



A new series, an old concept, continued value

This month we introduce a new series, The Physical Examination, kicked off by a paper by Drs. Diaz-Guzman and Budev on evaluating pleural effusions (page 297). The series will be managed by David Rolston, MD, our deputy editor. We encourage you to submit your suggestions for topics (or your willingness to write articles on these topics) to him at ccjm@ccf.org.

The physical examination used to be a foundation of clinical practice, but it is under assault. A specialist in inpatient medicine here at Cleveland Clinic decried the inefficiency of time spent by residents performing and documenting the examination. How often, he asked, does the examination actually change the diagnostic workup? Academic provocateurs have done sensitivity and specificity analyses on components of the physical examination and found them to be imperfect. Imperfect, yes, but I would argue not worthless.

One reason for the imperfection is that skills of examination are not always appropriately emphasized during training, and then are not utilized in practice (especially in a 10-minute visit). Several published studies describe the attrition of examination skills. While doing teaching rounds as a visiting professor, I have found that some residents and medical students have difficulty distinguishing a murmur of aortic sclerosis from one of aortic insufficiency or detecting epitrochlear adenopathy.

The structured physical examination still fulfills a legitimate need. When approaching a patient with an ill-defined, potentially multisystem disorder, the examination should provide an initial “staging” of the disease process that contributes to the construction of the differential diagnosis, and thus refines the ordering of specific tests.

Adenopathy, enlarged lacrimal glands, and retinal exudates can all be asymptomatic and, if detected, may affect the differential diagnosis. Yet how many examinations focus attention on these areas? We often teach (and we were taught) the physical examination as a rote skill to be performed in toto. But the examination is not a static procedure. It needs to be tailored to the patient in front of us, in a reiterative, reflective manner. I am more likely to find adenopathy or an abdominal aneurysm if I am specifically looking for it, as opposed to performing a perfunctory examination. I am less likely to be struck by a pronounced second heart sound if I am not considering pulmonary hypertension as a possible explanation for the patient's dyspnea.

I believe that a reflective physical examination is effective and valuable. Besides, our patients actually expect (and deserve) to be carefully examined.

BRIAN F. MANDELL, MD, PhD
Editor-in-Chief