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
- [ ] Asking for appropriate exposure (from the waist and above)
- [ ] 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

- [ ] Examine for fine 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”
- [ ] 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, gently assess the carotid pulse anterior to sternocleidomastoid 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)
- [ ] Check iris for Corneal arcus (Hyper-lipidema)
- [ ] Check conjunctiva for pallor and petechial hemorrhage (Infective endocarditis)
- [ ] 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.

☐ comment, Double peaked, Inward pulsating JVP

Palpation

☐ 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

☐ Ask the patient to lie flat → Increased JVP (comment)

☐ Ask the patient to sit straight → Decreased JVP (comment)

☐ Ask the patient to take a deep inspiration → 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 a deep breath
- [ ] 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

- [ ] Try to find it using your whole hand
- [ ] try to find it using 2 fingers (roll the pt to the left side if you couldn't find it)
- [ ] locate it → 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)
- [ ] Comment! No right or left ventricular heaves

Thrills

- [ ] 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

- [ ] 4 valvular spots, Mitral, tricuspid, aortic and pulmonary
- [ ] 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