

ASSESSMENT FOR PULMONARY CONDITIONS

Demographic details

Date of assessment:

Ward: Bed no:

Name:

Height:

Age:

Weight:

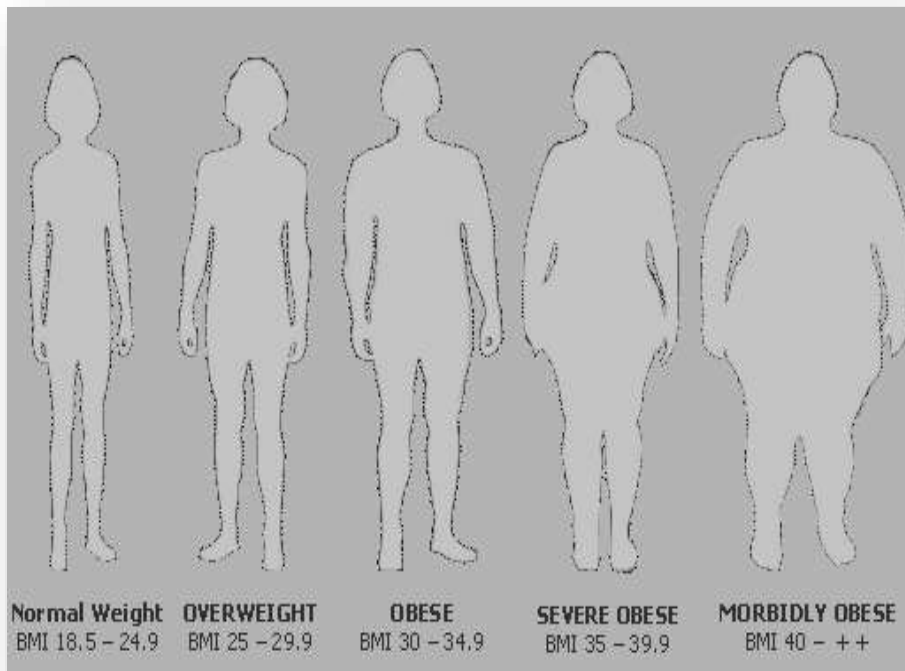
Gender:

BMI

Address:

Marital Status:

BMI Classification (WHO)



Chief complaint: as per the words of the patient or read from the case file.

Present history:

✓ Onset

✓ Progression

History related to main respiratory symptoms. The main respiratory symptoms are:

- Dyspnoea
- Cough and sputum
- Haemoptysis.
- Chest pain.
- Wheeze
- severe asthma may cause a silent chest with no wheeze.

Other systems

- Loss of appetite is a common feature whenever people are unwell. It suggests that the disease is having a significant effect on well-being.
- Significant loss of weight may well be indicative of serious illness - eg, malignancy or tuberculosis.
- Upper gastrointestinal symptoms: gastro-oesophageal reflux is a common cause of chronic cough.
- Heart disease may cause respiratory symptoms. Establish whether there are any indications of heart failure or coronary heart disease.
- Severe anaemia may cause breathlessness.
- Rheumatoid arthritis and other connective tissue diseases may cause respiratory symptoms.
- Neuromuscular diseases may cause respiratory symptoms, particularly dyspnoea.

Past history:

Asthma/PTB/Jaundice/Chronic cough/Any Heart or lung pathology

Medical History

- Use of inhalers (assess compliance and technique).
- Use of steroids (some measure of severity in asthma).
- Other drugs which may have relevance in respiratory disease - eg, angiotensin-converting enzyme (ACE) inhibitors (cough).

Surgical history:

Any allergies: Ask about all allergies including, for example, food, inhaled allergens and drugs.

Socio-economic History:

Family History:

- Respiratory diseases with a genetic component - eg, cystic fibrosis, emphysema (alpha-1-antitrypsin deficiency).
- Infectious diseases such as tuberculosis (remember high-risk groups).
- Atopic diseases such as asthma, hay fever and eczema.

Personal History

Smoking history:

Smoker: Yes/No

If yes:

Duration:

No. of cigarettes per day:

Stopped smoking: _____years back

Reason for quitting smoking:

On Observation:

- Level of consciousness
- Body type
- Skin:
 - ✓ Cyanosis (Central or peripheral)
 - ✓ Pallor
 - ✓ Scaring,
 - ✓ Bruises
 - ✓ Erythema
- Facial signs or expression:
- Jugular vein engorgement:
- Pattern of breathing:
 - Abdominothoracic or thoracoabdominal/
 - Kussmaul's breathing: deep and laboured breathing, often associated with severe metabolic acidosis.
 - Cheyne-Stokes' breathing: progressively deeper breathing followed by temporary apnoea, which may occur with heart failure, cerebrovascular disease, head injury, carbon monoxide poisoning or brain tumours, or be a normal variant during sleep or at high altitude.
 - Paradoxical chest movement may indicate a fractured rib.
 - Pursed lip
 - Upper chest use? Use of secondary muscles
 - Hyp/hyperventilation

- Swelling:
- Clubbing:
- Chest Wall Configuration:

Normal shape of the chest can be observed by the diameter of anterior and lateral views, where the ratio of diameter between anterior and lateral measurement should be more than 1.0.

- Mobility:
- External equipments/ lines/ drains:

Evidence of respiratory distress

- breathlessness,
- talking in short phrases rather than full sentences,
- use of accessory muscles
- exhalation with pursed lips.

On Palpation

- Chest Pain:
- Tenderness:
- Warmth:
- Oedema:
- Chest wall Excursion
 - Usual chest expansion in an adult should be symmetrical.
 - Symmetrical reduction: overinflated lungs (eg, bronchial asthma, emphysema), stiff lungs (eg, pulmonary fibrosis), ankylosing spondylitis.

- Asymmetrical reduction of chest wall expansion: absent expansion (eg, empyema and pleural effusion) or reduced expansion (eg, pulmonary consolidation and collapse).

The three levels of upper, middle, and lower lobes can be performed manually.

Tape Evaluation

This method can be applied in a upright position, which is better than lying supine. The three levels: upper, middle and lower, can be measured at the axillary, nipple line, and xiphoid process. It suggests anatomic landmarks on the chest wall.

- Symmetry of chest and trunk

Palpation of the chest wall for flexibility can be evaluated in sitting, side lying, supine, or prone position.

- Mediastinal Shift:

Use the index finger to feel the trachea and to determine whether the trachea feels central or is deviated:

The trachea is deviated away from pneumothorax and effusion and towards collapse and consolidation.

The trachea may also be deviated by a mass - eg, enlarged lymph nodes.

- Tactile Fremitus

- To assess tactile vocal fremitus, use the ulnar side of the hand, by the hypothenar eminence with the palms facing upwards. Place it at various levels over the back, each time asking the patient to say "ninety-nine". Note how the sound is transmitted to the hand.

- Tactile vocal fremitus is increased over areas of consolidation and decreased or absent over areas of effusion or collapse

On Auscultation

- Heart sounds:
 - ✓ S₁
 - ✓ S₂
 - ✓ Murmurs
- Breath sounds:
 - ✓ Place the stethoscope over each of the five lobes of the lungs in turn, on the front and back of the chest. Ask the patient to take deep breaths.
 - ✓ Normal breath sounds are described as quiet and gentle.
 - ✓ Rhonchi :
 - Musical sound heard on expiration. In severe cases they may be both inspiratory and expiratory. Imply narrowing of the airways.
 - The loudness of rhonchi gives no indication of the severity of the condition.
 - ✓ Wheeze
 - ✓ Rales (sometimes called crackles)
 - Probably represent opening of small airways and alveoli.
 - They may be normal at the lung bases if they clear on coughing or after taking a few deep breaths.

