General Physical Examination

Beginning the Examination:

OSCE Comment: Standing on the right side of the patient & performing hand washing.

- *On the patient's right side, perform hand washing while introducing yourself and your chaperone.*
- *Ensure **warm temperature**, **good illumination** and **privacy**.*

OSCE Comment: The temperature is warm, the room is well lit, and privacy is ensured.

- *Instruct the patient to sit upright and expose the area from above the umbilicus to the neck.*

OSCE Comment: The patient is sitting upright and the area from the umbilicus to the neck is exposed.

General Appearance:

Ask the patient about time, place and person.

OSCE Comment:

- **The patient is conscious, alert, and oriented to time, place, and person.**
- **The patient looks generally well.**
- **There is no slurring of speech or hoarseness of voice, and no abnormal facial expressions such as agitated or startled expressions.**

Breathing

Observe the patient's chest.

OSCE Comment:

- **The patient is breathing well, does not use accessory respiratory muscles, is not in a tripod position, and is not leaning forward and there is no audible breath sound like wheezing or stridor.**

Medical Devices

Observe the surroundings of the patient.

OSCE Comment:

- **There are no oxygen delivery devices such as masks or nasal cannula.**
- **There is no oxygen monitor, no IV line, no cannula, no catheter, and no inhalers present.**

Skin and Color

Observe the patient's skin.

OSCE Comment:

- **There is no cyanosis, no pallor, no jaundice, no skin discoloration, no hypercarotenemia, and no bruises.**

Odor

Move a bit closer to the patient.

OSCE Comment:

- **The patient's body odor is normal.**

Body Habitus and Symmetry

Observe the patient's body.

OSCE Comment:

- **There is no obvious weight loss like cachexia.**
- **The patient is not overweight or obese.**
- **The body appears symmetric.**

Behavior, Posture, and Gait

Ask the patient to walk around and observe him from top to bottom and from the side.

OSCE Comment:

- **The patient appears calm and not anxious, with normal posture and normal gait upon walking.**

Vital Signs

Ask the patient if they have any pain and warm your hands.

OSCE Comment:

- **I would like to assess the vital signs, including:**
    - **Heart rate**
    - **Oxygen saturation**
    - **Blood pressure**
    - **Respiratory rate**
    - **Temperature**
    - **BMI**
- **Heart rate**: *Palpate the **radial pulse** using three fingers for **one full minute**.*
- **Blood pressure**:
    - *Locate the **brachial artery** using the index and middle fingers, on the **medial aspect of the antecubital fossa**.*
    - *Measure BP in **both arms**, at **heart level**, while the patient is at **rest**.*

- **Respiratory rate**: *Count respirations for **one full minute** while acting as if measuring the pulse.*
- **BMI**: Calculated using the formula: weight (kg) / height $(m)^2$

Nutritional status	BMI non-Asian
Underweight	<18.5
Normal	18.5–24.9
Overweight	25–29.9
Obese	30–39.9
Morbidly obese	≥40

General Inspection – Head to Neck

Hair and Eyebrows

Ask the patient's hairline and eyebrows.

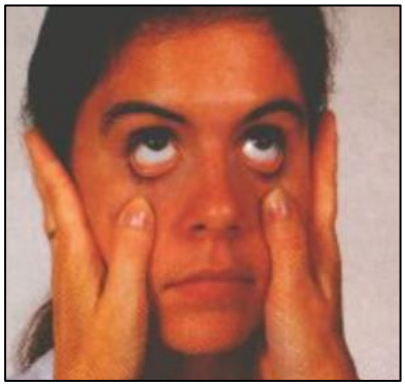
OSCE Comment:

- **Hairline is normal**, with **no alopecia**.
- **Eyebrows appear normal**.

Eyes

Observe the patient's sclera.

Ask the patient if they have any eye pain and warm your hands, then gently lower both lower eyelids to inspect the palpebral conjunctiva.



OSCE Comment:

- **No scleral jaundice bilaterally.**
- **No conjunctival pallor bilaterally**

Nose

Ask the patient if they have any neck pain, then ask the patient to raise their head slightly.

OSCE Comment:

- **Nasal mucosa appears normal.**
- **No nasal flaring.**

Mouth and Tongue

Inspect lips and ask the patient to lift their tongue to inspect the mucosa and protrude the tongue to assess the following;

OSCE Comment:

- **Normal lip and tongue color, no central cyanosis**.
- **Good dental hygiene**, **no caries**.
- **Normal oral odor**.
- **Tongue is normally smooth** and **symmetrical**, with **no deviation**, **ulceration**, **masses, lesions**, **fluctuations**, or **abnormal size.**
- **Normal oral mucosa**, with no **dryness**, **pallor**, or **cyanosis**.

Face

Inspect the patient's face.

