritoneal cavity. Blood within the peritoneal cavity results in chemical peritonitis and irritates the diaphragm, causing referred pain to the shoulder (because the diaphragm is innervated by C3–5). An ectopic pregnancy was confirmed from a positive β-hCG urine test and by transvaginal USS which showed an anembryonic uterus and blood in the cul-de-sac (but no adnexal mass). At laparoscopy she was...
found to have a ruptured ectopic pregnancy within the right fallopian tube. This was surgically managed and she subsequently made a full recovery.

This case illustrates well the fundamental point of never forgetting to take a full gynaecological history for all women presenting with either acute abdominal pain, amenorrhoea and/or vaginal bleeding. For all women of child-bearing age presenting with such symptoms, always think at the back of your mind – Could this lady be pregnant and now be presenting with a complication of pregnancy?
Case 2

You are the GP of a 39-year-old postman who comes to your practice complaining of a painful red eye.

Please take a history from him to try and determine what is wrong.

What questions would you like to ask the patient?

PC

When you ask the patient what the trouble has been he explains that he has had a three-day history of a painful, left eye.

HPC

Site – Is truly unilateral and has not had any problems with the contralateral (right) eye.

Onset – It came on quite acutely over a day or so. ODQ no history trauma/foreign bodies to eye.

Character – ODQ it is actual pain rather than discomfort/irritation/itching/dryness or a gritty eye. No obvious diurnal variation in symptoms.

Radiation – No headache, no radiation.

Associated symptoms:

- ODQ he has noticed vision has become more blurred in that eye when he covers up the other eye.
- ODQ no changes to colour vision.
- ODQ parts of the visual field are not obviously missing.
- ODQ no eye discharge or stickiness.
- ODQ no nausea/vomiting.
- ODQ eye has been watering.
- ODQ no rhinorrhoea.

Timing – It has been getting worse over the past few days.

Exacerbating factors – Light (photophobia).

No Relieving factors.

Severity – Pain 8–9/10. He normally wears disposable contact lenses but has been unable to do so over the last few days because the pain is so bad.
ODQ the patient also has noticed that over the past six months, or so, he has had generalised aches and pains in his joints but particularly his lower back. He attributes this to his job.

ODQ he describes a bit of loose stools (on and off for the last few months), ODQ with slime and mucus but no blood. No fever. ODQ mild abdominal tenderness but nothing compared to his eye pain.

ODQ no urethral discharge. No other urogenital symptoms.

No contacts with a similar problem. No SOB or skin changes.

**PMHx**

ODQ no history of glaucoma.

No history of previous eye problems. Contact lens hygiene is good.

Only history of note is a meniscal tear ten years previously sustained whilst playing football.

ODQ no history of headaches or migraines. ODQ no history of psoriasis. ODQ no history of ankylosing spondylitis.

**DHx**

- Paracetamol for pain.
- NKDA

**SHx**

Smokes 10 a day for 20 years. Drinks 15 units alcohol a week.

Lives with his girlfriend. Functionally independent.

ODQ no new sexual partners recently.

ODQ not IVDU.

**FHx**

Nil. ODQ he thinks his grandfather (maternal side) had glaucoma.

**SE**

Nil. No weight change.
What is your differential diagnosis?
What investigations would you like to carry out?

Case discussion

The history is fairly vague but indicates favourably a diagnosis of an acute iritis (anterior uveitis). The features that fit with this are a unilateral, painful, watering red eye of relatively acute onset, that is exacerbated by light and is associated with a loss of visual acuity.

Having said that, the diagnosis of an acute angle-closure glaucoma presenting in this way should always be at the back of one’s mind and can present in a similar fashion, although there are no systemic symptoms here (such as nausea and vomiting) which usually accompanies acute angle-closure glaucoma. The pre-test probability of glaucoma is increased further in this case by the presence of a positive family history. Tonometry should be a mandatory part of the examination in all such cases where a patient presents with a unilateral painful red eye and should never be forgotten as the condition is potentially sight-threatening. Never forget that missing a diagnosis of acute angle-closure glaucoma may result in permanent visual loss.

The other differential that should also feature high up in the differential diagnosis is an infectious process in view of the fact that the patient is normally a contact lenses wearer, although he wears disposable lenses and hygiene is good so this makes an infection due to contact lenses less likely. However, it does not rule out the possibility of an inflammatory process within the cornea (keratitis, corneal abrasion, corneal ulceration, dendritic ulcer etc.).

Having considered the possibility that this may be an iritis the astute clinician should try to find out the possible cause for such a process. The fact that ODQ the patient describes what sounds like sacro-ilitis makes the possibility of an HLA-B27 associated disease more likely for the cause for his iritis. There is no history of psoriasis or ankylosing spondylitis, or nothing from the sexual history to indicate a possible Reiter’s syndrome (no urethral discharge). In view of the loose stools and associated mucus this makes the possibility of an enteropathic arthritis associated with inflammatory bowel disease, or a reactive arthritis associated with infective diarrhoea, more likely. Indeed this patient turned out to be within the 10% of patients with inflammatory bowel disease that initially present with extra-intestinal manifestations of the disease as their main presenting problem (in this case an acutely painful red eye as an extra-intestinal manifestation of ulcerative colitis).