CHECKLIST FOR ABDOMINAL EXAMINATION – UNDERGRADUATE GUIDE

Ones in BLACK must do or comment on, Ones in BLUE must comment on only if present or applicable to patient. Content in blue should be in back of your mind so say when you are practicing but not during exam unless seen on the patient in the exam. **FOLLOW THIS CHECKLIST IN PUBLISHED ORDER**

Stage 1 – Pre Exam Checklist	
1. Alcohol Gel / Bare Below Elbows	
2. Introduction – "Shake hands/ hello my name is……."	
3. Consent – "Will it be okay if I examine your hands and tummy?"	
4. Positioning – Lie flat as possible, check if patient comfortable in said position	
5. Exposure – Say "ideally nipple to knee but to preserve dignity from costal margins to groin" and do so (groin crease must be visible). Expose patient yourself with consent	
Stage 2 – General inspection NB: POSITION YOURSELF TO THE RIGHT SIDE IF NOT ALREADY DONE SO AS ALL EXAMINATION SHOULD BE PERFORMED FROM THE RIGHT SIDE OF PATIENT	
1. Take a step back to end of the bed	
2. Comment on patient (obvious only) • Comfortable at rest or not • Obvious jaundice or pallor • Obvious signs of distress (e.g. hyperventilation, clammy, pale and gray)	
3. Comment on obvious tubes / connections attached to patient • Urinary catheters – is there urine / what colour? • Connected Drips – Saline / IV medication – antibiotics, analgaesia • Infusion pumps – PCA, sliding scale, TPN/enteral feed infusions • Ryles tube (NGT for drainage) • Nephrostomy tubes • Feeding tubes – NG / NJ tubes, PEG tubes	
4. Obvious abdominal findings • Distension yes / no • Stoma bags • Drains – wound drains, abdominal drains • Obvious scars Remember this is not close inspection of abdomen, So only mention obvious things. Don't commit to things at this stage.	
5. Comment on surroundings • Dietary status (check top of the bed) – NBM, FF, LD, Sips, D&F/E&D, diabetic diet, low residue diet etc • If no other clues "say no other obvious clues around the bed" • Fluid restrictions signs from top of bed	

• Food or drink around indicating e&d • Comment on monitoring attached – observations etc	
Stage 3: Peripheral Examination	
1. Hands • Nails – Clubbing (*Causes)Schamroth's window test, Koilonychia(iron deficiency anaemia), Leukonychia (low albumin – chronic liver disease) • Nails other – Splinter haemorrhages, tar staining • Warmth – Very cold and clammy (bleeding, dehydration) vs. warm and clammy (sepsis), or normal • Palmar erythema (chronic liver disease) • Dupuytren's contracture (chronic liver disease) • Liver flap – decompensated liver disease (acute/chronic) due to encephalopathy from ammonia toxicity • Other: Bruising, tattoos, jaundice • Other rare: Tendon xanthomata (high chol)	
2. Wrist • Pulse: rate, rhythm and volume	
3. Forearm /arm • Bruising / Tattoos / Rail road tracks (IVDU) • Fistulae for dialysis – active or old • Other rare – rashes (psoriatic), gouty tophi	
4. Offer to do blood pressure at this stage (examiner will say move on)	
5. Head • Face: Pallor or jaundice • Eyes - Conjunctiva (pull lower lid down on one side and ask patient to look up) – "No conjunctival pallor" or "pale conjunctiva – possible anaemia" - Sclera (lift upper lid and ask patient to look down) – "No scleral icterus (jaundice), normal sclera" or "Scleral icterus present" - Cornea: Arcus (old age / high chol), Kayser Fleischer rings – orange tinged (Wilsons disease) - Xanthelasma – Cholesterol deposits around the eyes • Mouth - Hydration (moist or dry) - Ulcers (IBD) - Dental hygiene - Glossitis (Vit B12 deficiency) - Angular stomatitis – iron deficiency anaemia	
6. Neck • In reality check all lymph nodes • But in exam say – "I would like to check all lymph nodes but due to time pressure I will examine for Virchow's node only" • Then Examine supraclavicular fossa for above, if such LN present it is called Troisier's sign – possible gastric/pancreatic cancer	

7. Chest • Spider Naevi - Central venule with spider like extensions of small thread veins. 3 or less normal. Any more abnormal. In distribution of SVC – seen in chronic liver disease • Gynaecomastia / Hair loss	
Stage 4: Abdomen	
1. Closer inspection – Now is the time to look closely at things you may have briefly commented on in general inspection • Distension – Yes / No • Bruising - From Clexane , insulin injections - Rare: Grey Turner's or Cullen's sign – Retroperitoneal haemorrhage • Scars : - Look for common scars: midline laparotomy, gridiron / appendectomy scar / open cholecystectomy scar - If recent scar comment on any erythema/cellulitis, whether clips/stitches insitu, temperature, swelling (?collection) around scar or discharge • Stomas – see how to examine a stoma checklist. Follow this if stoma noted. • Drains: location, content in bag (blood, serous, haemoserous, pus, bile, faeces, urine) • Obvious swelling (e.g. hernias) – ask patient to cough and look in groin and then ask to cough again and look in the rest of the abdomen for obvious hernias.	
2. Ask the patient if in pain or any pain in the tummy	
3. Warn them you will press on the tummy and say "let me know if you have any pain"	
4. Other – warn if you have cold hands etc and rub them to make them warm	
5. Kneel down by the side of patient on the right side	
6. Palpation (superficial and deep) • Superficial, starting either from RIF or from most distal to site of pain • Working systematically through all 9 quadrants • KEEP LOOKING AT PATIENT FACE NOT ABDOMEN • Followed by deep palpation • Feeling for: Areas of tenderness, masses, especially looking for pulsatile mass above the umbilicus. (if felt see peripheral vascular exam checklist) • If area of tenderness need to establish if soft or signs of peritonism • Signs of peritonism include: Guarding (involuntary), rebound	

- If other mass felt comment on site, size, shape, surface, consistency, tenderness, mobility, fluctuance

REMEMBER: Peritonism can be localised or generalised.
REMEMBER: Guarding can be voluntary or involuntary. Latter is true sign of peritonism. In former patient can be distracted

7. Palpation (for organomegaly)
    - For hepatomegaly
        - Start in RIF, work upwards to RUQ
        - Trying to feel liver edge as patient inspire on the edge of your hand
        - Therefore important for you to control patient breathing
        - Say “breath in” then “breath out” – make sure hand in position on the abdomen when you say breath in
        - If edge felt work along it to picture the shape then feel over it to see if smooth/irregular, whether tender or not.

REMEMBER: The liver is in the RUQ and expands inferiorly, moves with respiration, cannot get above it and dull to percussion

- For splenomegaly
    - From RUQ work to LUQ (as this is direction of enlargement of spleen)
    - Similar technique mandatory as with liver, control patient breathing
    - If no edge also feel upwards from the LIF as enlargement may be vertical in a small proportion
    - If edge felt follow same steps as with liver

REMEMBER: The spleen is in the LUQ and expands obliquely, moves with inspiration, has the splenic notch, cannot get above it and is dull to percussion. The spleen must typically be > 3 times normal size to be palpable

- Balloting the kidneys
    - Place one hand under the flank and find the spine with tips of fingers, then come 1-2cm laterally (kidneys are medial and deep).
    - Place other hand on top of the side just above the umbilicus and to the side of interest.
    - THE TOP HAND DOES NOT MOVE
    - Push with the bottom hand to feel a sensation of a mass on top hand.
    - Positive only if enlarged. Kidneys not palpable in health

REMEMBER: Kidneys do not move with inspiration, you can get above them, dull to percussion and are ballotable

8. Percussion
    - If areas of tenderness if not already done so you may wish to percuss to see if percussion tenderness present which is a sign of peritonism
    - Percuss for hepatomegaly
        - Percuss from RIF up to RUQ until change of tone to dull from resonant
        - Then go to top of right side of chest and work down right side of chest until change in tone to dull
        - Keep working down to abdomen until change in tone from dull to resonant
        - Use an approximate length of dull distance as size of liver

NB: In reality percussion for organmegaly is if a liver edge is felt. However, for the exam you will be required to show how to do this in a normal healthy patient or one with hepatomegaly.

Percussion for splenomegaly is similar but working obliquely from RIF to LUQ and then down left side of chest to work out approximate size.

9. Tests for fluid (ascites)

    - Fluid thrill
        - Do first – (if abdo full of ascites second may not work)
        - Examiner or patient to place hand pressed deeply in midline (stops energy from being transmitted across abdominal wall)
        - Place dominant hand palm side down on abdomen of patient distal to examiners hand
        - With other hand gently tap tummy on the opposite side. Should feel the tap on your hand on opposite side.
        - This only occurs in presence of ascites

    - Shifting dullness
        - Start percussing horizontally along a transverse line working distal from umbilicus
        - Until resonant changes to stony dull (fluid)
        - At the point of change keep hand still to mark point
        - Ask the patient to “roll towards me”
        - Then wait for 10 seconds
        - Then percuss at the same point
        - If resonant at that point then positive shifting dullness (i.e. presence of ascites)
        - If still dull then not fluid or negative test

NB: In reality these tests will only be done if obvious signs of distension as they

help distinguish between fluid and other causes of distension. You may be asked to show how these tests on a normal patient in the exam do. So always offer to do them. If the examiner does not want you to do them they will ask you to move on or talk them through it instead.

REMEMBER: Five F's for abdo distension – flatus, fluid, faces, fat, foetus

10. Auscultate – four quadrants
    - Bowel sounds
        - Present or absent
        - If present are they normal, sluggish or tinkling
    - Renal bruit – comment only if you here them

STAGE 5: The Legs

1. Inspect for swelling pitting oedema
    - If bilateral swelling / oedema: Heart failure, low albumin (e.g. liver disease, nephrotic syndrome)
    - If unilateral think DVT
    - Check for calf tenderness
    - Comment if patient is wearing TEDs (VTE prophylaxis) stockings or not)

STAGE 6: TO FINISH OFF

Turn to the examiner and say:
"To complete my examination I would like to:"

- Examine the hernia orifices
- Examine the external genitalia
- Digital rectal examination (or PR)
- Urine DIP

STAGE 7: COMPLETION

- Thank the patient
- Offer to help get dressed and cover up
- USE ALCOHOL GEL AGAIN AT THE END

STAGE 8: PRESENT FINDINGS

END OF EXAMINATION

NB: In the OSCE due to time constraints you may be asked to "move on" during various parts of the exam (e.g. feeling for spleen, looking for fluid thrill / shifting dullness). Offer to do all of above and if examiner wants you to move on they will direct you. Be aware of this and do not be put off by this.