- Basal rales are a classical feature of pulmonary congestion with left ventricular failure. They may be more diffuse in pulmonary fibrosis.
- ✓ Bronchial breathing:
 - The sounds of bronchial breathing are generated by turbulent air flow in large airways (similar sounds can be heard in healthy patients by listening over the trachea.
 - Sounds are harsh and poor in nature. Unlike normal vesicular breath sounds, there is a gap between the inspiratory and expiratory phase sounds.
 - Bronchial breathing suggests consolidation or fibrosis, which permits the sound to be conducted more effectively to the chest wall.
- ✓ Pleural rub: a creaking sound caused by stiff pleural membranes such as with pleurisy.
- ✓ Stridor: harsh inspiratory sound caused by partial obstruction of a large airway.
- ✓ Vocal resonance:
 - Place the stethoscope at various levels over the back and ask the patient to whisper "ninety-nine" each time. Note how well the sound is transmitted.
 - The sound is muffled over a normal lung, increased if there is consolidation and decreased or absent if there is effusion or collapse.
- ✓ Whispering pectoriloquy:
 - Is elicited as for vocal fremitus but ask the patient to whisper "one, two, three".
 - Whispering pectoriloquy is the increased quality and loudness of whispers that are heard with a stethoscope over an area of lung consolidation
- Mediate Percussion

For percussion of the chest, it is usual to use the middle finger of the dominant hand to do this.

. The chest is percussed by placing the non-dominant hand on the chest and using the dominant middle finger to tap the other middle finger over the middle phalanx.

Percuss over all the lobes of the lung, front and back except that the middle lobe does not have surface anatomy on the back.

Percuss over the heart. In hyperinflation of the chest, there is loss of cardiac dullness. A hyper-resonant sound suggests hyperinflation or a pneumothorax.

A dull sound is easier to distinguish from normal. It may suggest collapse or consolidation, or a pleural effusion.

On Examination

- Chest Pain
 - ✓ Type
 - ✓ Onset
 - ✓ Aggravating factor
 - ✓ Relieving factors
- Dyspnoea (Borg Scale or Modified Borg Scale):
- Modified Borg Rating Of Perceived Exertion

0	Nothing at all
0.5	Very, very slight (just noticeable)
1	Very slight

2	Slight (light)
3	Moderate
4	Somewhat severe
5	Severe (heavy)
6	
7	Very severe
8	
9	
10	Very, very severe (maximal)

- Cough

- ✓ Type
- ✓ Onset
- ✓ Duration
- ✓ Frequency

- Sputum

- ✓ Colour
- ✓ Consistency
- ✓ Amount
- ✓ Odor:

- Blood Pressure
 - ✓ Systolic BP
 - ✓ Diastolic

JNC VII CLASSIFICATION OF BLOOD PRESSURE

Blood pressure Classification	systolic(mmHg)	Diastolic (mmHg)
Normal	<120	and <80
Prehypertension	120-139	or 80-90
Stage1 hypertension	140-159	or 90 -99
Stage2 hypertension	>=160	or >=100

- Heart Rate:
- Pulse Rate:
- Respiratory Rate:
- Temperature:
- Capillary Refill Time:
- Oxyhaemoglobin Saturation:
- Anaemia:
- Jaundice:
- Respiratory Muscle Strength:
- Peripheral Muscle Strength:
- ROM of neck, shoulder, trunk muscles:
- Fatigue:
- Functional limitation:

Investigations

Pulmonary Cases

- ✓ X- Ray:
- ✓ PFT:
- ✓ ECG:
- ✓ ABG:
- ✓ Exercise Testing:
- ✓ Sputum Culture
- ✓ Bronchoscopy

Provisional Diagnosis:

Final Diagnosis:

Problem List:

Aims of PT Management:

Short Term Goal

Long Term Goal

Physiotherapy Management:

Follow Up:

