

The Nervous System

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The Difficulties

Knowing what to do

Learning how to do it

Understanding what it means

The Principles

History: guide to underlying disease and area of examination to focus on

Examination: localises site of disease

History, Examination & Localization: help to determine the disease

Competence

Knowledge: mostly self learned

Skills: need to be taught, learned & practised

Experience: comes with time

Neurological History Taking

Neurology History Taking

Aim to be: a good listener

Show: interest, sympathy and understanding

Clinical findings: may become obvious during history

History Taking 1

Determine handedness: **which hand used for writing**

Start with an open question: **tell me what problem is**

Let the patient tell: **story of the illness**

Record illness chronologically: **date/month/year onset**

Ideally not more than: **3 or 4 main PCs**

Determine order of importance: **of each PC**

History of Presenting Complaint

Character/Nature: *e.g.* seizure or loss of power

Site/Location: *where is it*

Severity: *how bad is it*

Time Course, onset: *sudden/gradual*

Duration: *how long*

Progression: *continuous/intermittent, improve/worse*

Exacerbating & Relieving factors: *better/worse*

Associated symptoms: *others*

Past Hist: *same illness, investigations, treatments*

History Taking 2

System Review: Screen for other neurological symptoms (see next slide)

Repeat briefly the main **PCs** to the patient

Ask: Is there anything else you would like to tell me?

System Review

Headaches, pain: **in head, face, trunk or limbs**

Loss of power *or* weakness: **in limbs *or* trunk**

Loss of feeling, numbness *or* pins & needles: **in limbs *or* body**

Loss of consciousness *or* dizzy spells: **blackouts, unsteadyness**

Incontinence: **loss of control of bladder and/or bowel**

Vision and Hearing: **loss of vision *or* hearing**

Past Medical History

Medical illnesses, accidents, hospitalizations & operations: **List chronological order/yr for each**

Determine whether illness: **active or inactive**

Ask re history of: **infections, seizures, head injuries, diabetes (DM), hypertension (BP) etc**

Family History

Neurological illness: record 1st degree family relatives: *parents, siblings and children*

If relevant document family tree: *names, age, sex*

Hereditary disease: enquire if family affected: *e.g. muscular dystrophy, epilepsy, Huntington's disease*

Social History

Occupation and Education: ask re employment

Life Style Habits:

Smoking: pack yrs

Alcohol: amount & duration

Diet: estimated calories intake/day if indicated

Exercise: daily & amount

Marital status and household dependants

Drug History

List the drugs/medication patient is taking

Include following:

name of drug

dose & duration

frequency per day

side effects of medication

Allergies

Key points

- Establish good communication
- Allow patient to tell the story of the illness
- Ask questions in a logical order and listen to the answers
- Better often to get pts description of PC than your summary
- Observe patient during history
- Hypothesise likely anatomical basis for patient's symptoms

Neurological Examination

Key Points

Learn basic neurological skills

Practise on student colleagues and patients

Become familiar with range of what is normal

Learn abnormal neurology or hard neurology signs

Hard signs are objective, reproducible and can't be altered by patient

Neurological Examination

Level of Consciousness, Cognitive Function,

Mental Function: *Only assessed if an abnormality is suspected*

Cranial Nerves

Limbs

Gait

General Observations

Level of consciousness: **confused, comatose, conscious**

Abnormalities in: **speech, posture, movement & gait**

Higher cerebral function: **attention, memory, learned abilities**

Mental health: **mood, attitude, concern, insight**

Appearance & Behaviour: **dress, self neglect, familiarity**

Neurological Examination

The 12 Cranial Nerves

The Limbs: Upper & Lower

Gait

Key Points

Neurological examination is considered difficult

Main reasons are uncertainty re examining technique and not knowing what is normal

Student needs to become familiar with examination routine and the range of normal findings

Abnormal findings need to be first demonstrated and taught by tutor and then learned and practised by student