Complete CVS PEx checklist -Ahmad AlHurani (1.1)

WIPPER and the intro

Introduce yourself and shake hands
Washing of hands and appropriate hand hygiene
Asking for permission
Ensuring the room's privacy
Ensuring the environmental warmth and good lighting conditions
\Box Asking for appropriate exposure (from the waist and above)
\Box Asking the patient to be in the appropriate position (semi-sitting at 45 degrees in bed)
Relocating to the right side of the patient
Asking for a chaperon
"I have all of my equipment's"
General look of the patient
Consciousness, alertness and orientation of the patient to time, place and

person (After asking the 3 questions)

Comment on the patient's **position and comfort**

Comment on the patient's **external devices** status (No oxygen masks, nebulizers etc.)

Comment on respiratory rate (Not tachypneic), respiratory distress

Comment on cyanosis

Comment on **edema**

Vital Signs

Measure the vital signs (make sure you can mention all of them + BMI)

Hands

INSPECTION: Starting with the hand

- 🗌 No cyanosis
- □ No pallor
- No palmar erythema
- □ No petechial rash
- 🗌 No Xanthomata (Hyper-lipidemia)
- □ No Janeway lesion's (not painful, thenar region) (Infecting endocarditis)
- □ No Osler's nodes (painful, tip of fingers) (Infective endocarditis)
- □ No tar staining
- □ No IV drug abuse signs

moving on to the nails;

- □ No clubbing
- □ No splinter hemorrhages (Infective endocarditis)

End this section by examining for tremor

PALPATION of the hands:

Check hands' temperature, dry/sweatiness

Check Capillary refill (<2 seconds for normal cap refill)

Check pulses (BILATERALLY)

All pulses are done with 2 fingers, except for radial;

Radial pulse

☐ Radial pulse; using 3 fingers, lateral to flexor carpi radialis, after 1 minute (do 15sec) , comment on the rate, rhythm, volume, character and compressability.

Check both radial pulses simultaneously to assess "Radio-radial delay", a sign for aortic dissection

Check radial and femoral pulses simultaneously to assess "Radio-femoral delay", a sign for aortic coarctation (ONLY MENTION)

☐ Calculate pulse deficit, we don't do this during exams (Mention it), but a difference of +10 BPM is abnormal

□ Now ask the patient about shoulder pain first, if none is present, elevate hand above level of patient's head while checking the radial pulse, to check for "Collapsing pulse"

$\hfill\square$ Don't forget to comment your findings, mention the HR measured, regular
rhythm, normal volume, normal character, compressible, no radio-radial/radio-
femoral delays, no pulse deficit, no collapsing pulse.

Brachial pulse

Using 2 fingers, assess the brachial pulse medial to the biceps tendon in antecubital fossa. (Bilaterally)

Mention rate, rhythm,volume,character and compressability

Carotid pulse

Using 2 fingers	s, gently assess th	e carotid pulse	anterior to	sternocleido	mastoid
near the jaw.					

Bilaterally, but Never feel both sides at the same time as that might trigger vasovagal attack, comment on rate, rhythm, volume, character and compressibility

Ask the patient to hold his breath, and auscultate for the bruit

Comment on the bruit

Femoral (mention only), posterior tibial and dorsalis pedis are done in PVS / we do them if the station was a focused pulses station

Face

	Check eyelids for	xanthelasmata	(Hyper-lipidemia)
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Check iris for Corneal arcus (Hyper-lipidema)



Mention that you need fundoscopy to check for Roth spots (Infective endocarditis), HTN/DM changes

Check for malar flush on cheeks

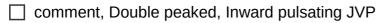
Check for any signs of central cyanosis (Under the tongue), peripheral cyanosis (On the lips)

JVP Examination

As JVP is very important and might be a full station on its own, make sure you're ready for it.

Inspection

Rest the pt's head on a pillow (Make sure its rested, we need sternocleidomastoid relaxed), ask him to turn his head slightly to the left, using a torch, try to find JVP pulsation.



Palpation

 $\hfill\square$ After doing the usuals for any palpation, try to palpate it

JVP is normally impalpable, so make this comment and move on

Compress the root of the neck, JVP should disappear, comment that it disappeared after compressing root of the neck

 \square Ask the patient to lie flat \rightarrow Increased JVP (comment)

 \square Ask the patient to sit straight \rightarrow Decreased JVP (comment)

 \square Ask the patient to take a deep inspiration \rightarrow Decreased JVP (comment)

Check abdominojugular reflex, press on the Rt upper quadrant for 30 seconds (don't do full 30 of course), on a positive reflex (normally positive), JVP increases (comment whether positive or negative reflex)

Measuring JVP

Use a ruler, put it on the sternal angle (Straight with the ground not pt's body), assess using a straight object that's put on the highest pulsation you see of the JVP, measure on the ruler and add 5cm and comment on the measured JVP (Normally it's <9cmH20)

Precordium Examination

Inspection

From the foot of the bed;

First ask the	patient to take	e a deep breath
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Comment "Symmetrical chest with no visible deformities, bilateral movement of chest with respiration"

From the right side of the pt;

Check for scars, make sure you know what scars mean; midsternotomy is for CABG, left submammary is for mitral valvotomy, infraclavicular is for pacemakers. (mention no scars)

mention no swellings, visible masses, dilated veins.

mention normal hair distribution

Using the torch, mention afterwards that you see no visible pulsation/no visible apex beat

Palpation

hand hygiene, warm hands, ask for permission, ask for presence of any pain, hold eye to eye contact to assess tenderness

generally palpate the chest, don't miss any point, use your whole hand

comment no palpable masses, no tenderness

Apex beat

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	-			g	,		

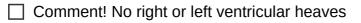
try to find it using 2 fingers (roll the pt to the left side if you couldn't find it)

 \Box locate it \rightarrow which intercostal space, is it midclavicular?

Comment; gently tapping apex beat, located in the 5th intercostal space, midclavicular line.

Heaves

Ask the patient to hold breath, assess both right ventricular heave (lower left sternal angle), and left ventricular heave (apex, hence "apical heave") (EXPIRE AND HOLD)



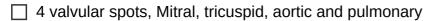
Thrills

$\hfill \Box$ Using your flat fingers; not the tips nor the base, check for thrills in 4 locations;
apex, parasternal, right and left second intercostals.

Comment! No thrills

Auscultation

First, with the diaphragm, 6 spots



2 radiation spots;

1 carotid, for radiation of aortic stenosis

1 left axilla, for radiation of mitral regurgitation

Second, with the bell, 4 spots

4 valvular spots (some only use the bell for mitral and tricuspid, you'll not be penalized for more spots anyway)

Last, finish with 2 maneuvers

Aortic regurgitation, using the diaphragm, ask the patient to sit straight and then lean forward, examine (aortic area), and Era's area.

☐ Mitral stenosis, using the bell, ask the patient to roll to his left side and then put the bell on the apex.

Comment on the whole auscultation; "Normal S1,S2, no S3,S4, normal physiological splitting of S2, no murmurs, no added sounds like opening snap, ejection click or friction rub

Ending the station

□ I will auscultate lung bases for crackles

I will examine the abdomen for ascites; hepatomegaly, sacral edema

I will examine lower limb for edema, ulcers, pulses