OSCE Comment:

- **Face is symmetrical, with no swelling.**
- **Normal facial color, no cyanosis, no pallor, no jaundice.**

Hands Examination

Inspection

*Ask the patient to extend arms, show both **palmar and dorsal** sides, and open fingers fully.*

OSCE Comment:

- **No deformities such as ulnar deviation or swan neck deformity.**
- **Normal hand color with no peripheral cyanosis or palmar erythema.**
- **No thenar or hypothenar muscle wasting.**
- **Normal nail shape with no deformity, no pitting, no onychomycosis, no yellow nails, and no tar staining.**
- **No Dupuytren's contracture.**

Palpation

*Ask for **consent** and **any pain** and **warm your hands** before touching.*

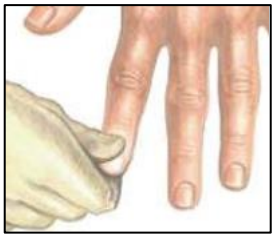
*Use **dorsum and palm** of your hand to assess for **temperature**.*

OSCE Comment: Normal temperature bilaterally.

*Gently palpate for **tenderness** while maintaining **eye contact**.*

OSCE Comment: No tenderness bilaterally.

Capillary Refill & Skin Turgor



*Perform **capillary refill test**: press on the nail bed; refill should be <2 seconds.*

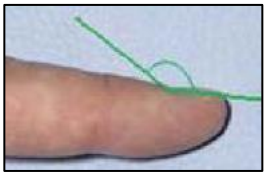
OSCE Comment: Normal capillary refill.

*Perform **skin turgor test**: pinch skin; it should return promptly.*

OSCE Comment: Normal skin turgor.

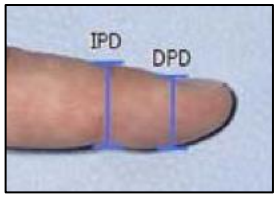
Clubbing

- *Use the **index finger** of one hand only:*
    - *View finger **from the side** and observe the **hyponychial angle**.*



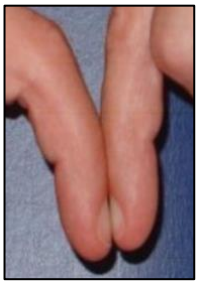
OSCE Comment: The Hyponychial angle is <160°.

    - *View finger **from the side** and check the* **distal phalangeal to interphalangeal depth ratio** — should be <1.



OSCE Comment: The distal phalangeal to interphalangeal depth ratio is less than 1.

    - *Perform **Schamroth's window test**: place dorsal surfaces of corresponding index fingers together.*



OSCE Comment: The diamond-shaped gap is present.

    - *Perform **fluctuation test**: place the **thumb and index finger of both hands** on the **lateral sides of the patient's nail bed** to hold it gently. Then, place your **middle fingers on either side of the interphalangeal joint** to **support***

and stabilize the finger**. Gently press the nail bed using your thumb and index fingers to assess for **sponginess.

OSCE Comment: No fluctuation.

Neck

Inspect the patient's neck.

OSCE Comment: No scars, no masses, no dilated veins, no visible abnormal pulsations.

Skin

Inspect the patient's skin.

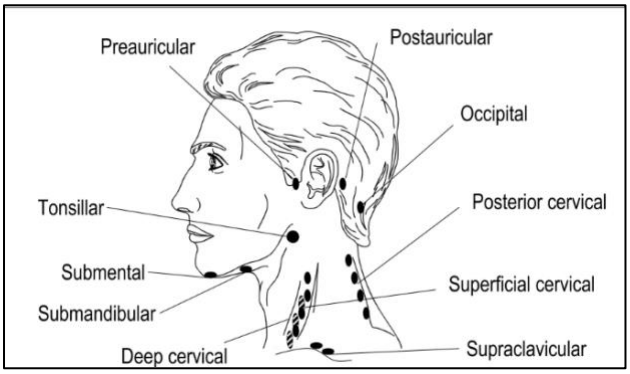
OSCE Comment: No rashes, no ulcers, no bruises, no vitiligo, no discoloration, no cyanosis, no jaundice and no pallor.

- If a mass is noted, assess and comment on:
  - **Site, size, surface, shape**
  - **Tenderness, temperature**
  - **Attachment (fixed or mobile)**
  - **Edges (smooth or irregular)**
  - **Pulsatility**
  - **Color and translucency**

Lymph Nodes Examination

***Always maintain eye contact** during palpation to assess for pain or discomfort, use gentle circular motions with your fingers to feel the lymph nodes on one side first. Keep the other hand still. Then switch hands and do the same on the other side to assess both sides.*

From Behind the Patient, palpate:



- **Submental**: *under the chin.*
- **Submandibular**: *under the jawline.*
- **Tonsillar**: at the angle of the mandible.
- **Preauricular**: *in front of the ear.*
- **Superficial cervical**: *over the sternocleidomastoid (SCM) muscle.*
- **Deep cervical**: *under the SCM, requiring gentle pressure.*
- **Supraclavicular**: *above the clavicle.*
- **Scalene**: *just above the clavicle, posterior to SCM — ask the patient to **lower their head slightly and turn it toward the same side** to expose the area better and use **one finger only**.*

From the Front of the Patient:

- **Posterior auricular**: *behind the ears.*
- **Occipital**: *at the base of the skull.*
- **Posterior cervical**: *along the posterior triangle of the neck.*

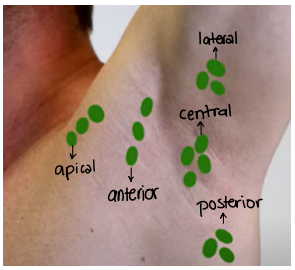
*Use **2 fingers** for all lymph nodes except **scalene**.*

OSCE Comment: No lymphadenopathy, normal size, soft, non-tender, mobile, not fixed to underlying structures.

