Preface

The Disease-Based Physical Examination

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Editor

Despite a decline in both the quality and the quantity of teaching of the physical examination in medical schools and postgraduate training programs over the past 4 decades, the physical examination remains a vital component of the patient assessment. Unlike most laboratory and radiologic tests, the physical examination provides immediate, often essential information at the patient bedside. Since the exam follows the history, it provides an opportunity to test hypotheses initially generated while the history is taken. For example, will a patient complaining of dyspnea, orthopnea, paroxysmal nocturnal dyspnea, and lower-extremity edema have an elevated jugular venous pulse, displaced cardiac point of maximal impulse, an S3 and crackles indicative of congestive heart failure? Will the patient suffering from alcoholism who presents reporting that her skin has turned yellow and that her pants no longer fit due to increased abdominal girth have dilated abdominal vessels, decreased body hair, and palmar erythema indicative of cirrhosis of the liver? The physical exam often also provides crucial information regarding response to therapy. Has the patient admitted to the hospital for erysipelas improved since being started on antibiotics? Has the jugular venous distension in the patient with congestive heart failure decreased after diuresis? Knowledge and skill at assessing disease-specific findings on the physical examination and, where possible, knowing and understanding the test characteristics of these findings elevate the clinician from novice data gatherer to master clinician.

In our health care systems that tend to elevate and reward frequent and sometimes unnecessary test ordering by providers who often don’t feel confident in their own physical examination skills, acquiring and then maintaining disease-focused physical exam skills is difficult. A sense that technology, no matter the cost, is almost always better can lead to a sense of nihilism about the physical examination from the perspectives of both beginners and the experienced. Fifteen years ago, while working at a

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busy, urban hospital, I had consulted one of our best cardiologists—a clinician known
to be highly skilled in the cardiac physical exam. I happened to be at the nursing sta-
tion when he exited my patient’s room.

“Can I borrow your stethoscope?” he asked me.
“What kind of a cardiologist does not carry a stethoscope?” I quipped.
“I stopped carrying it last year,” he responded. “Now I mostly just order an Echocar-
diogram on all of my new patients, and I don’t worry about listening to their hearts.
" He was completely serious. Despite the years he had invested in building up his
considerable skillset in the cardiac physical exam, it had become less time
consuming and, from his perspective, higher yield to push a few buttons in the
electronic medical record and order an echocardiogram. As depressing as this
anecdote is, the counter to it is that I have rarely met a learner who wasn’t inter-
ested in improving her physical examination skills and learning more about the art
and history of physical diagnosis.

However, the era of bedside rounds, bedside presentations, and bedside phys-
ical examination has been supplanted by the electronic medical record and a
golden age of radiology. Medical schools teach the physical examination, but it is
mostly taught in state-of-the-art simulation centers on healthy standardized pa-
tients paid by the hour and devoid of significant physical findings. They are often
taught to perform the exam in a rote fashion, not really knowing what they are look-
ing, feeling, or listening for. It is good to know what is normal—clearly essential
knowledge in order to be able to know what is abnormal—but this physical exam-
ination teaching often fails to continue into the setting of the hospital or clinic in the
company of meaningful and authentic patients with real disease and physical exam
abnormalities. The opportunity to compare and contrast normal with abnormal
physical findings is not taught and cultivated, and so these skills wither, if they
ever existed at all.

In the stressful and hectic work environments of modern clinics and hospitals, phys-
ical finding rounds—sometimes called “Discovery Rounds”—and bedside rounds
have faded to practically nothing. The vast preponderance of attending rounds time
is spent rounding in conference rooms or hallways and not at the bedsides of patients.
A cardiac murmur or an extra heart sound is a recording heard in a classroom, not in a
patient in the Cardiac Care Unit or the Emergency Department. When learners do
come across patients with notable physical findings during their work, the findings
are often missed, or the learner fails to have these findings corroborated by a clinician
with adequate skill or confidence or because a clinician who possesses skill and con-
fidence in the physical exam does not have the time to come and verify findings at a
patient’s bedside with a curious learner.

This issue seeks to emphasize the physical examination in specific diseases. Almost
by definition, if readers have made it this far in this issue, they desire to learn more
about disease-specific physical findings. Acquiring mastery in the physical exam is
a highly rewarding but challenging journey that only comes with many years spent
in the company of patients. Knowledge of test characteristics—whether sensitivity
and specificity or positive and negative likelihood ratios—requires dedicated study
as well as humility about the fact that for some physical exam maneuvers, there are
little data in the medical literature. The experienced practitioner of the physical
exam recognizes that some findings may clinch a diagnosis—lid retraction and fine
tremor in hyperthyroidism, for example—while others, such as the puddle sign in as-
cites, are practically useless and not worth subjecting patients to.
This issue attempts to build upon a foundation of curiosity on the part of the reader and upon the reader’s desire to know more about disease-specific physical examination. The humble goal of this issue is to make the reader a better and more skilled clinician, and above and beyond that, to help patients receive the excellent care that they seek and deserve.

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