INTRODUCTION

In the practice of medicine, examining the patient fully and not in part is rewarding—as many a senior (experienced) physician will corroborate.

After symptom elicitation with probing questions like a lawyer, a physician should go through the exercise of symptom analysis and later perform a complete physical examination.

Relevant investigations should be asked for.

The author realizes that all this is known to every physician, but we also know that this does not happen in many consultations for various reasons.

The author is giving hereunder a few examples of transgressing the basic principle—"examine the whole patient and not part of him" however trivial the complaint.

• A Cauda Equina tumor that remained undetected for 10 years
  A middle-aged male who had difficulty in micturition saw an urologist initially without consulting a family physician. The urologist concentrated on the urinary tract and a colleague of his in the United Kingdom suggested sectioning the urethral sphincter.
  A routine clinical examination—including the nervous system—because he also had difficulty in bowel evacuation—revealed a Cauda Equina lesion.
  The lesson in this case is that one should take cognizance of seemingly irrelevant symptoms. The bowel problem which presented along with wasted gastrocnemius, absent ankle jerks and saddle anesthesia helped to detect the tumor which remained undetected for 10 years and the urologist clinician barking up the wrong tree.

• Hazard of a cursory examination of a fully-dressed patient
  A middle-aged muslim lady in burka was seen by a practitioner. Not wanting to embarrass her, he did a cursory chest examination for her cough and asked for a chest X-ray.
  The X-ray showed a localized shadow in one lung field. This was taken as TB and antituberculosis treatment (ATT) was advised.
  After 3 months, a repeat chest X-ray showed that the lesion was unchanged. The practitioner had the clothes removed by persuasion and what was found—shocked him.
  It was a lipoma on the chest wall that casts the shadow in the X-ray—interpreted as patient (PT).
  • Unilateral exophthalmos of thyrotoxicosis in a young boy—misjudged by faulty interpretation of CT of the orbit in the early days of CT
    A boy with exophthalmos in one eye was straight away referred to a neurosurgeon and he proposed surgery since the CT of the orbit was interpreted as showing a tumor of the medical rectus.
    Proper examination of the patient revealed thyrotoxicosis and the “eye problem” regressed with appropriate treatment.
    *The lesson:* Examine the whole patient and not part of him.

• A nodule in the scrotum—key to diagnosis of cerebral cysticercosis
  A patient with recurrent seizures was examined by an examination going bright PG student.
  He went through the examination in the conventional manner—including examination of the genitalia.
  A subcutaneous nodule in the scrotum was discovered by him. The patient being a pork eater, the candidate suggested cysticercosis as a possibility for his seizures. Biopsy of the nodule and CT of the brain confirmed the suggested diagnosis.

• Familiarity breeds contempt
  A surgeon in a teaching hospital demonstrated a clinical problem to a group of medical students in their clinical years.
  A young boy with an abdominal lump: The surgeon asked the boys to examine the abdomen and suggest the probable diagnosis. Boy after boy gave various diagnoses—rolled up omentum, omental cyst, etc.
  The first girl student, who examined the patient, pulled the trousers of the patient, examined the genitalia and discovered an undescended testis—and suggested a tumor in the abdomen arising from an undescended testis.
  The surgeon, a wit, looked at the boys and said “familiarity breeds contempt”. Apparently because the boys did not examine the genitalia in abdominal examination.
  The author has given some instances in clinical practice, where the basic principle of examining the whole patient and not part of him, will stand the clinician in good stead. The reward will be wholesome.