Axillary Lymph Nodes

- *Rest the patient's right forearm on your left forearm, hold their right elbow with your left hand to relax the arm, then use your right hand (4 fingers) to palpate the axilla:*

1. **Anterior (pectoral)**: along the lateral border of the pectoralis major.
2. **Posterior (subscapular)**: along the lateral border of the scapula.
3. **Lateral**: along the humerus in the upper arm.
4. **Central**: along the chest wall.
5. **Apical**: deep in the apex of the axilla, toward the clavicle.



- Use a **circular motion**, palpating systematically around the axilla then toward the apex.

OSCE Comment: No lymphadenopathy, normal size, soft, non-tender, mobile, not fixed to underlying structures.

Epitrochlear Lymph Nodes

- *Hold the patient's right hand with your left hand and use your right hand (thumb) to palpate about 3 cm above the medial epicondyle in the groove between the biceps and triceps.*
- **OSCE Comment: No lymphadenopathy, normal size, soft, non-tender, mobile, not fixed to underlying structures.**

Inguinal Lymph Nodes

OSCE Comment: I would like to examine the inguinal lymph nodes located in the femoral triangle, just inferior to the inguinal ligament and along the upper inner thigh.

- ***(This part is only stated; not performed during the general exam)***.

Respiratory System Physical Examination

Beginning the Examination:

OSCE Comment: Standing on the right side of the patient & performing hand washing.

- On the patient's right side, perform hand washing while introducing yourself and your chaperone.

OSCE Comment: Hello, my name is _____. I'm a fourth-year medical student. Would it be alright if I performed a general physical examination on you today? A chaperone will be present during the examination.

- Ensure **warm temperature**, **good illumination** and **privacy**.

OSCE Comment: The temperature is warm, the room is well lit, and privacy is ensured.

- Instruct the patient to lie at a 45-degree angle and expose the area from above the umbilicus to the neck.

OSCE Comment: The patient is lying at 45 degrees and the area from the umbilicus to the neck is exposed.

---

1. Inspection:

- **Move to the foot of the bed and observe the patient's chest and breathing.**

OSCE Comment: Normal, bilateral, symmetrical chest movements. Abdominothoracic breathing, with inspiration longer than expiration. No tachypnea. The chest is elliptical in shape. There are no deformities; no barrel chest, pectus carinatum or pectus excavatum. No use of accessory muscles.

- **Move to the right side of the bed to inspect the patient's chest and axilla.**

OSCE Comment: No scars, swelling or dilated veins. No superficial nodules or masses. There is normal hair distribution.

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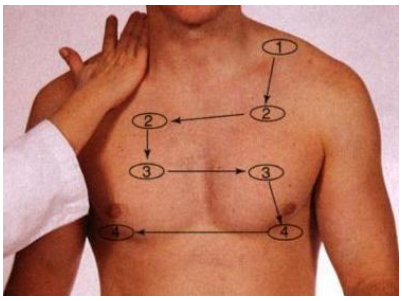
2. Palpation:

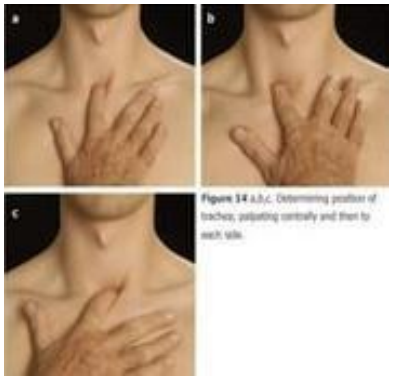


- **Warm hands, ask for permission to touch, and ask about any pain in the chest.**
- **While maintaining eye contact, palpate the chest using four fingers (index to little finger), making sure to include the lateral chest wall. (In a zigzag fashion as shown in the picture)**

OSCE Comment (during test): Palpating the chest while maintaining eye contact.

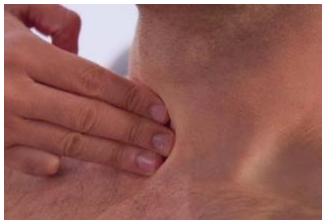
OSCE Comment (after test): No tenderness, masses or subcutaneous emphysema.

Palpation Maneuvers:



- **Tracheal Deviation:**
  - **Ask for permission to touch and ask about any pain.**
  - **Using your index finger, palpate the suprasternal notch to locate the trachea. Then palpate the space between the trachea and the sternocleidomastoid muscles on both the right and left sides to assess for any deviation from the midline.**

OSCE Comment: No tracheal deviation.



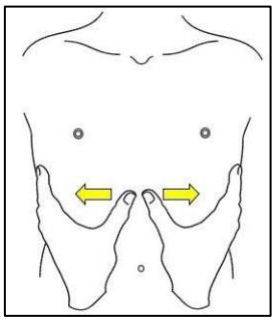
- **Cricosternal Distance:**
  - **Ask for permission to touch and ask about any pain.**
  - **Place three fingers vertically between the cricoid cartilage (just below the Adam's apple) and the sternal notch to estimate the cricosternal distance.**

OSCE Comment: Normal cricosternal distance.

- **Tracheal Tug:**
  - **Ask for permission to touch and ask about any pain.**
  - **Palpate the carotid pulse and observe for any downward movement of the trachea during systole.**

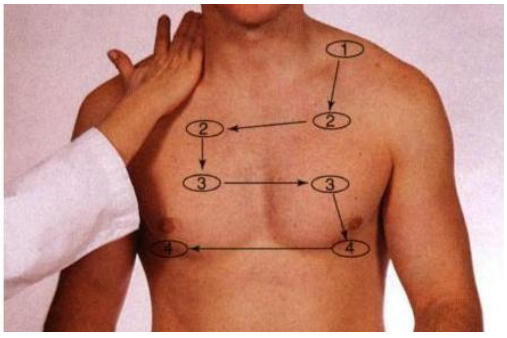
OSCE Comment: No tracheal tug.

- **Chest Expansion:**
  - **Ask for permission to touch and ask about any pain.**
  - **Ask the patient to exhale fully. Place your thumbs symmetrically on the center of the chest, just below the sternum, with your fingers spread laterally. Then ask the patient to take a deep breath in and observe the movement of your thumbs.**
  - **Perform above and below nipples.**



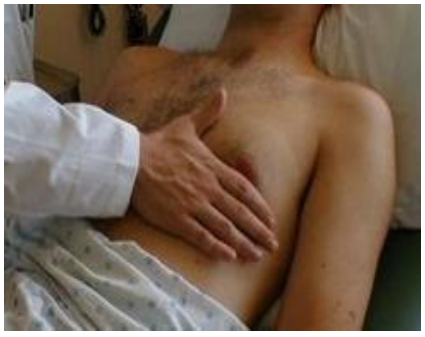
OSCE Comment: Normal chest expansion.

- **TVF:**
  - **Ask for permission to touch and ask about any pain.**
  - **Palpate the chest with the base of your palm and ask the patient to say "44" repeatedly in a normal voice. (In a zigzag fashion as shown in the picture)**
  - **<u>Make sure to include the lateral chest wall</u>.**



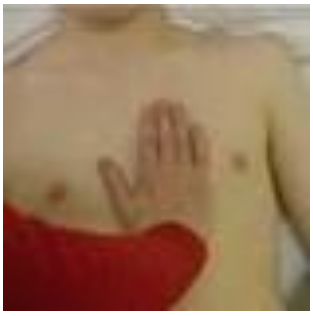
OSCE Comment: Normal bilateral symmetrical TVF.

- **Apex Beat:**
  - **Ask for permission to touch and ask about any pain.**
  - **Begin by palpating the apex beat using the palm of your hand to localize its general area. Once detected, use two fingers to precisely locate its position. Then, using your non-dominant hand, palpate the sternum starting from the suprasternal notch down to the Angle of Louis. From there, identify the 2nd intercostal space at the left sternal border and continue palpating down to the 5th intercostal space at the mid-clavicular line to confirm the apex location.**



OSCE Comment: Gentle tapping on the 5th intercostal space at the midclavicular line.

- **Left Heave:**
  - **Ask for permission to touch and ask about any pain.**
  - **Ask the patient to exhale fully and hold their breath.**
  - **Place the heel of your hand along the left sternal border and feel for a sustained outward movement, which may indicate a left ventricular heave.**



OSCE Comment: No right ventricular hypertrophy heave / No left sternal border heave (only mention one).

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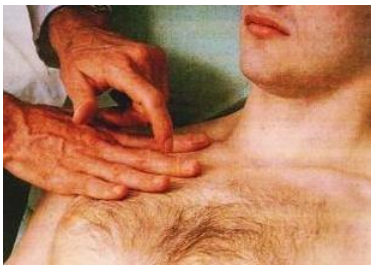
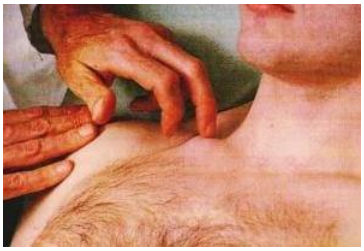
3. Percussion:

- **Ask for permission to touch and ask about any pain in the chest.**
- **Place the middle finger of your non-dominant hand flat on the chest between the ribs. Using a fixed elbow, tap sharply with the tip of your dominant hand's middle finger on that finger, moving only your wrist.**
- **Begin percussion at the supraclavicular area, then directly percuss over the clavicle using your dominant hand. Continue to the infraclavicular area, followed by the 2nd to 5th intercostal spaces along the midclavicular line on the anterior chest. Next, move to the lateral chest wall (midaxillary line) and percuss the 6th to 8th intercostal spaces in a zigzag pattern for comparison.**





OSCE Comment (during test): Bilateral, symmetrical, resonant percussion all over the chest.

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4. Auscultation Maneuvers:

- **Breathing:**
  - **Ask for permission to touch and ask about any pain.**
  - **Auscultate while asking the patient to take deep breaths in and out through an open mouth at each site.**
  - **Move in a zigzag pattern for comparison.**
  - **Listen at the same sites used for percussion, excluding the clavicular areas.**

OSCE Comment: Symmetrical bilateral good air entry, and bilateral symmetrical vesicular breathing with inspiration duration longer than expiration. No added sounds, wheeze, crackles or pleural rub.

- **Vocal Fremitus:**
  - **Ask for permission to touch and ask about any pain.**
  - **Auscultate while asking the patient to repeat the number "44" in a normal voice at each site.**
  - **Listen at the same sites used for percussion, excluding the clavicular areas.**

OSCE Comment: Symmetrical bilateral vocal resonance.

- **Whispered Pectoriloquy:**
  - **Ask for permission to touch and ask about any pain.**
  - **Auscultate while asking the patient to whisper "44" repeatedly at each site.**
  - **Listen at the same sites used for percussion, excluding the clavicular areas.**

OSCE Comment: Absent whispered pectoriloquy.

- **Egophony:**
  - **Ask for permission to touch and ask about any pain.**
  - **Auscultate while asking the patient to say "eeee" continuously.**
  - **Listen at the same sites used for percussion, excluding the clavicular areas.**

OSCE Comment: Absent egophony.

Ending the Exam: (comment only)

OSCE Comment: I would like to examine for lower limb edema, erythema nodosum, ascites, hepatosplenomegaly, and DVT.

CVS Physical Examination

Cardiac Examination

Beginning the Examination:

OSCE Comment: Standing on the right side of the patient & performing hand washing.

- On the patient's right side, perform hand washing while introducing yourself and your chaperone.
- Ensure **warm temperature**, **good illumination** and **privacy**.

OSCE Comment: The temperature is warm, the room is well lit, and privacy is ensured.

- Instruct the patient to lie at a 45-degree angle and expose the area from above the umbilicus to the neck.

OSCE Comment: The patient is lying at 45 degrees and the area from the umbilicus to the neck is exposed.

General Appearance

OSCE Comment: The patient is alert, conscious, and oriented to time, place, and person. The patient is not in distress. He has a normal body habitus—neither overweight nor cachectic. His skin color is normal, with no evidence of cyanosis, petechiae, or bruising. Breathing is normal. There are no physical signs suggestive of Marfan syndrome, Turner syndrome, Down syndrome, or ankylosing spondylitis.

Vital Signs:

OSCE Comment: I would like to assess the patient's vital signs, including temperature, BP, heart rate, respiratory rate, oxygen saturation and BMI, and urinalysis.

Inspection

- **From the right side of the patient.**

Facial Examination:

- **Skin: No pallor, petechiae or malar flush.**
- **Eyelids: No xanthelasmata or conjunctival pallor.**
- **Iris: No corneal arcus.**

- **Further Examination:**
  - **OSCE Comment: I would like to perform a fundoscopic (fundal) examination to assess for diabetic and hypertensive changes, as well as Roth spots.**

- **Mouth, Lips, and Tongue:**
  - **OSCE Comment: No central cyanosis noted. The patient has good dental hygiene and normal oral odor.**
  - **OSCE Comment: No signs of anemia, such as glossitis, angular cheilitis, beefy tongue and pallor.**
  - **OSCE Comment: no high arched palate.**

Hands Examination:

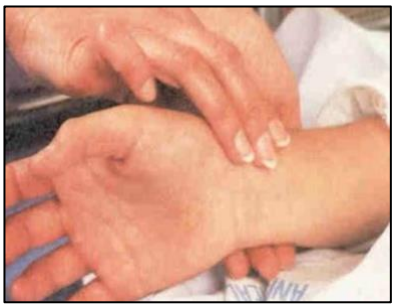
- **Dorsal (Extensor) Surface:**
  - **OSCE Comment: Normal color and temperature. No peripheral cyanosis, tar staining, or tendon xanthomata. No tremor. Normal capillary refill.**

- **Nails:**
  - **OSCE Comment: No splinter haemorrhages or clubbing.**

- **Palmar Aspect:**
  - **OSCE Comment: No Janeway lesions or Osler nodes.**

Pulses:

Radial Pulse:



To palpate the radial artery, position the patient's forearm palm-up and use the pads of your index, middle, and ring fingers to gently press just ***lateral to the flexor carpi radialis tendon*** *at the wrist.*

OSCE Comment: Normal rate and regular rhythm. The pulse is compressible but not collapsing. Normal volume and character.

Radioradial Delay:

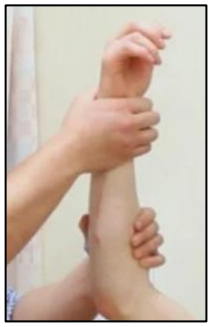
Assessed by palpating both radial pulses simultaneously to check for any delay between them.

OSCE Comment: Absent radiofemoral delay.

Further Examination:

OSCE Comment: I would like to examine for radiofemoral delay.

Collapsing Pulse:



Check for any shoulder pain or discomfort before assessing for a collapsing pulse. Assessed by palpating the radial pulse while quickly elevating the patient's arm above the head.

