DEPARTMENT OF MEDICINE
COLLEGE OF MEDICINE
KING KHALID UNIVERSITY HOSPITL
KING SAUD UNIVERSITY

COURSE 341 -GUIDELINES
School year 1430 – 1431
2009-2010

GENERAL COURSE ORGANIZER
DR.Abdulrahman Al-Jebreen; CHAIRMAN OF DEPARTMENT OF MEDICINE
DR.WALEED K AL-HAMOUDI & Nahla Azzam; GENERAL COURSE ORGANIZERS

DEPARTMENT OF MEDICINE

MED COURSE 341

Curriculum Proposal Form

Course Name : Internal Medicine	اسم المقرر: الباطنة العام
Course Code & No : 341	رقم المقرر ورمزه: طبب ٣٤١
Credits : 10 (7 +3)*	الساعات المعتمده: ١٠ (٧+٣)*
Duration :one year	مدة المقرر: سنة كاملة
Study year: Third year	سنة الدراسة: الثالثة

-*تدريب عملي
(جلستين عمليتين إسبوعياً بمعدل ٣ ساعات في كل جلسة) =====
٣ محاضرات إسبوعياً على مدار السنة بمعدل ساعة واحدة =====

-*clinical teaching ===
2 sessions per week(3 hours each)
-3 lecture per week (one hour each)

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Curriculum revion date (3 / 7/ 2009)

Revised by:
Course Development committee:

Name	Title	Position
Dr. Abdulrahman Al-jebreen	Assoct.Professor.	Chairman Department
Dr. Waleed AL Hamoudi	Asst. Professor.	General Course organizer
Dr. Nahla Azzam	Asst.Professor	General Course organizer
Dr. A Al-Daif	Professor.	Member
Dr. Ahmed Hersi	Asst. Professor.	Member
Dr. Hussam Al Falih	Asst. Professor.	Member
Dr. Amer Aleem	Asst. Professor.	Member
Dr. Sultan Al-Mugarin	Asst. Professor.	Member
Dr. Anwar Jamah	Asst. Profeesor	Member
Dr. Hussein Al Arafj	Assoct.Professor.	Member

Departement of medicine written exam committee

Dr. Waleed AL Hamoudi
Dr. Nahla Azzam
DR.H Al-faleh
Dr. Ahmed Hersi
Dr. Anwer Jamah

Departement of medicine clinical/OSCE exam committee

Dr. Waleed AL Hamoudi
Dr. Nahla Azzam
DR.A Aleem
Dr. Ahmed Hersi
Dr. Anwer Jamah
Dr. Niaz
Dr. Abba

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MED COURSE 341

10 Credit hours

Med Course 341 is the first clinical course for the medical students. It is a 10 credit hours course of theoretical part (lectures) and clinical part (bedside teaching). The main objective of the course is mastering history taking: learning the technique of how do physical exam and know the physical sings of patients. The course was taught over 28 week's period.

TEACHING PART OF THE COURSE

THEORETICAL PART: There shall be three lectures per week covering all the general medicine aspect such as cardiology, rheumatology, pulmonology, endocrinology, nephrology, gastroenterology, hematology/oncology, infectious diseases and neurology given over 72 lectures during 28 weeks.

CLINICAL BEDSIDE TEACHING: There shall be two clinical sessions per week. The teaching consists mainly of basic history taking, basic technique of different system examinations and definition and identification of physical sings.

ATTENDANCE

Attendance is continuously monitored and kept to see whether students will meet the required percentage of attendance set by the University.
To facilitate that an additional secretary will be added to the administrative office, with a main role of day to day monitor of the course.

Any student noticed to have poor attendance would be given warning letters to call their attention and given them a chance to improve. As a rule, students should have attended at least 75% of the total 70 lectures and 56 sessions of the bedside clinical teaching of the course to be allowed to sit in the final exam. Names of students who will have less than 75% attendance will be submitted to the Vice Dean – Academic Affairs Office and will not be included in the exam until the University gives their approval. At the end of

each clinical session the group leader should make sure that the attendance is checked and the attendance sheet should be given to the tutor, it's the role of the tutor to deliver the attendance sheet to the course secretary immediately after the session.
Teaching staff will receive a notice of their attendance that will also be forwarded to the department chairman. It is the responsibility of the tutor to make sure that the teaching session is conducted efficiently (at least for two hours). Each tutor should give the sessions assigned to him and in case of prescheduled traveling, meetings, conferences,…etc the tutor must assign a replacement and inform the course organizers in advance.

CONTRIBUTING TEACHING STAFF / HOSPITALS

Students were distributed in two different hospitals, King Khalid University Hospital and Riyadh Medical Complex for their bedside clinical teaching. Consultants from KKUH rotate between the two hospitals to do the teaching.

RECOMMENDED REFERENCES

A. Textbook of Medicine
:

1- **Cecil Essentials of Medicine** (Preferred)
by Thomas E. Andreoli (Author), Charles C. J. Carpenter (Author), Robert C. Griggs (Author), Joseph Loscalzo

or

2-Clinical Medicine – A textbook for Medical students and doctors.
P.J Kumar and M.L. Clark "Latest Edition"

3. Davidson's Principles and Practices of Medicine – C.R. Edward and Ian, A.D Bonchir – Latest Edition.

B. Physical Examination
Any one of the following books:

1. Clinical Examination – latest addition by Nicholas Talley and Simon O'Connor.
2. A guide to physical examination and history taking, by Barbara Bates – Latest Edition.
3. Macleod's Clinical Examination by John Munro and C. Edwards.

EXAMINATIONS

Continuous assessment exam 40% from the total 100% marks.

- This is the first exam done after the students finished the first half of the course and it
  Consists of Written Exam (20%) and Clinical – Long Case Exam (20%)

FINAL EXAMINATION 60% from the total 100% marks.

- This will be the second exam after the students finished the 28 weeks of teaching and
  Just like the first exam it consists of written exam (30%) and an OSCE (30%)

Written exam – Is composed of 60 best single answer questions, each question has 4-5 stems.

OSCE exam - Is becoming the standard way of assessment and is widely used
The OSCE increase the fairness by:
1. Increase the range of skills that the students are tasted for
2. Increase the numbers of examiners by whom the students are assessed
3. Asking the students the same questions over the same period of time

It consist of 6 stations over 60 minutes
•Divided by 3 clinical stations
2 history taking
1 rest stations

•All are patients oriented
What are examiners looking for
1. A confident approach

2. A good skill performance
3. Good applied knowledge
4. Clear answers
5. Level-headedness (say I don't know rather than waffling)
6. Good communications

Common mistakes in OSCE

Arrive late
Forget to introduce ourselves to the patients
Examine the patients in wrong positions
Jump to a particular interpretation of some data and ignore all examiners attempts to steer you away from it

MED COURSE 341 LECTURS

THE FOLLOWING ARE LECTURES GIVEN ON THE FIRST SEMESTER:

A. CARDIOLOGY

1. Hypertension/hypertensive Heart Disease
2. Hyperlipidemia – Diagnosis and Management
3. Investigation of Heart Disease
4. Angina Pectoris
5. Acute Myocardial Infarction
6. Chronic Valvular Heart Disease – 1
7. Chronic Valvular Heart Disease - 11
8. Infective Endocarditis
9. Cardiac Arrhythmias
10. Heart Failure
11. Cardiomyopathies
12. Pericardial Disorders

B. PULMONOLOGY

1. Pleural Effusion
2. Pulmonary Embolism
3. Interstitial Lung Disease (Allergic Alveolitis)
4. Respiratory Emergencies
5. Pneumonia
6. Investigation of Lung Disease
7. C.O.P.D.
8. Bronchial Asthma
9. Respiratory Failure

C. INFECTIOUS DISEASES

1. Malaria
2. Some Viral Infections
3. Diarrheal Diseases
4. Prevention and Prophylaxis of Infectious Diseases
5. Infection in the immuno-compromised host
6. Typhoid Fever and Brucellosis
7. Tuberculosis
8. Bacteremia and Septic Shock
9. AIDS
10. Leishmania / Schistosomiasis
11. Fever of Unknown Origin
12. Use of Antibiotics

D. GASTROENTEROLOGY

1. Pancreatic Diseases
2. Malabsorption and Diarrhea
3. Peptic Ulcer Diseases
4. Irritable Bowel Syndrome
5. Acute Hepatitis and Complications
6. Chronic Liver Diseases (Chronic Hepatitis, Cirrhosis)
7. Oesophageal Diseases
8. Liver Cirrhosis and Complication
9. Liver Tumours
10. Inflammatory Bowel Disease (Specific and Non-specific)

MED COURSE 341 LECTURS

THE FOLLOWING ARE LECTURES GIVEN ON THE SECOND SEMESTER:

E. ENDOCRINOLOGY

1. Clinical Aspects of Diabetes
2. Management and Complications of Diabetes
3. Metabolic Bone Disease
4. Disorders of the Parathyroid Glands
5. Obesity
6. Pituitary Disorders - I
7. Pituitary Disorders - II
8. Adrenal Disorders - I
9. Adrenal Disorders - II
10. Hypothyroidism and Other Thyroid Disorders
11. Hypothyroidism
12. Sexual Disorders

F. ONCOLOGY / HAEMATOLOGY

1. Anemia - I
2. Anemia - II
3. Cancer Treatment
4. Acute Leukemia
5. Chronic Leukemia
6. Myeloproliferative Disorder
7. Lymphoma - I
8. Lymphoma - II
9. Haemostasis - I
10. Haemostasis - II

G. NEPHROLOGY

1. Acute Glomerulonephritis
2. Nephrotic Syndrome
3. Tubulointerstitial Disease
4. Fluid and Electrolyte Acid Base Balance
5. Chronic Renal Failure
6. Dialysis and Immunology of Renal Transplantation
7. U.T.I. (including renal tuberculosis)
8. Acute Renal Failure

H. NEUROLOGY

1. Myelopathy & AbHC diseases
2. Epilepsy
3. Myopathies and Myasthenia Gravis
4. CNS Infections
5. Peripheral Neuropathies
6. Extra pyramidal Disorders
7. Dementia
8. CNS Demyelination
9. Headache and Migraine
10. Localization in Clinical Neurology
11. Cerebrovascular Diseases

I. RHEUMATOLOGY

1. SLE and Progressive Systemic Sclerosis
2. Infective Arthritis and Crystal Induced arthritis
3. Vasculitis / Myositis
4. Chronic Arthritis - I
5. Chronic Arthritis - II

THE MEDICAL INTERVIEW

The main purpose of the medical interview is to obtain information about the patient's illness in order to reach a diagnosis. Diagnosis means identifying and characterizing the disease that the patient has. It is a mental exercise that depends on three basic components.

a. History of illness
b. Physical examination
c. Diagnostic procedures (Laboratory of radiological, etc.)

Patient history is the most important component as 80% of diagnosis can be made from history alone. Physical examination increases the diagnostic yield by 10% and laboratory investigations by another 10%. Therefore taking a good medical history is essential in providing good patient care.

Clinical manifestation of disease are classified as:

a. Symptoms: Abnormal sensations/changes that the patient feel or observe (e.g. pain, weakness, shortness of breath).

b. Sings: Abnormal findings detected by physician on examination (e.g. high temperature, enlarged liver, heart murmur).

HISTORY TAKING:

The objective of taking a medical history is to obtain information about patient illness to make a diagnosis, assess the severity of illness and evaluate its effects on patient's bodily functions and life. It also serves to establish a relationship between the physician and the patient. The medical history consists of eight components:

1. Personal data.
2. Chief complaint (presenting illness)
3. History of presenting illness
4. Past history (medical and surgical)
5. Family history
6. Social history
7. Drugs and allergies
8. Review of systems

GENERAL GUDELINES:

Obtaining a good history and physical examination depends largely on patient's cooperation and confidence in his physician. Students should learn ways to facilitate communication with patients and increase their cooperation during history taking and physical examination. The following are helpful guidelines:

a. At the beginning, greet the patient and introduce yourself to him: call the patient by his/her first name (if young, use brother/sister: if old, use uncle/aunt). Ask the patient "how is he feeling now?"

b. Put the patient at ease, make sure that he is comfortable, e.g. in posture, light and
Temperature. Draw the curtains around him to ensure privacy. For females, a female attendant or nurse has to be present.

c. Show the patient that you are interested in him: by paying attention to his words,
Making sure he is comfortable, answering his needs (e.g. blanket, glass of water , bathroom, etc.). Your posture, words and facial expression should show continuous
Attention to the patient.

d. Facilitate communication to promote free flow of information. This id done by
Asking general open-ended questions. Encourage the patient to speak freely about
His problem. Show interest in his statements by nodding your head, saying ÿes", ähah", änd then repeating the last phrase of his account.

e. Avoid actions or words that reduce communication, e.g. using technical terms
(patients did not study pathology) or interrupting patient's speech. Avoid actions that suggest to the patient that you are not interested in him, e.g. taking to another person while the patient talks, reading the hospital chart or book or not actively listening to him.

TECHNIQUE OF HISTORY TAKING

For proper history taking, you are advised to use a systematic approach covering the major components of the medical history mentioned above. I advise you to use the following method:

Step 1: **Introduction**

- Greet the patient (as above)
- Introduce yourself "I am (mention your name), I am part of the medical team responsible for your care, and I wish to speak to you about your illness".
- Make sure he is comfortable … (as above), put him at ease.
  Ask "how are you feeling now?" "where are from, uncle?"
- To improve communication, you may chat with him about the weather, his city or
  Region, etc.

Step 2: **Personal data**

- Get the patient's name (preferably from records), age, sex, nationality, and area of
  Residence, occupation.

Step 3: **Chief complaint (presenting illness)**

- Ask the patient about the symptom, complaint or problem that brought him to the
  Hospital, e.g. "What was the problem that brought you to the hospital? "When did
  It starts?" "Were you well before that?" "What was the first thing that you felt?"
  Here, encourages the patient to speak freely, and give a full account of his problem.
  Do not interrupt except by nodding your head or saying "Yes ", "ah ". "What else "? When the patient finishes his initial description, ask him "are there any other problems ". Repeat until the patient has nothing to add. Avoid suggestions and do not ask leading questions, e.g. "Do you have loin pain?".
  Your objective here is to identify the main symptom or symptoms that the patient has and their duration. This is the chief complaint(s).

Step 4: **History of present illness (HPI)**

Here, your objective is to analyze or dissect the main symptom(s) in details, and in

A chronological order. Symptoms (e.g. pain) are usually characterized by the

Following features:

1. Body site (exact are a of body affected)
2. Duration – since the beginning of the symptom
3. Radiation – to other areas of the body
4. Character – describe the symptom (what is it like) and clarify what the patient means by symptom.
5. Onset – did it start gradually or suddenly
6. Severity – mid, moderate, sever
   - Does it interfere with daily activity or sleep?
   - Frequency of the symptom (if intermittent)
   - Size (swelling), volume (fluid, sputum, etc.)
7. Aggravating factors – factors that make it worse.
   Precipitating factors – factors that lead to it.
   Reliving factors – factors that make it better.
8. Course of the symptom since the beginning: did it improve or get worse? If
   Multiple attacks, frequency and duration of attacks
9. Associated symptoms: these include:
   - Positive symptoms within the same system or other systems.
   - Negative symptoms of the same system (state that they are absent)
   - General symptoms of disease (fatigue, weight loss, anorexia, fever) whether present or absent.

Step 5: **Past History**

- Ask about any significant medical problems in the past – since childhood. Hospital
  Admissions, trauma, fractures, surgical operations, blood transfusions. Mention diseases/ surgeries and the dates (year).

  N.B.: Remember that past medical history includes illnesses that happened in the past and are cured. Chronic diseases that started in the past and are still present (like diabetes mellitus, hypertension, rheumatoid arthritis) are not past medical problems, they are current problems and should be included in history of present illness.

Step 6: **Family History**

Ask about:

- Family members and their state of health (parents, brothers and sisters, wife and Children)
- Illnesses and deaths in the family
- Any similar illness family members

Step 7: **Social History**

Ask about:

- Nature of occupation – recent and old
- Home surroundings
- Any problems with work or family members or financial problems
- Habits: Drinking/smoking
- History of travel

Step 8: **Drugs and Allergies**

- Is the patient using any drugs? Mention names, dosages.
- Is the allergic to any drugs or substances?

Step 9: **Review of system**

General : Anorexia, weight loss, fatigue, fever, sleep disturbance

CVS : Chest pain, dyspnea, cough, hemoptysis, palpitations, syncope,
Ankle swelling, leg pains.

Respiratory : Chest pain, dyspnea, cough, sputum, hemoptysis, wheezing.

G.I.T. : Nausea, vomiting, dysphagia, heartburn, abdominal pain, Distension, dyspepsia, diarrhea, constipation, jaundice.

Urinary : History of loin pain, dysuria, hematuria, frequency, polyuria, Hesitancy, difficulty in micturition, urethral discharge.

Locomotor : Joint pain, swelling, muscle pain, weakness, backpain, bone pain.

C.N.S. : Headache, dizziness, loss of consciousness, seizures, visual or

Auditory symptoms. Weakness and numbness in any part of the Body.

Skin : Skin lesion, itching

Blood : History of blood loss, bleeding tendency

COURSE PROGRAM

MED COURSE 341
BEDSIDE CLINICAL TEACHING

General Exam	WEEK 1
Abdomen Exam	WEEK 2
Cardiovascular Exam	WEEK 3
Chest Exam	WEEK 4
Musculoskeletal Exam	WEEK 5
All Systems on wards	WEEK 6

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Sultan

COURSE PROGRAm

MED COURSE 341
BEDSIDE CLINICAL TEACHING 2nd semester

For all 6 weeks 2-3 history are required each week in addition to the physical exam as the following

General Exam (OSCE oriented) WEEK 1

Abdomen Exam (OSCE oriented) WEEK 2

Cardiovascular Exam (OSCE oriented) WEEK 3

Chest Exam (OSCE oriented) WEEK 4

Musculoskeletal Exam (OSCE oriented) WEEK 5

All Systems Review WEEK 6

± NEUROLOGY**DR. Waleed Al Hamoudi**

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