Fourth Stage

General Surgery

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Lecture 2

PREOPERATIVE PREPARATION (HISTORY TAKING)

History taking is a most important process and must be rehearsed well. No matter how efficient and skilled the surgeon is, he or she must make the patient feel confident.

Introduction to the patient is a most important moment, this allows a rapport to develop with the patient that will facilitate the rest of the interview and enhance the possibility of achieving an appropriate diagnosis and treatment plan.

Premature physical examination of a lesion may not only reduce the patient's confidence but also unnerve the surgeon if the diagnosis is not immediately apparent with visual examination.

Patient I.D

Name

Age

Sex

Occupation

Religion

Address

History of the presenting Complaint: This is the patient's opportunity to tell the surgeon about the problem and it is important to avoid leading questions.

many will also have difficulty in remembering the timescale of the illness. A good initial beginning with history taking is to ask the patient to think back to the start of the problem to ensure that he or she gives an account in chronological order.

It is also important, while the patient is giving the history, to ensure that he or she gives a clear account of what has happened, and does not discuss what he or she thinks is the cause of the problem.

Patients wishing to avail themselves of the best medical attention will usually wish to please and will therefore tend to agree, using a positive response, to any direct question asked.

This problem can be overcome by providing the patient with alternatives: 'Is the pain constant?' is more likely to be answered accurately if the patient is asked 'Is the pain constant or not?'. Several features of the presenting problem should then be elicited:

- **When was the problem first noted?**
- **What is the location?**
- **Are the symptoms continuous or intermittent?**
- **Does anything make the problem' better or worse?**
- **Is the problem getting better or worse? Relevant medical history This is the surgeon's chance to take a history from the patient.**

This part has two aspects:

first, the opportunity to elaborate on any points in the history that the surgeon felt were unclear;

second, to enquire from the patient any aspect of his or her health that might otherwise influence the treatment plan.

Family history: Two main items are worth enquiring regarding family history:

(1) is there a genetic family problem, especially any blood-related problem such as haemophilia?

(2) has any member of the family had any problem with anaesthetics, Drug therapy As outlined above, it is critical to know about certain drugs prior to performing any surgery. Dosage of corticosteroids and anticoagulants need to be controlled and monitored carefully.

Social history Knowledge of tobacco smoking and alcohol consumption will not only inform the surgeon of the potential risks for general anesthesia and surgery but also the patient's likelihood of smoking- and alcohol-related diseases.

Allergies: A history of asthma and anaphylaxis is important.

The surgeon must know about drug allergies.

Past surgical history:

1. For Each Procedure.
2. Timing - when they had the procedure.
3. Surgeon - who performed the procedure.
4. Indication - why the procedure was performed, and what symptoms they were experiencing prior.
5. Complications - whether the surgery resulted in any undesired effects, such as infection, bleeding or pain.

Past medical history:

What is included in the past medical history?

A record of information about a person's health. A personal medical history may include **information about allergies, illnesses, immunizations, hypertention.diabetes; cardiac ischemia.**

Reviews of systems:

GENERAL
Fatigue/malaise
Fever/rigors/night sweats
Weight/appetite
Skin: rashes/bruising
Sleep disturbance

CARDIOVASCULAR
Chest pain/angina
Shortness of breath (including on exercise)
Orthopnoea
Paroxysmal nocturnal dyspnoea
Palpitations
Ankle swelling

RESPIRATORY
Chest pain
Shortness of breath/wheeze
Cough/sputum/haemoptysis
Exercise tolerance

GASTROINTESTINAL
Appetite/weight loss
Dysphagia
Nausea/vomiting/haematemesis
Indigestion/heart burn
Jaundice
Abdominal pain
Bowels: change/constipation/diarrhoea/
description of stool/blood/mucus/flatus

MUSCULOSKELETAL
Pain/swelling/stiffness – muscles/joints/
back
Restriction of movement or function
Power
Able to wash and dress without difficulty
Able to climb up and down stairs

GENITO-URINARY
Frequency/dysuria/nocturia/polyuria/oli
Haematuria
Incontinence/urgency
Prostatic symptoms
Impotence
Menstruation (if appropriate):
menarche (age at onset)
duration of bleeding, periodicity
menorrhagia (blood loss)
dysmenorrhoea, dyspareunia
menopause, post-menopausal blee

CENTRAL NERVOUS SYSTEM
Headaches
Fits/faints/loss of consciousness
Dizziness
Vision – acuity, diplopia
Hearing
Weakness
Numbness/tingling
Loss of memory/personality change
Anxiety/depression

ENDOCRINE
Menstrual abnormalities
Hirsutism/alopecia
Abnormal secondary sexual features
Polyuria/polydipsia
Amount of sweating
Quality of hair

SKIN
Rash
Pruritus
Acne

Common surgical symptoms :Pain anywhere should have the same features elicited. These can be summarized by the acronym **SOCRATES.**

• **Site**: Where is the pain, is it localized, in a region, or generalized?

• **Onset**: Gradual, rapid, or sudden? Intermittent or constant?

• **Character**: Sharp, stabbing, dull, aching, tight, sore?

• **Radiation**: Does it spread to other areas? (From loin to groin in ureteric pain, to shoulder tip in diaphragmatic irritation, to back in retroperitoneal pain, to jaw and neck in myocardial pain.)

• **Associated symptoms**: Nausea, vomiting, dysuria, jaundice?

• **Timing**: Does it occur at any particular time?

• **Exacerbating or relieving factors:** Worse with deep breathing, moving, or coughing suggests irritation of somatic nerves either in the pleura or peritoneum; relief with hot water bottles suggests deep inflammatory or infiltrative pain.

Does the pain relate to surgical interventions? Terms used in General Surgery and History Taking: Dyspepsia (epigastric discomfort or pain, usually after eating) What is the frequency? Is it always precipitated by food or is it spontaneous in onset? Is there any relief, especially with milky drinks or food? Is it positional?

Dysphagia (difficulty during swallowing) Is the symptom new or longstanding? Is it rapidly worsening or relatively constant? Is it worse with solid food or fluids? (Worse with fluids suggests a motility problem, rather than a stenosis.)

Oesophageal reflux (bitter or acidic tasting fluid in the pharynx or mouth) How frequently? What colour is it? (Green suggests bile whereas white suggests only stomach contents). When does it occur (lying only, on bending, spontaneously when standing)? Is it associated with coughing?

Haematemesis (the presence of blood in vomit) What colour is the blood (dark redbrown 'coffee grounds' is old or small-volume stomach bleeding; dark red may be venous from the oesophagus; bright red is arterial and often from major gastric or duodenal arterial bleeding)?

Bleeding per rectum What colour is the blood? Is it pink-red and only on the paper when wiping? Does it splash in the pan? (Both suggest a case from the anal canal.) Is it bright red on the surface of the stool (suggests a lower rectal cause)? Is the blood darker with clots or marbled into the stools (suggests a colonic cause)? Is the blood fully mixed with the stool or altered (suggests a proximal colonic cause)?

Haematuria (blood in the urine) Does the blood occur at the start (suggests bladder origin), during, or end (suggests prostatic or penile origin) of the stream? Is there associated pain (suggests infection or stone disease)? Dyspnoea (difficulty in or increased awareness of breathing) When does the dyspnoea occur—quantify the amount of effort. Is it positional?

- **Orthopnoea:** Difficulty in breathing that occurs on lying flat; quantify it by asking how many pillows the patient needs at night to remain symptom-free.

- **Paroxysmal nocturnal dyspnoea:** Intermittent breathlessness at night. Both orthopnoea and paroxysmal nocturnal dyspnoea suggest cardiac failure.