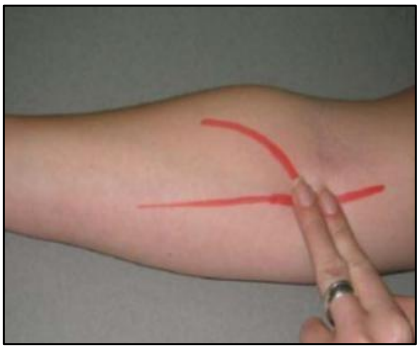
OSCE Comment: Absent collapsing pulse.

Pulse Deficit:

OSCE Comment: Absent pulse deficit.

Assessed by simultaneously auscultating the heart and palpating the radial pulse; a difference of more than 10 between the number of heartbeats is pathological.

Brachial Pulse:

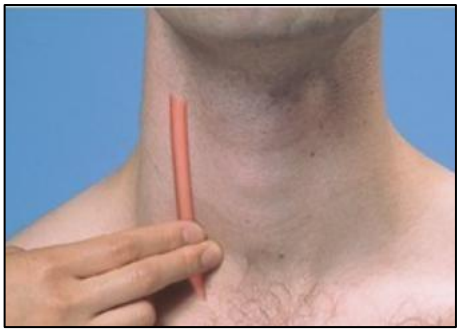


To palpate the brachial pulse, have the patient's arm slightly flexed and relaxed with the palm facing upward. Use the pads of your index and middle fingers to press gently on the medial side of the upper arm, about halfway between the shoulder and elbow, just medial to the biceps tendon.

OSCE Comment: Normal in character and volume.

OSCE Comment: I would like to check the blood pressure.

Carotid Pulse:



To palpate the carotid pulse, place the pads of your index and middle fingers gently on one side of the neck, just lateral to the trachea and medial to the sternocleidomastoid muscle, at the level of the thyroid cartilage. Apply light pressure to avoid compressing the artery completely. Assess the pulse for rate, rhythm, and strength. Avoid palpating both sides simultaneously to prevent compromising blood flow.

Carotid Bruit:

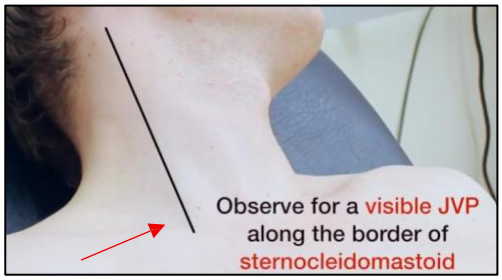
Auscultate for carotid bruits by asking the patient to take a deep breath and hold it.

OSCE Comment: No carotid bruits detected.

Further Examination:

OSCE Comment: I would like to examine the femoral, popliteal, posterior tibial, and dorsalis pedis pulses.

Jugular Venous Pressure (JVP) Examination:



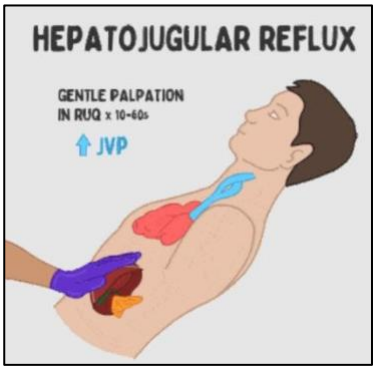
- Patient Positioning: Asked the patient to turn their head to the left side.

Use the torch throughout this whole examination (at red arrow).

- Inspection: **Two inward movements per pulse.**
- Palpation: **JVP is impalpable.**

Inspection Maneuvers:

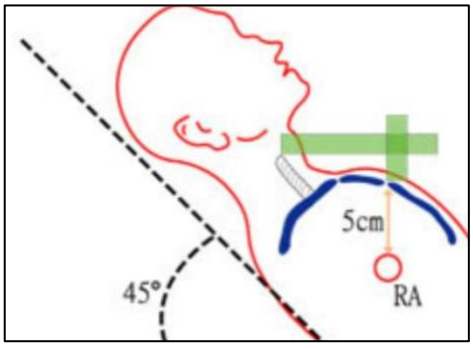
- Compression at the root of the neck (above clavicle): **JVP disappears.**
- Inspiration: **JVP decreases.**
- Sitting upright: **JVP decreases.**
- Lying flat: **JVP increases.**



- Hepatojugular Reflex: *Performed by applying firm, sustained pressure (about 20–30 seconds) over the right upper quadrant of the abdomen while observing for a sustained rise in JVP.* **OSCE Comment: JVP increases.**

JVP Measurement:

Position the patient at a 45° angle with their head turned slightly to the left. Use a torchlight shining obliquely from the side to visualize the right internal jugular vein's pulsations. To measure the JVP, place a vertical (to the ground) ruler on the sternal angle and use the torchlight horizontally from the highest point of the venous pulsation to the vertical ruler.



OSCE Comment: JVP is less than 9 cm water (equivalent to <7 mmHg).

Further Examination:

I would like to examine for signs of pulmonary edema, peripheral edema, pleural effusion, and ascites.

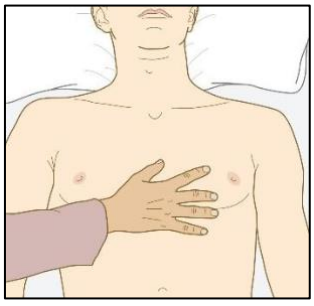
Precordium Examination

Inspection:

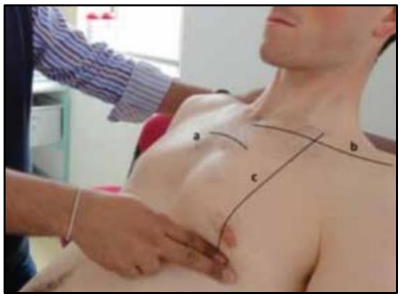
From the **foot of the bed**: **the chest appears bilaterally symmetrical with a normal contour, no visible deformities such as pectus carinatum or pectus excavatum, and bilateral symmetrical normal chest wall movements.**

From the **right side**: **there are no skin lesions, scars (such as sternotomy or infraclavicular scars), dilated veins, or implantable devices. Hair distribution is normal.**

Palpation:



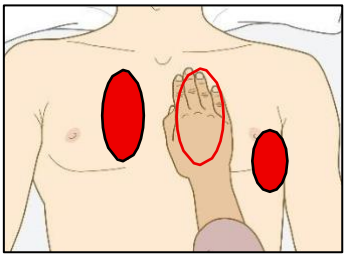
Palpate the chest using the full hand.



Then palpate the apex beat with the full hand, followed by two fingers once it is roughly located. Turn the patient to the left lateral position and locate the apex beat precisely using one finger. Return the patient to the supine position, then use the other hand to identify the sternal angle, the second intercostal space, and count down to the fifth intercostal space to confirm the apex beat location.

OSCE Comment: Gentle tapping at the 5th intercostal space, mid-clavicular line.

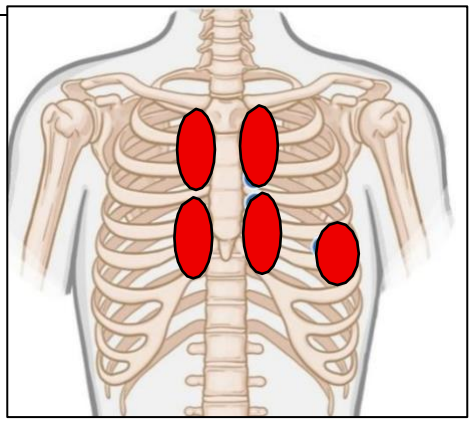
Heaves:



*Ask the patient to exhale fully and hold their breath. Assessed by placing the **base of the palm** along the right and left sternal borders and the apex (shown in the picture)*

OSCE Comment: No right or left ventricular hypertrophy heave.

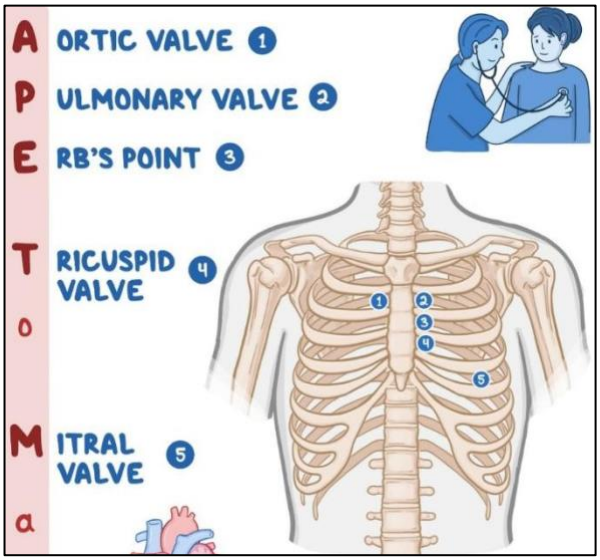
Thrills:



*Assessed using the flat surface of **four fingers** at five key sites (shown in the image) —apex, left and right lower sternal borders (at apex level), and left and right upper sternal borders (2nd intercostal spaces).*

OSCE Comment: No thrills were felt.

Auscultation:



Using the **diaphragm**, auscultation was performed at the **standard valve areas**.
(No comment here)

With the **bell** at the **apex** and the patient *turned to the left side*.
OSCE Comment: no mitral stenosis, S3, or S4 sounds.

With the **bell** at the **lower left sternal border**.
OSCE Comment: no tricuspid stenosis.

With the **diaphragm** at the **axilla** (at the level of the lower sternal border).
OSCE Comment: no mitral regurgitation.

With the **diaphragm** at the **carotid area** *during inspiration and breath-hold*.
OSCE Comment: no aortic stenosis.

With the **diaphragm** at **Erb's point** while the *patient sits, leans forward, and holds their breath at the end of expiration* (midpoint between the upper and lower left sternal border)
OSCE Comment: no aortic regurgitation.

Final Comment:

OSCE Comment: S1 and S2 are normal, with no splitting of S2. No added sounds (S3, S4, opening snap, ejection click, or pericardial friction rub) and no murmurs were heard.

Further Examination:

OSCE Comment: I would like to examine for pulses, ascites, lung crackles, hepatomegaly, and lower limb and sacral edema.

Peripheral Vascular Examination

Beginning the Examination:

OSCE Comment: Standing on the right side of the patient & performing hand washing.

- On the patient's right side, perform hand washing while introducing yourself and your chaperone.
- Ensure **warm temperature**, **good illumination** and **privacy**.

OSCE Comment: The temperature is warm, the room is well lit, and privacy is ensured.

- Instruct the patient to lie supine at a 45-degree angle, exposing the abdomen and the entire lower limb.

OSCE Comment: The patient is lying at a 45-degree angle with the abdomen and lower limbs exposed.

General Appearance:

Ask the patient about time, person, and place.

OSCE Comments:

- **The patient appears alert, conscious, and oriented to time, person, and place.**
- **There are no signs of respiratory distress or dyspnea.**
- **I would like to assess the patient's vital signs, including temperature, blood pressure, heart rate, respiratory rate, oxygen saturation and BMI.**

Inspection:

Before commenting on limb appearance, **begin by raising the patient's legs to 45 degrees to assess for venous guttering or ulceration**.

- Then lower the legs, inspect, **then Comment:**

  - Limb color is normal, with no pallor or cyanosis.

  - Hair distribution is normal.

  - No visible dilated veins or swellings.

  - No muscle wasting.

  - Skin is normal, no thin or shiny skin.

  - Nails are normal, with no brittleness, thickening or onychomycosis.

  - There is no venous guttering.

  - No ulcerations are seen. (If an ulcer is observed, comment on: **Size, shape, margins, depth, base, color, and surrounding**).

Palpation:

- Warm hands and ask the patient about any pain in the abdomen or lower limbs.

- Using the dorsum of the hand, **palpate** the abdomen and both lower limbs.

OSCE Comments:

- Temperature is normal bilaterally.

- No muscle tenderness or swelling noted.

- Perform **capillary refill test.**

OSCE Comment: Normal capillary refill.

Pulses:

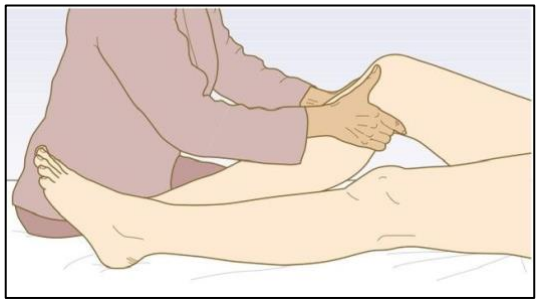
- **Femoral pulse**: *palpated at the mid-inguinal point (halfway between the anterior superior iliac spine and the pubic symphysis), using two fingers against the femoral head.*

OSCE Comment: I would like to palpate the femoral pulse at… (mention its location without palpating).

Then comment:

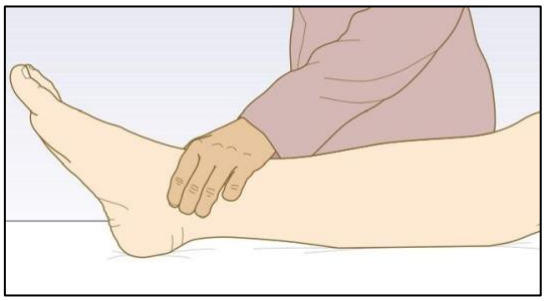
- **I would like to check for femoral bruits using auscultation.**
- **I would like to check for radio-femoral delay.**

- **Popliteal pulse:** *palpated with the knee flexed at approximately 30 degrees, placing both thumbs on the tibial tuberosity and the fingers in the midline of the popliteal fossa, approximately 2–3 cm above the skin crease, applying gentle pressure to feel the pulse*.



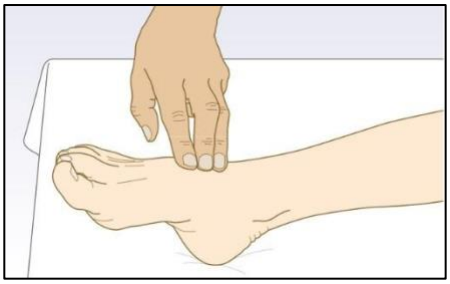
OSCE Comment: Palpating the popliteal pulse.

- **Posterior tibial pulse**: *palpated 2 cm posterior and 2 cm inferior to the medial malleolus, using two fingers.*



OSCE Comment: Palpating the posterior tibial pulse.

- **Dorsalis pedis pulse**: *palpated lateral to the extensor hallucis longus tendon, using three fingers.*



OSCE Comment: Palpating the dorsalis pedis pulse.

Special Tests:

- **Buerger's test:** With the patient laying supine, elevate the legs to 45 degrees for 2-3 minutes and observe for pallor, then ask the patient to sit up and dangle the legs over the edge of the bed. Observe for dependent redness.

OSCE Comment: Negative Buerger's test.

DVT Examination:

- Ask about **risk factors**.

OSCE Comment: I would like to ask about DVT risk factors, such as recent surgery or trauma, immobility, bed rest, or lower limb casts.

- Perform **circumferential measurement** of both legs at *10 cm (measure it) below the tibial tuberosity.*

OSCE Comment: Circumferential measurements are symmetrical.

- Ask the patient to walk, and **observe for** *changes in color, swelling, or prominent dilated veins.*

OSCE Comment: Upon walking, there are no changes in skin color, swelling, or dilated veins.

Remember: