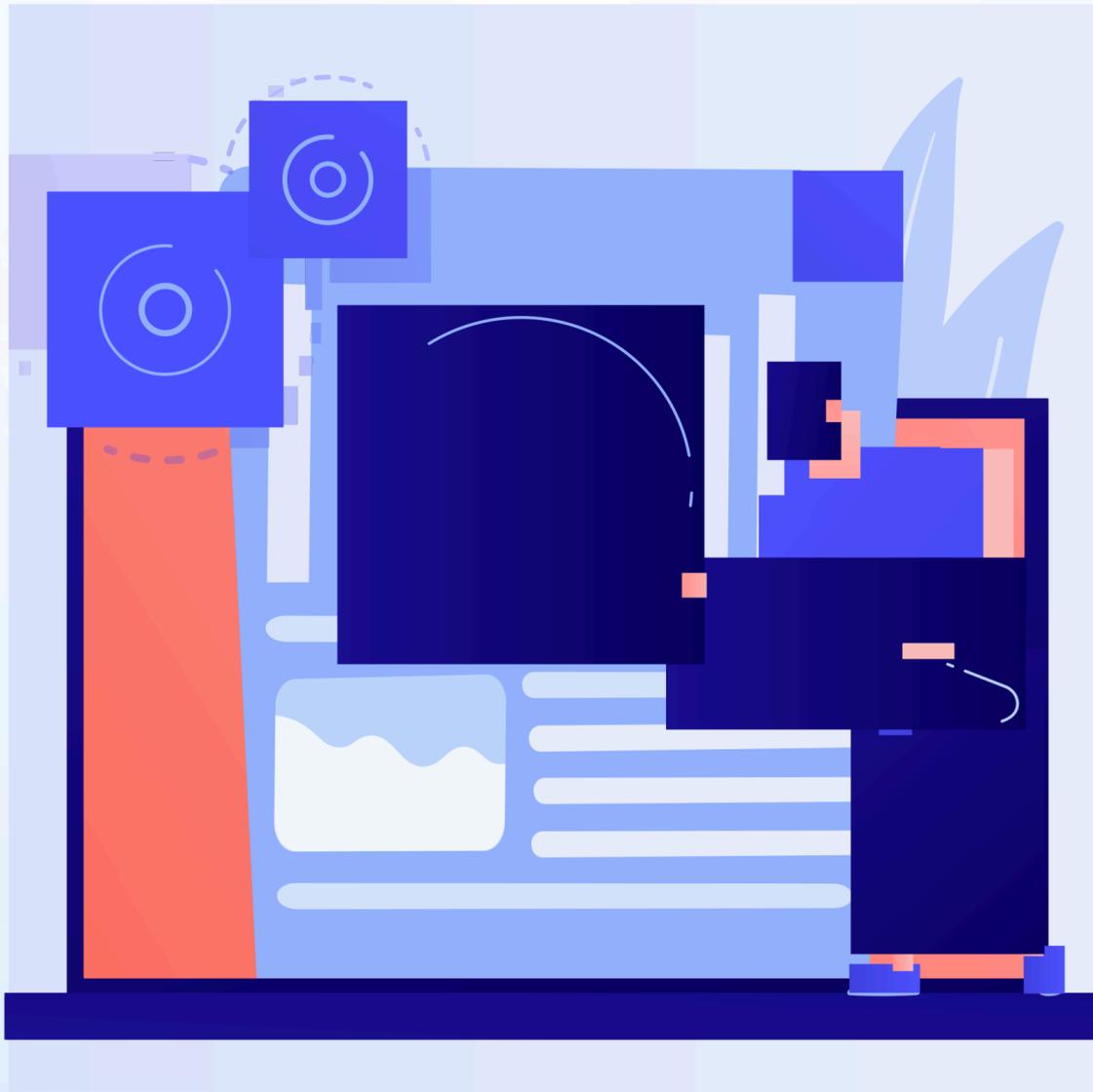


# MINI-OSCE MACLEOD

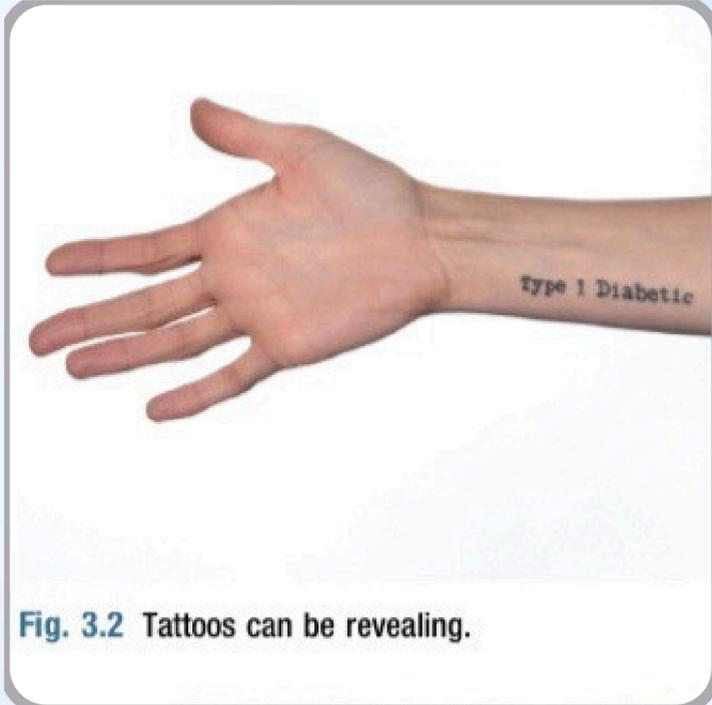
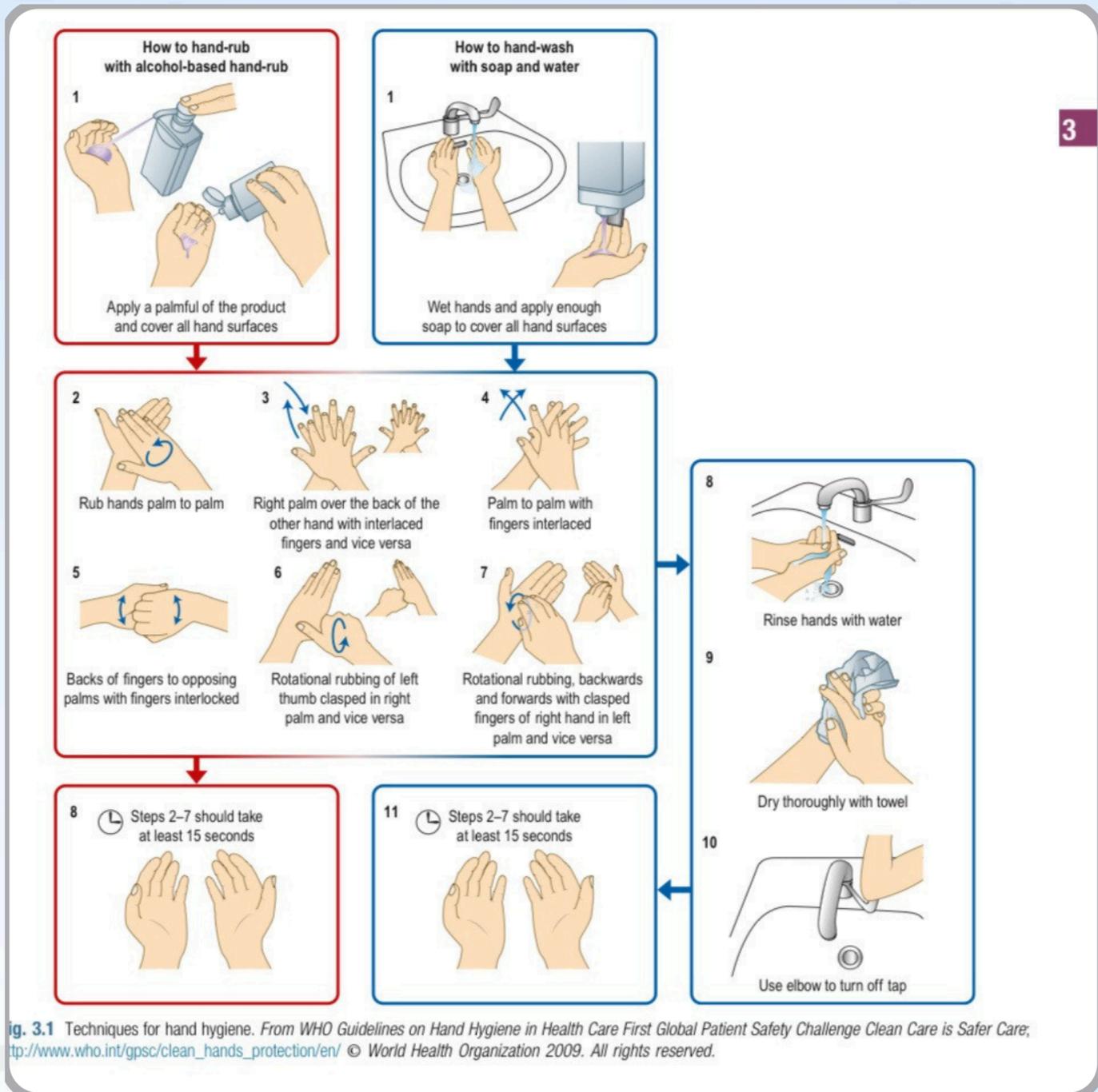
## GENERAL

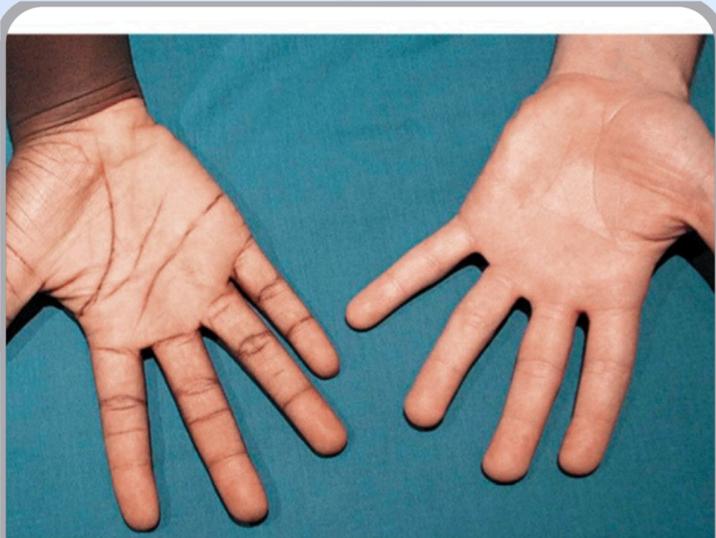
## EXAMINATION



Add a heading

الفريق الأكاديمي  
لجنة الطب والجراحة

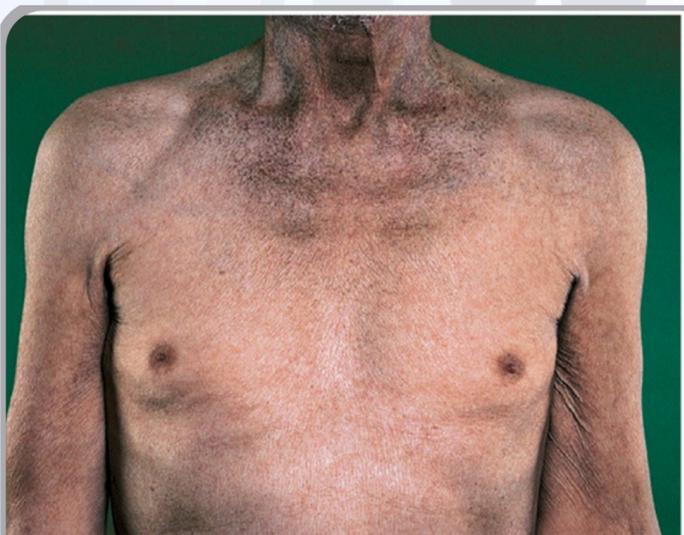




Normal palms. African (left) and European (right).



3.10 Vitiligo. Autoimmune; DM, pernicious anemia, thyroid, adrenal disorders



1 Haemochromatosis with increased skin pigmentation. Iron absorption-when deposits in pancreas causes Bronze diabetes



Fig. 3.12 Erythema ab igne. Or granny tartan

Local deposit of haemosiderin

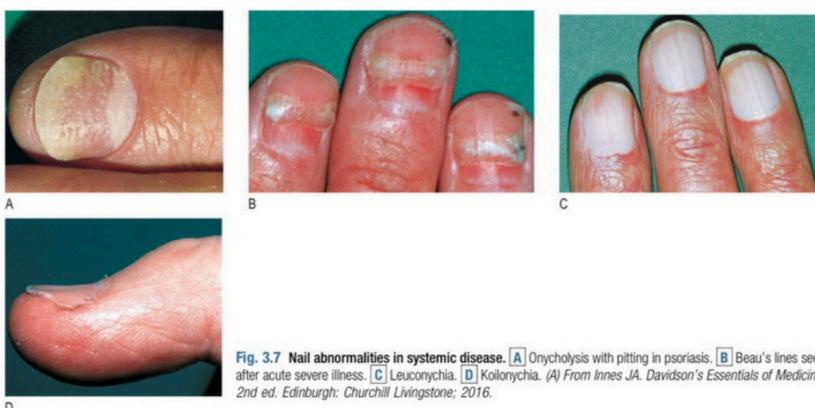


Fig. 3.7 Nail abnormalities in systemic disease. [A] Onycholysis with pitting in psoriasis. [B] Beau's lines seen after acute severe illness. [C] Leuconychia. [D] Koilonychia. (A) From Innes JA. Davidson's Essentials of Medicine, 2nd ed. Edinburgh: Churchill Livingstone; 2016.

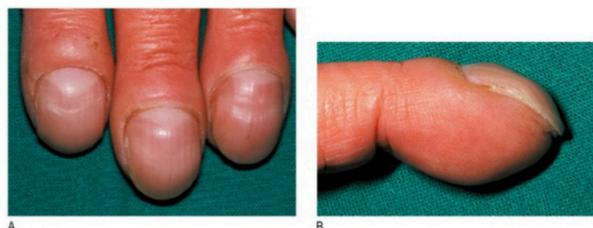
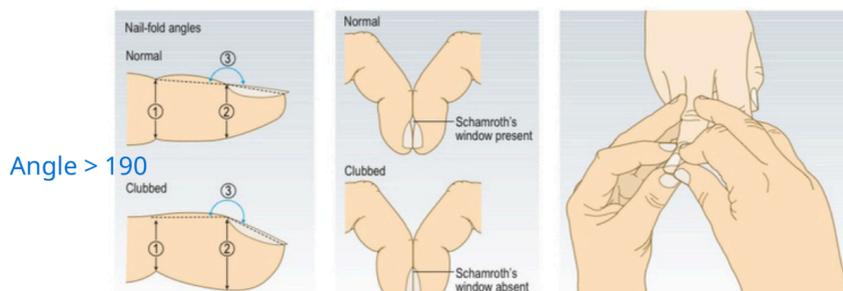


Fig. 3.8 Clubbing. [A] Anterior view. [B] Lateral view.



Angle > 190



Fig. 3.13 Hypercarotenaemia. A control normal hand is shown on the right for comparison. In hypothyroidism || not seen in sclera and conjunctiva

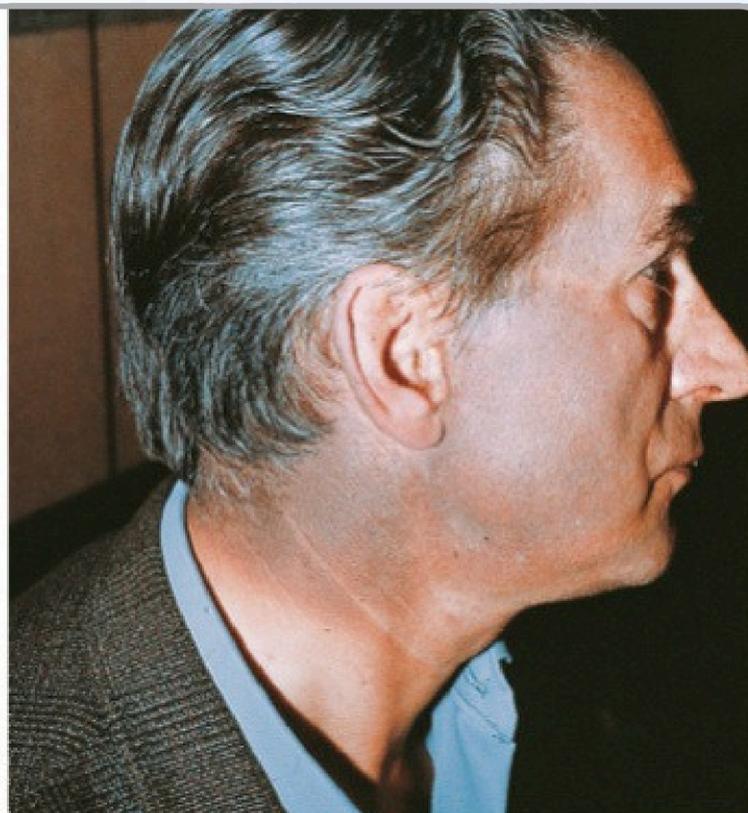
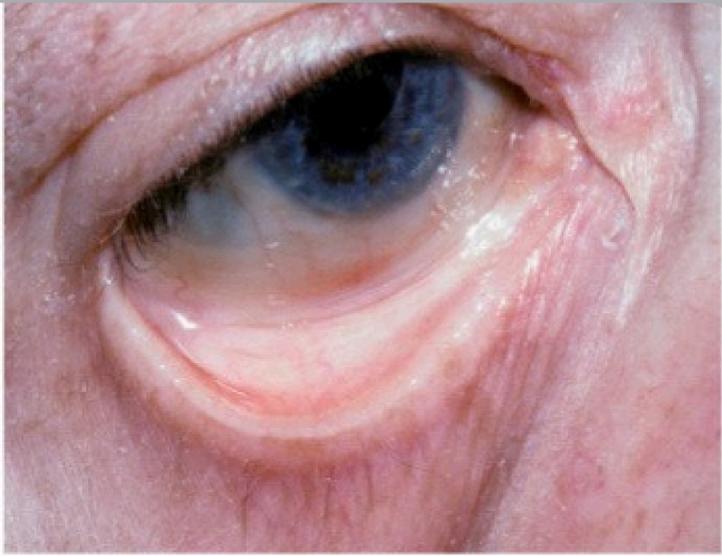
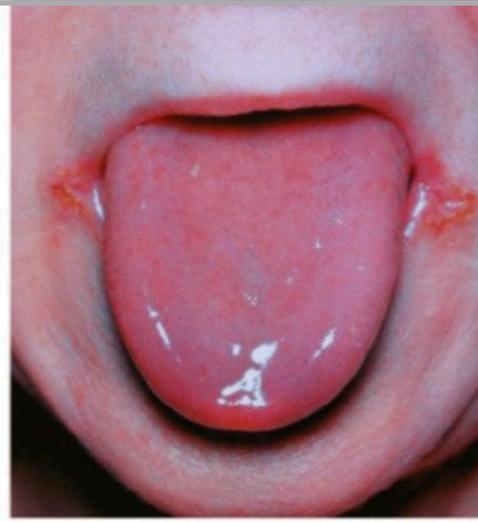


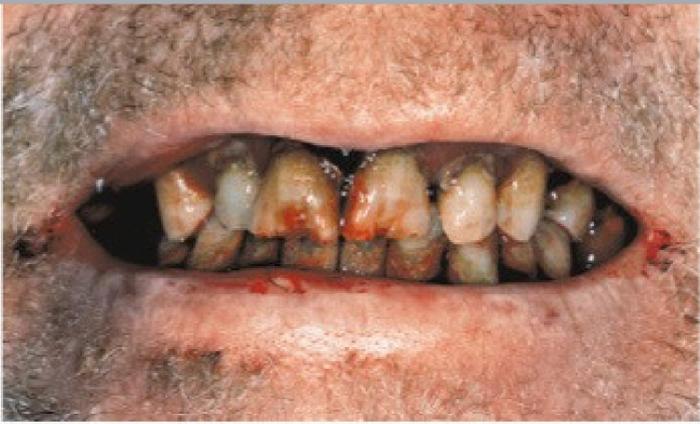
Fig. 3.14 Phenothiazine-induced pigmentation. Slate gray



**Fig. 3.15** Conjunctival pallor.



**Fig. 3.16** Smooth red tongue (glossitis) and angular stomatitis of iron deficiency.



A

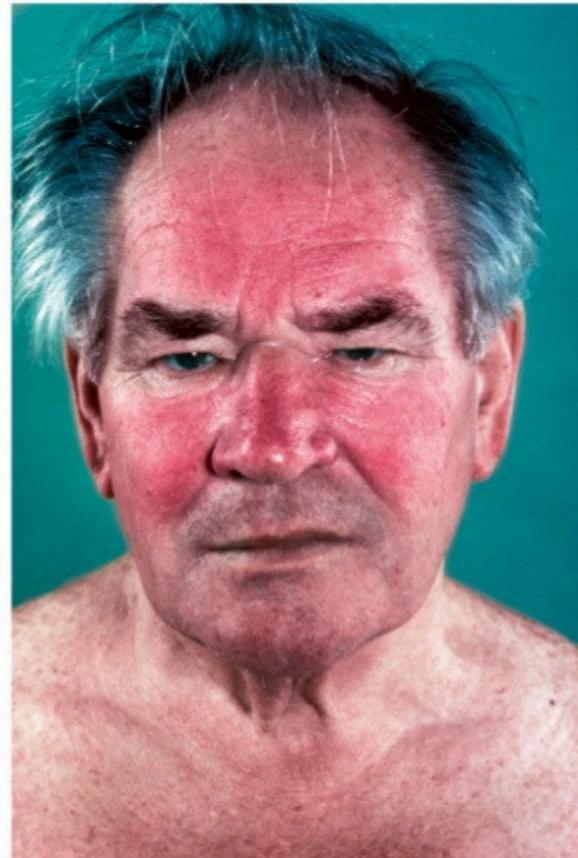


B

**3.19 Scurvy.** **A** Bleeding gums. **B** Bruising and perifollicular hemorrhages.  
Decreased of vit c



A



B

**Fig. 3.17** Flushing due to carcinoid syndrome. **A** Acute carcinoid flush. **B** Chronic telangiectasia.



**Fig. 3.20** Neurofibromatosis.

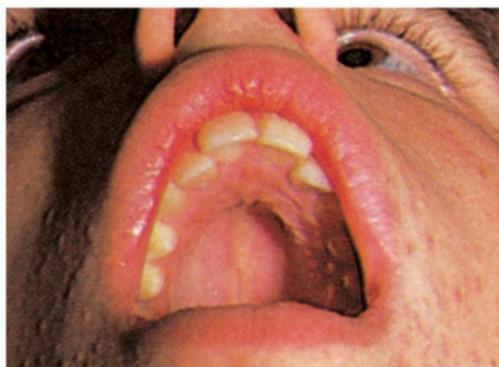


**3.18** Central cyanosis of the lips.

Deoxyhaemoglobin >50g/L, 5g/dl



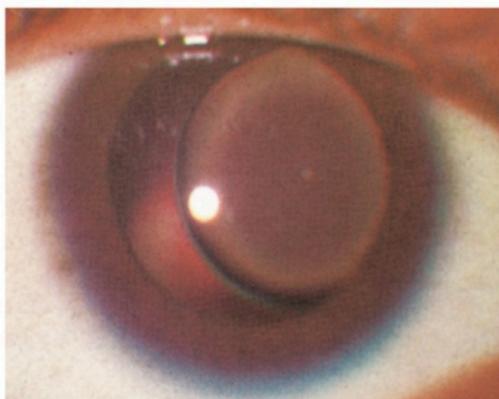
A



C



B



D

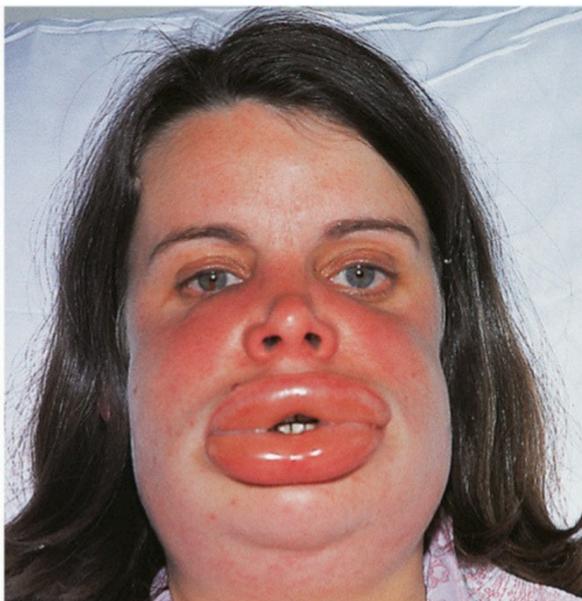
**Fig. 3.21** Marfan's syndrome, an autosomal dominant condition. **A** Tall stature, with the torso shorter than the legs (note surge [redacted] **B** Long fingers. **C** High-arched palate. **D** Dislocation of the lens in the eye. (A–D) From Forbes CD, Jackson WF. *Color Atlas of Clinical medicine*. 5th ed. Edinburgh: Mosby; 2003.



**Fig. 3.22** Swollen right leg, suggesting deep vein thrombosis or inflammation. Causes include soft tissue infection or a ruptured Baker's cyst.



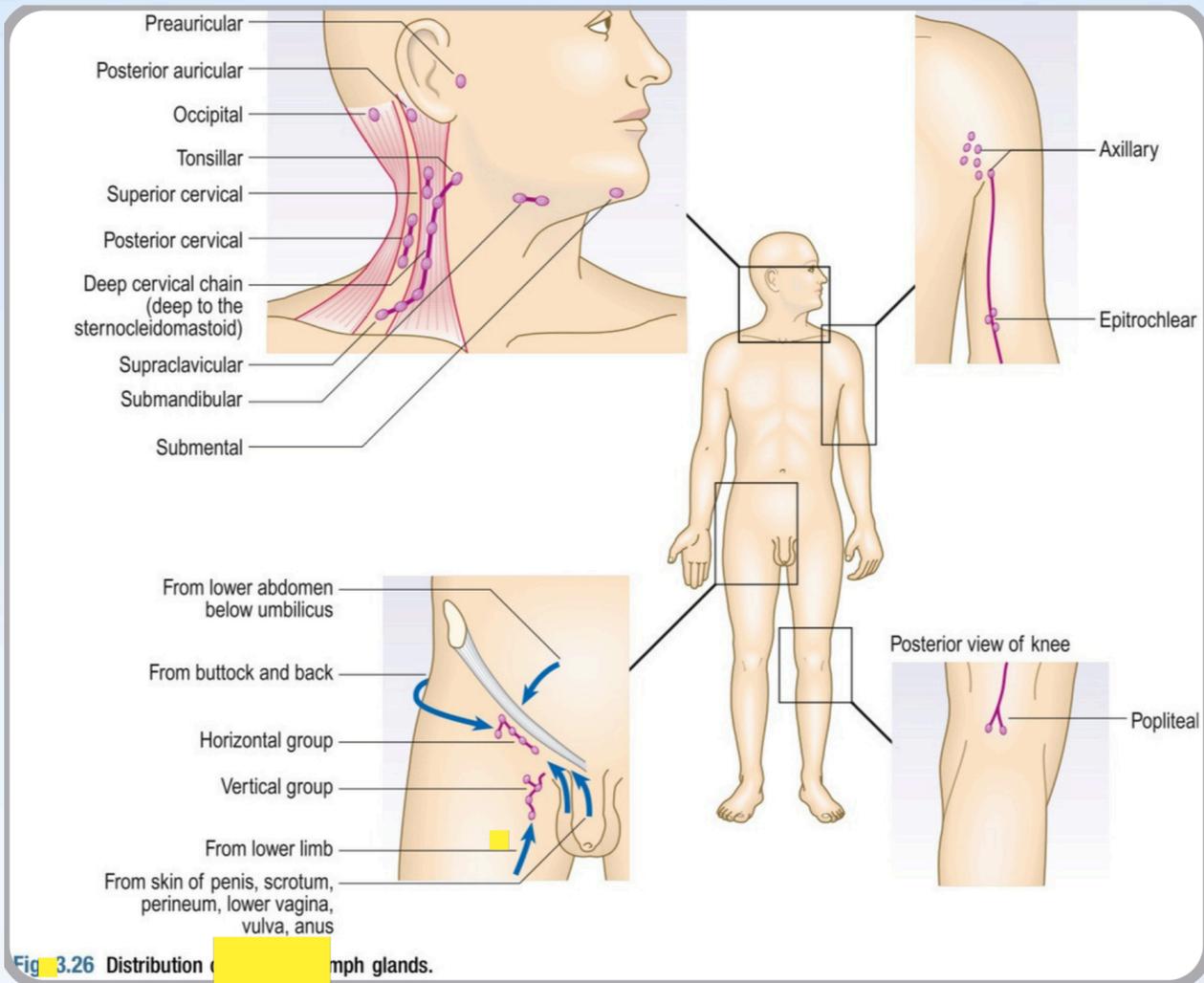
**Fig. 3.23** Lymphoedema of the right arm following right-sided mastectomy and radiotherapy.



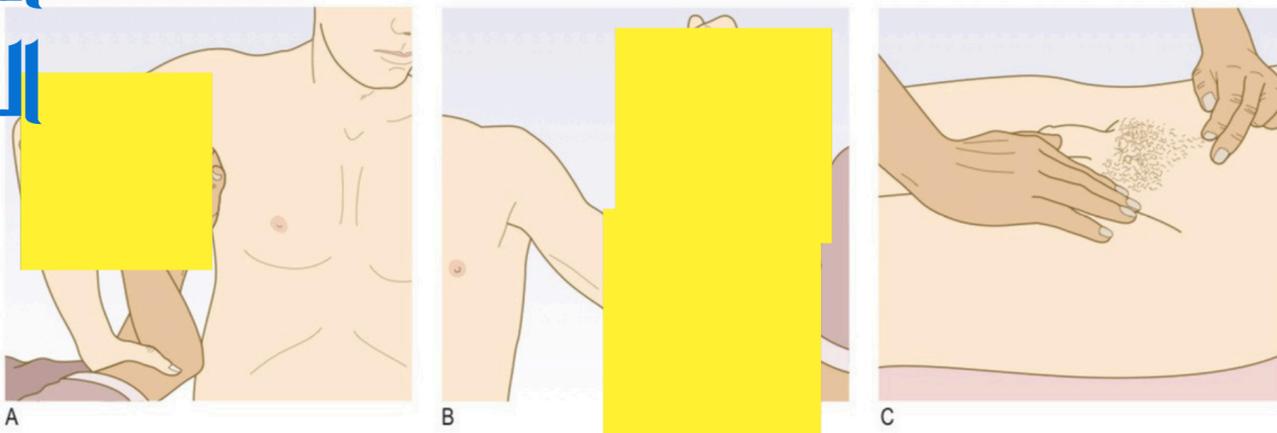
**Fig. 3.24** Angio-oedema following a wasp sting.



**Fig. 3.25** Blister on a leg.



**Fig. 3.27** Palpation of the cervical glands. **A** Examine the glands of the anterior triangle from behind, using both hands. **B** Examine for the scalene nodes from behind with your index finger in the angle between the sternocleidomastoid muscle and the clavicle. **C** Examine the glands in the posterior triangle from the front.



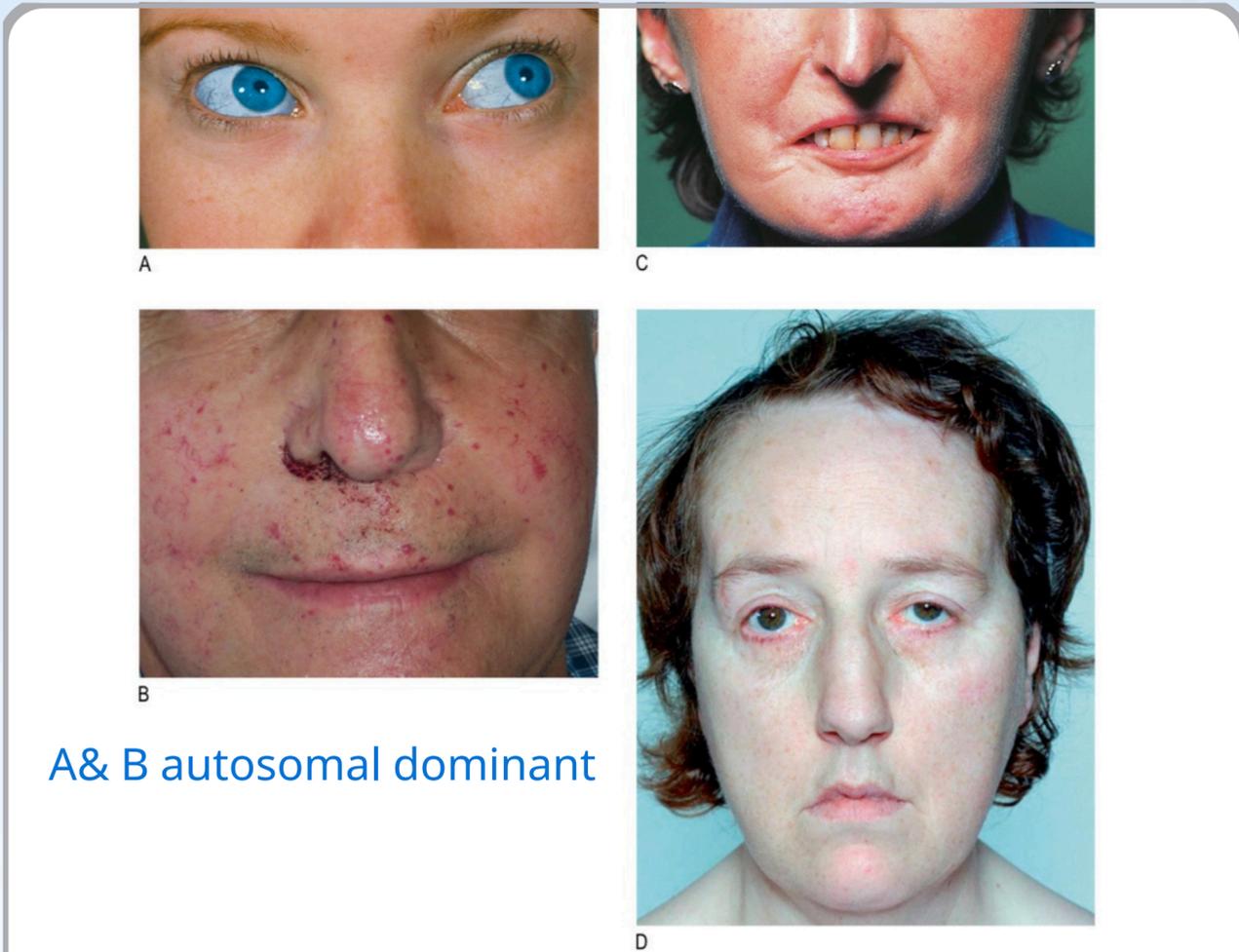
**Fig. 3.28** Palpation of the axillary, epitrochlear and inguinal glands. **A** Examination for right axillary lymphadenopathy. **B** Examination of the left epitrochlear glands. **C** Examination of the left inguinal glands.

انسه للايديين  
المستخدمة  
للفحص



**Fig. 3.29** Petechiae.

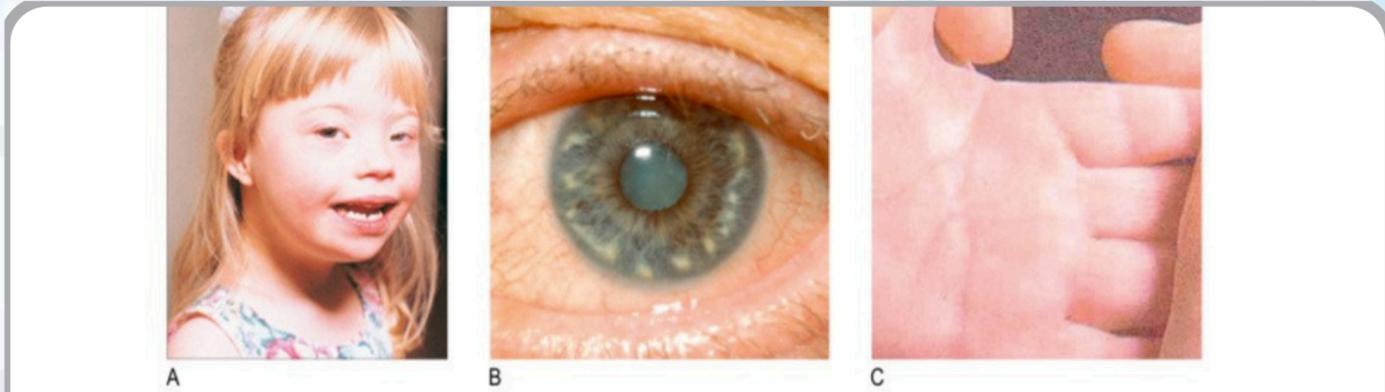
Pinpoint; haematological feature



A & B autosomal dominant

**Fig. 3.30** Characteristic facial features of some disorders. **A** Blue sclerae of osteogenesis imperfecta. **B** Telangiectasia around the mouth, typical of hereditary haemorrhagic telangiectasia. **C** Systemic sclerosis with 'beaking' of the nose and taut skin around the mouth. **D** Myotonic dystrophy with frontal balding and bilateral ptosis.

### Trisomy 21-47 xx/xy+21

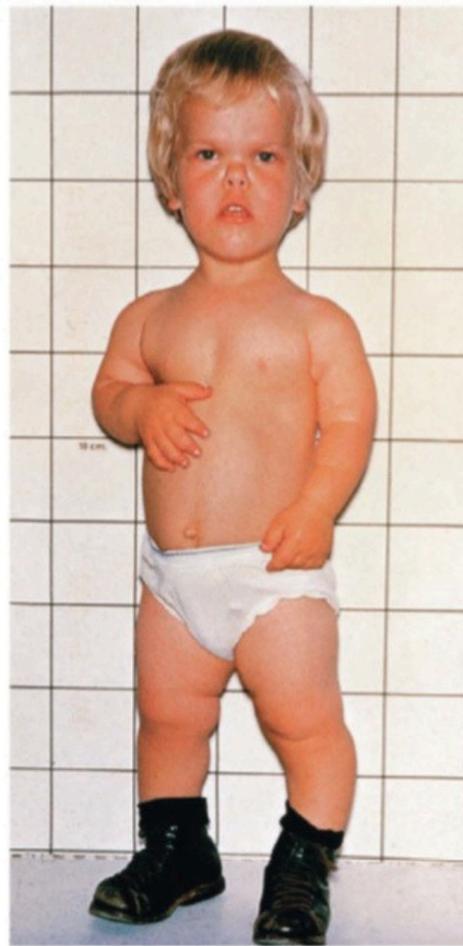


**Fig. 3.31** Down's syndrome. **A** Typical facial appearance. **B** Brushfield spots: grey-white areas of depigmentation in the iris. **C** Single palmar crease. (A) From Phelps K, Hassed C. Genetic conditions. In *General Practice: The Integrative Approach*. 1st ed. Churchill Livingstone; 2011.



**Fig. 3.32** Turner's syndrome. From Seidel HM, Ball J, Dain J, Benedict GW. Growth and measurement. In: *Mosby's Guide to Physical Examination*. 6th ed. 2006.

Shield like chest



**Fig. 3.33** Child with achondroplasia. From Moore KL, Persaud TVN. Congenital anatomic anomalies or human birth defects. In: *Developing Human: Clinically Oriented Embryology*. 8th ed. 2008.

Autosomal dominant of cartilage mutation of fibroblast growth factor gene normal trunk, very short and broad limbs vault of skull is enlarged, the face is small and the bridge of the nose is flat

45 X0

# MINI-OSCE MACLEOD

## LUMPS AND ULCERS



الفريق الأكاديمي  
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**Vascular deformities**



**Mostly hernia**



**Mostly is cancer in parotid gland or lymph node**



**Ulcer**



**Surgery for cleaning the ulcer till find the healthy base**

# Wagner classification of diabetic foot ulcers

Grade 0	Grade 1	Grade 2
<p>No ulcer in a high-risk foot</p> 	<p>Superficial ulcer involving the full skin thickness but not underlying tissues</p> 	<p>Deep ulcer, penetrating down to ligaments and muscle, but no bone involvement or abscess formation</p> 
Grade 3	Grade 4	Grade 5
<p>Deep ulcer with cellulitis or abscess formation, often with osteomyelitis</p> 	<p>Localized gangrene</p> 	<p>Extensive gangrene involving the whole foot</p> 



ischemic gangrene with ulcer



Diabetes ulcer



Diabetes ulcer with pus discharge



**Ulcer with amputation**



**Ulcer**



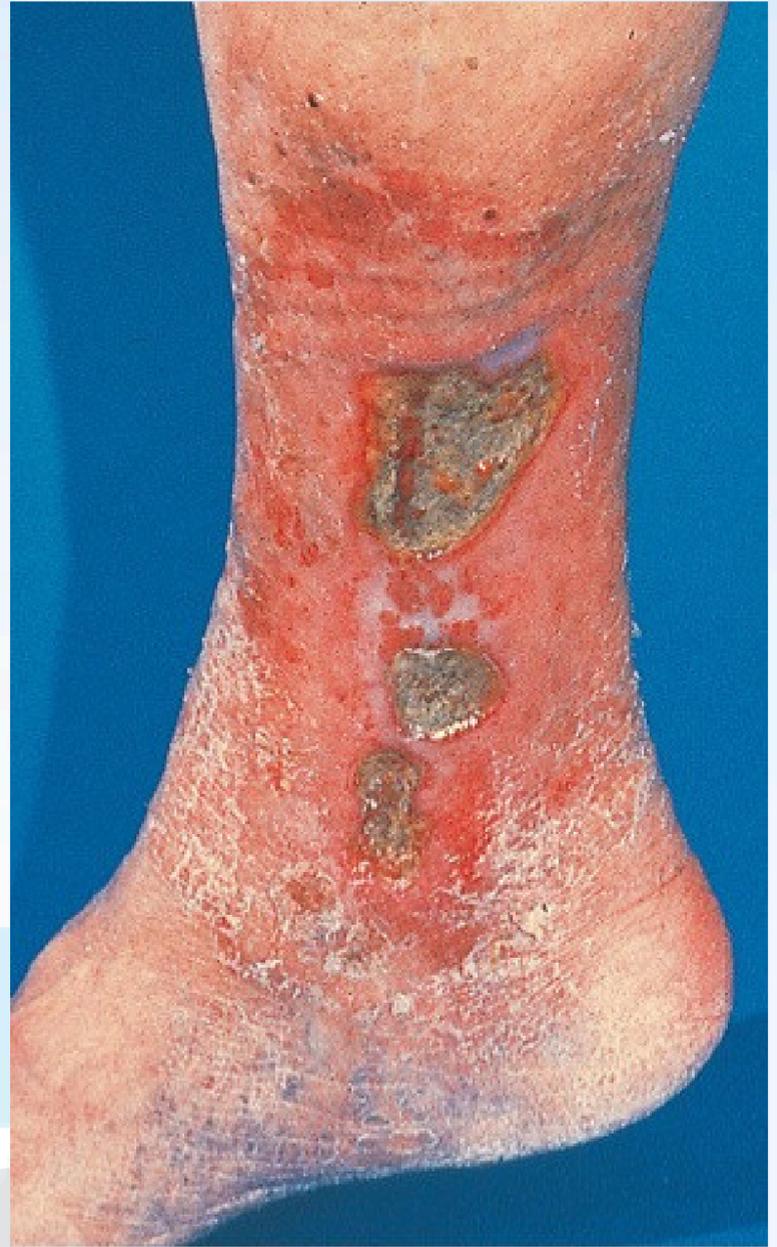
**VAC-Npwt device which is used for improve the healing of ulcer**



**Deep ulcer  
"visible tendon"**



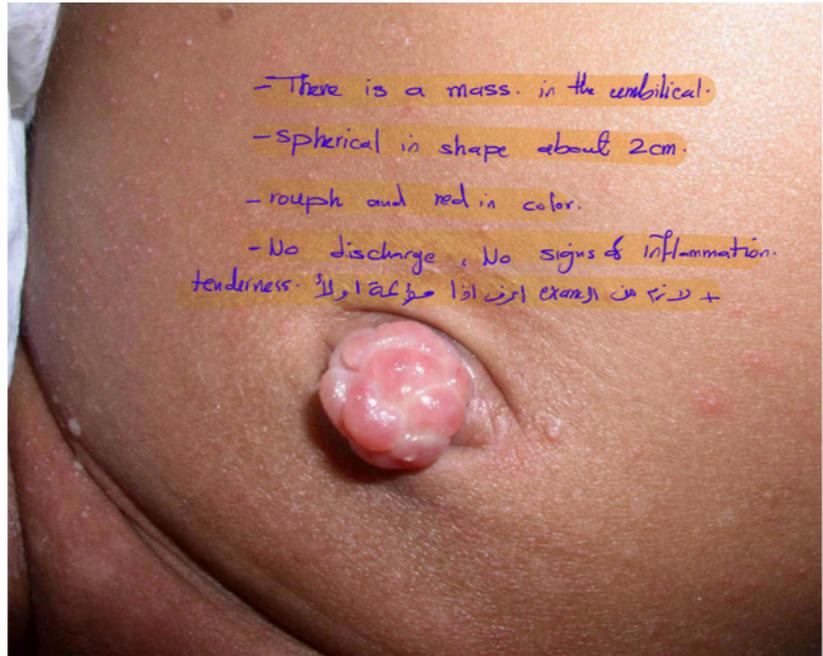
**Ulcer**



deposition. **B** Venous ulcer. (A) From Metcalfe M,

**Fig. 10.14** Diabetic foot complications. **A** Infected foot ulcer with cellulitis and ascending lymphangitis. **B** Ischaemic foot: digital gangrene. **C** Charcot arthropathy with plantar ulcer.

# Lumps



- There is a mass in the umbilical.
- spherical in shape about 2cm.
- rough and red in color.
- No discharge, No signs of inflammation, tenderness.  $\text{لا يوجد إفرازات ولا علامات التهابية ولا ألم}$



- There is an ulcer
- Irregular margin with spherical shape
- Black and shiny in color.



- There is a mass, spherical in shape and translucent  $\text{في الرسغ}$
- There is an fluctuation (fluid wave)
- Red in color.
- The surrounding area is Rinkles that's mean there was an edema
- In lat elbow  $\text{في الرسغ}$

# Ulcer



**Sloping**  
(a healing ulcer)



**Punched-out**  
(syphilis, trophic)



**Undermined**  
(tuberculosis)



**Rolled**  
(basal cell carcinoma)



**Everted**  
(squamous cell carcinoma)



- ulcer in the leg
- The surrounding area congested with blood
- The ulcer red and scale in shape
- white margin
- There is no discharge

Venous ulcer ( sloping edge) ↗



( sloping edge) ↗



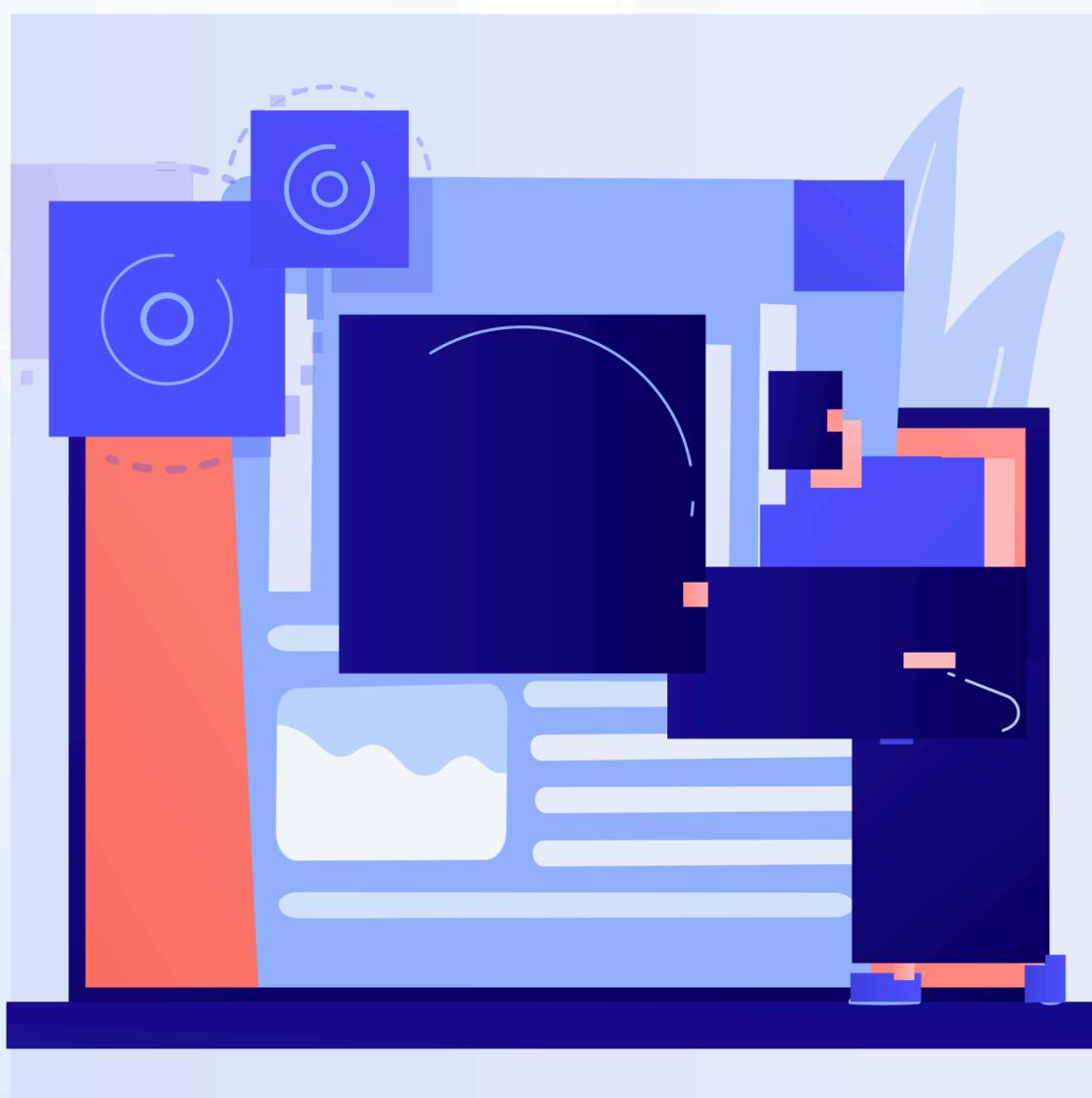
(sloping edge) —



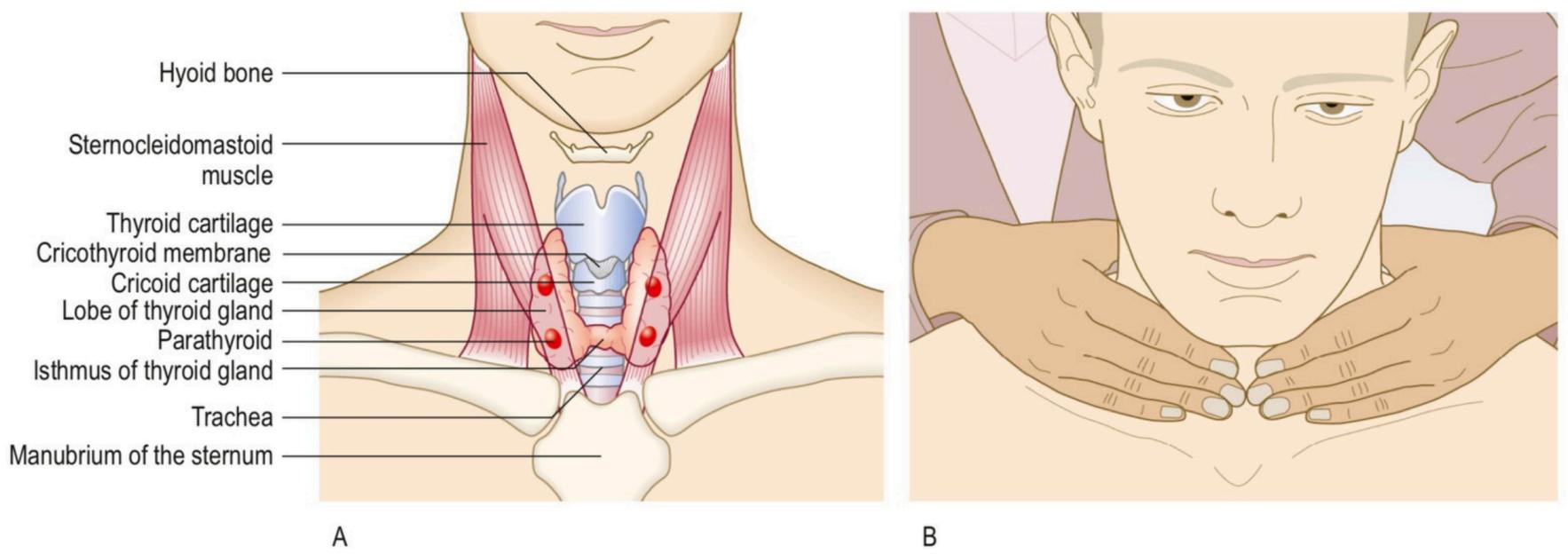


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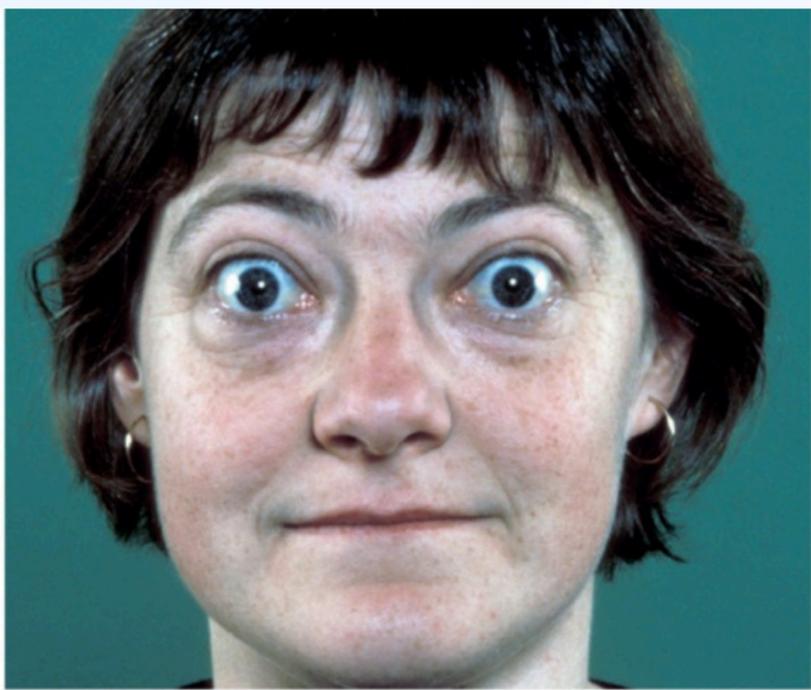
## THYROID



الفريق الأكاديمي  
لجنة الطب والجراحة



**Fig. 10.1 The thyroid gland.** **A** Anatomy of the gland and surrounding structures. **B** Palpating the thyroid gland from behind.



**A**



**B**



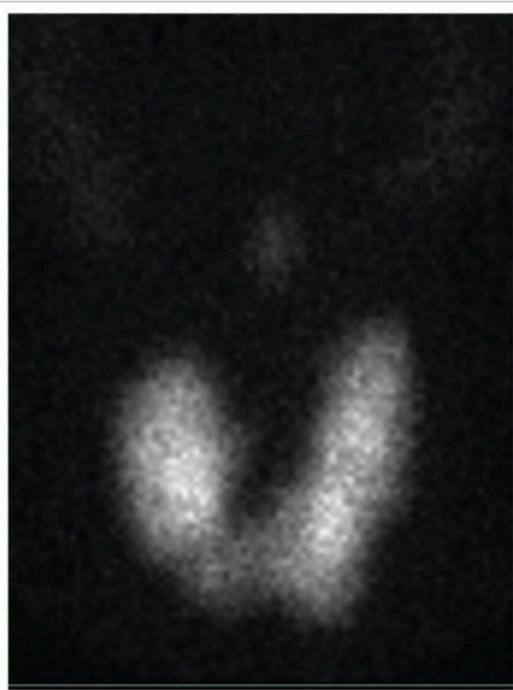
**C**



**D**

**Fig. 10.2 Graves' hyperthyroidism.** **A** Typical facies. **B** Severe inflammatory thyroid eye disease. **C** Thyroid acropachy. **D** Pretibial myxoedema. (A) From Strachan MWJ, Newell Price JDC. *Endocrinology*. In Ralston S, Penman I, Strachan MWJ, et al. (eds). *Davidson's Principles and Practice of Medicine*. 23rd ed. Philadelphia: Elsevier; 2018.

# Thyroid enlargement



A

A)  $^{99m}\text{Tc}$  Technetium radionuclide scan demonstrating diffuse goitre due to Graves' disease.



B

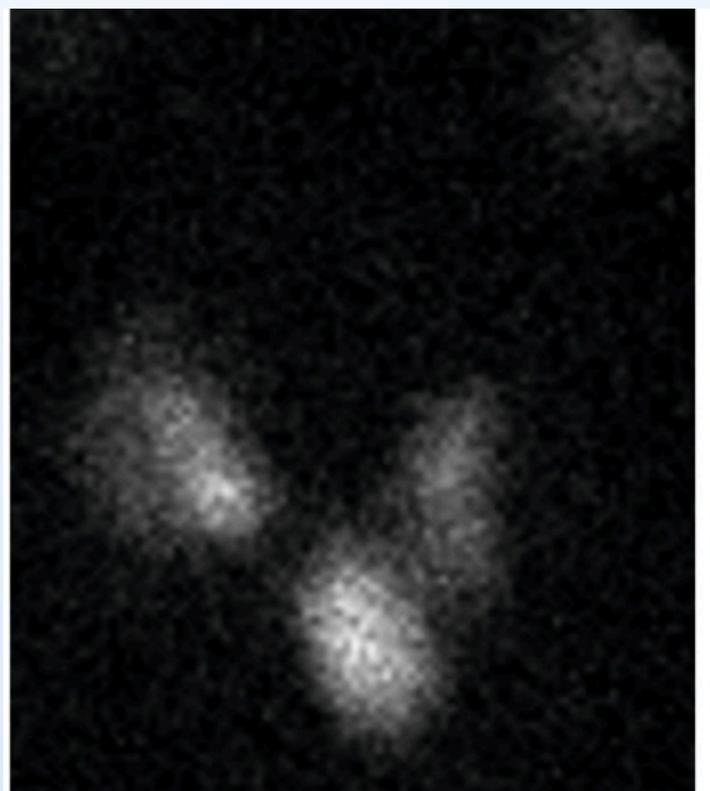
B) Diffuse goitre due to Graves' disease



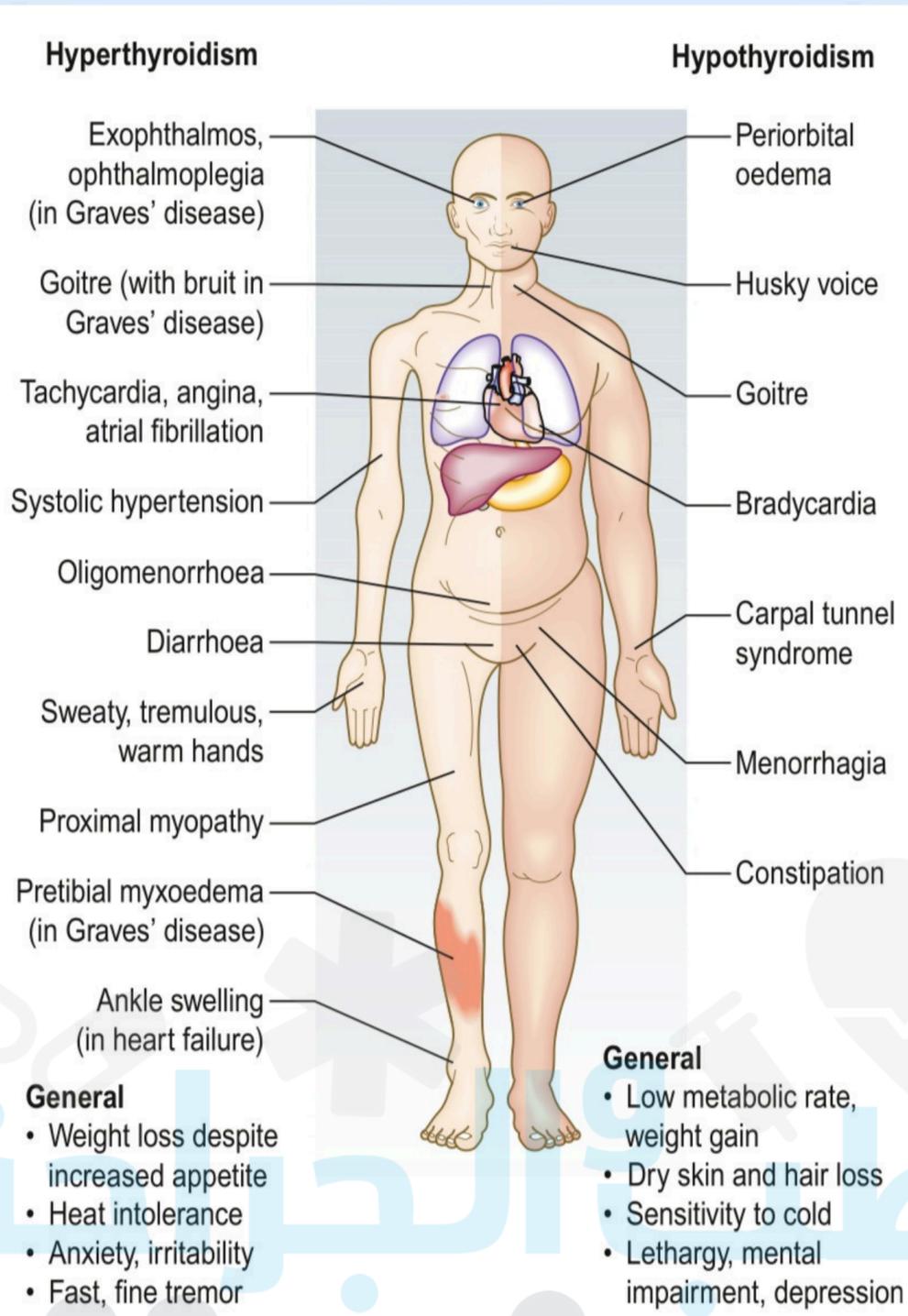
C

C) Solitary toxic nodule.

D)  $^{99m}\text{Tc}$  Technetium radionuclide scan confirming multinodular goitre.



D



**Fig. 10.4** Features of hyper- and hypothyroidism.

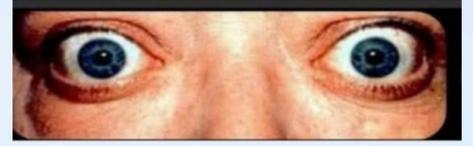


**Fig. 10.5** Typical facies in hypothyroidism.

# Thyroid Mini OSCE Archive :

1: 30yearsold patient admitted to surgical clinic with neck enlargement, after eye examination shows as in picture: Which wrong about this condition ?

1. Diarrhea is the common bowel habit for this patient.
2. The face is wet and sweaty .
3. Goiter indicated for hyperthyroidism condition. XXX
4. after treatment, exophthalmus not removed.
5. hyperthyroidism associated with arrhythmia, atrial fibrillation or tremor



2:

1. Deep venous thrombosis.
2. Hypothyroidism
3. Nephrotic syndrome.
4. Graves disease. XXXX
5. Liver cirrhosis

23-The most Dxx for this patient :



3:

1. lid lag xxxx
2. Lid retraction

13- this indicate ?



4:

goiter associated with all except :

- 1) Iodine deficiency
- 2) Thyrotoxicosis
- 3) Malignancy
- 4) Pregnancy "xxxxx"



5:

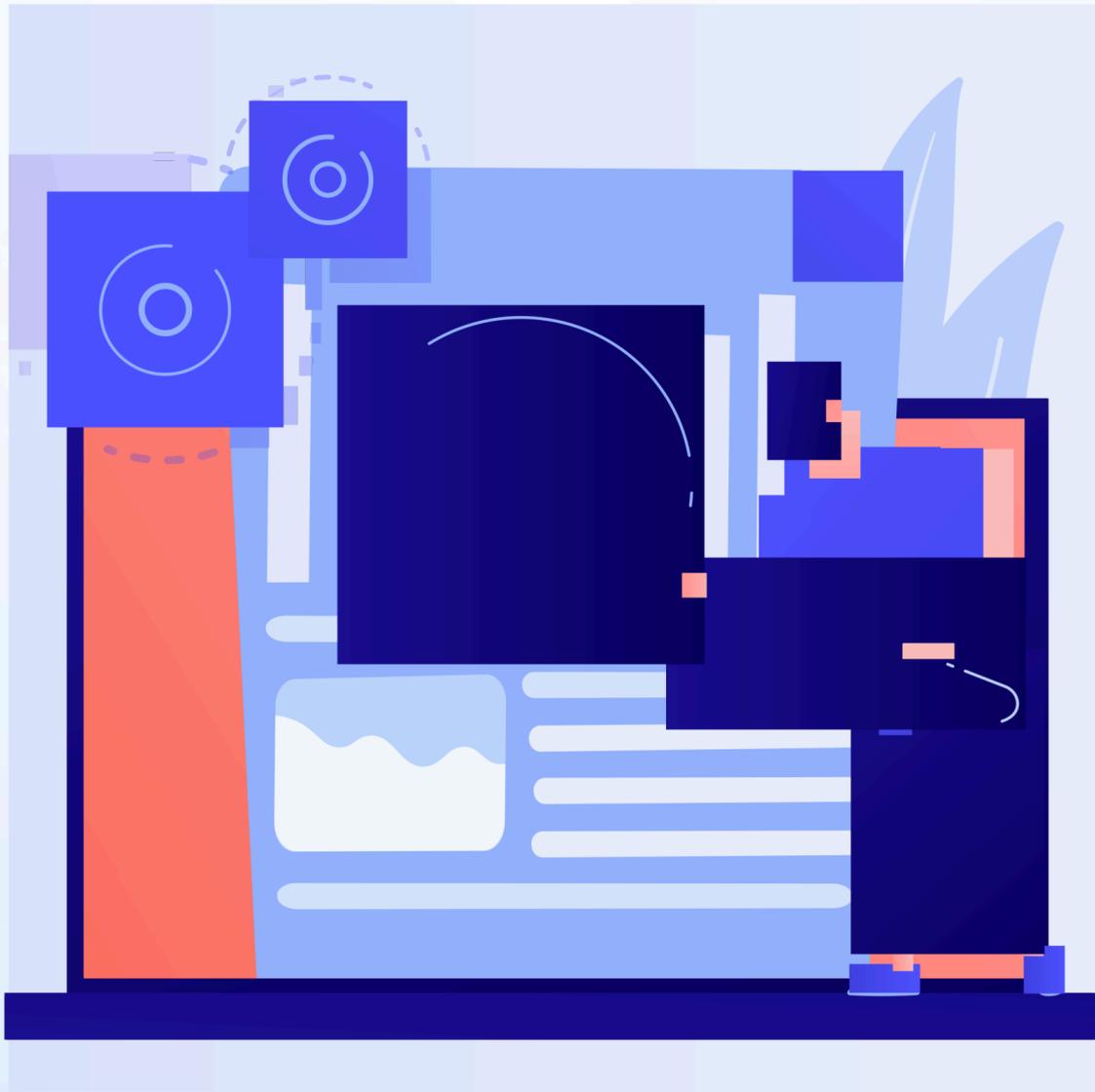
1. lid lag xxx
2. Lid retraction
3. periorbital edema

12- which of the following is not found in this ?



# MINI-OSCE MACLEOD

## BREAST



الفريق الأكاديمي  
لجنة الطب والجراحة



**Fig. 11.2** Accessory breast tissue in the axilla.



**Fig. 11.4** Breast volume and shape changes to right breast following lumpectomy (scar at upper outer quadrant) and radiotherapy (tattoo indicated by arrow). Radiotherapy has also resulted in right breast skin thickening and hyperpigmentation



**Fig. 11.5** Inflammatory breast cancer: patchy erythema, flattened nipple, peau d'orange of right breast.

patient if they have recently changed their bra size. In addition, ask if the changes are:

- unilateral or bilateral,
- recent or longstanding

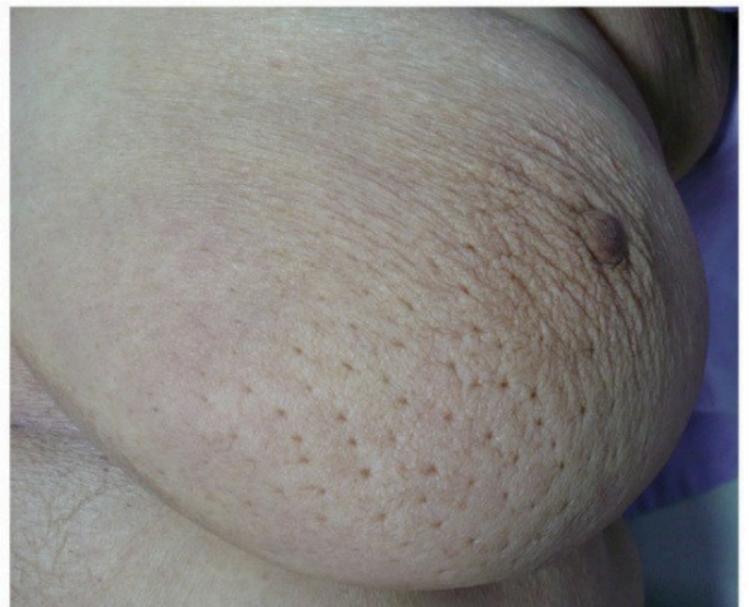
Breast cancer surgery or treatment, especially radiotherapy, are likely to cause scarring that results in breast skin colour, texture, shape and volume changes (Fig. 11.4).

Breast implant surgery is increasingly common, and changes to breast volume and shape may be a consequence of implant changes, such as capsular contracture or implant rupture.



**Fig. 11.7** Single duct, blood-stained nipple discharge.

symptoms. Malignant nipple retraction is unlikely to be correctable and often presents with other signs of malignancy.



**Fig. 11.6** Peau d'orange of the breast.



Fig. 11.12 Mammary duct fistula.



Fig. 11.6 Paget's disease of the nipple.



Fig. 11.5 Peau d'orange of the breast.

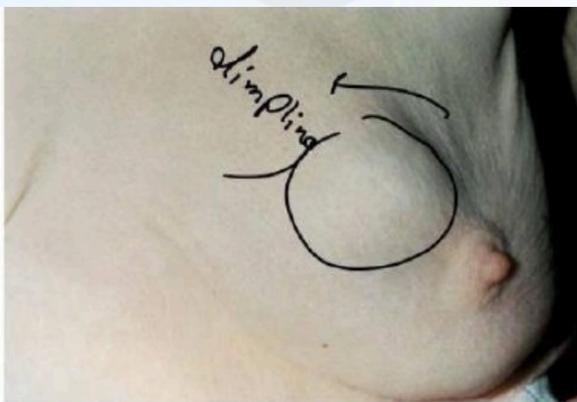


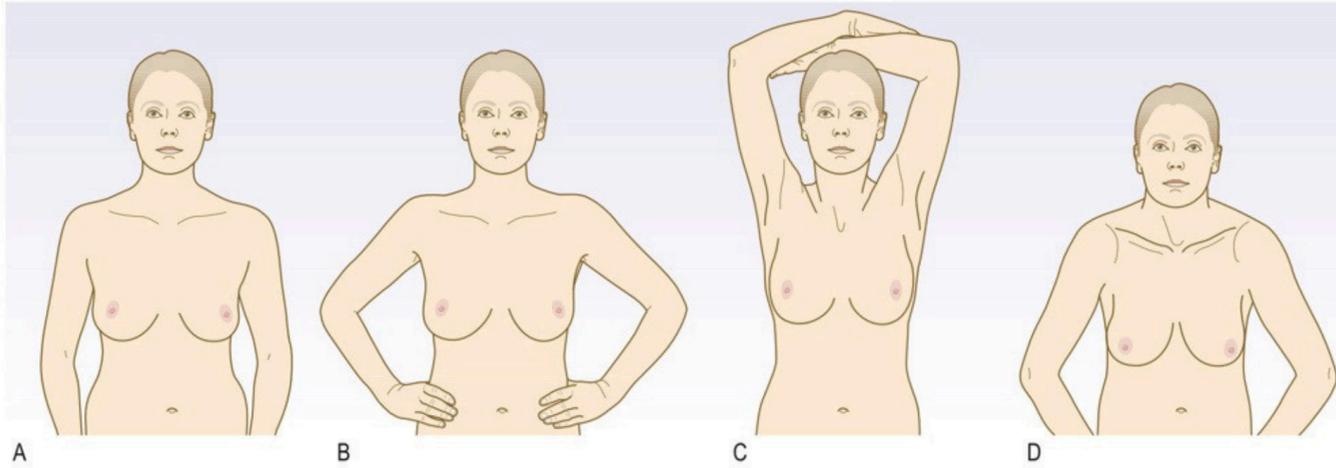
Fig. 11.4 Skin dimpling due to underlying malignancy.



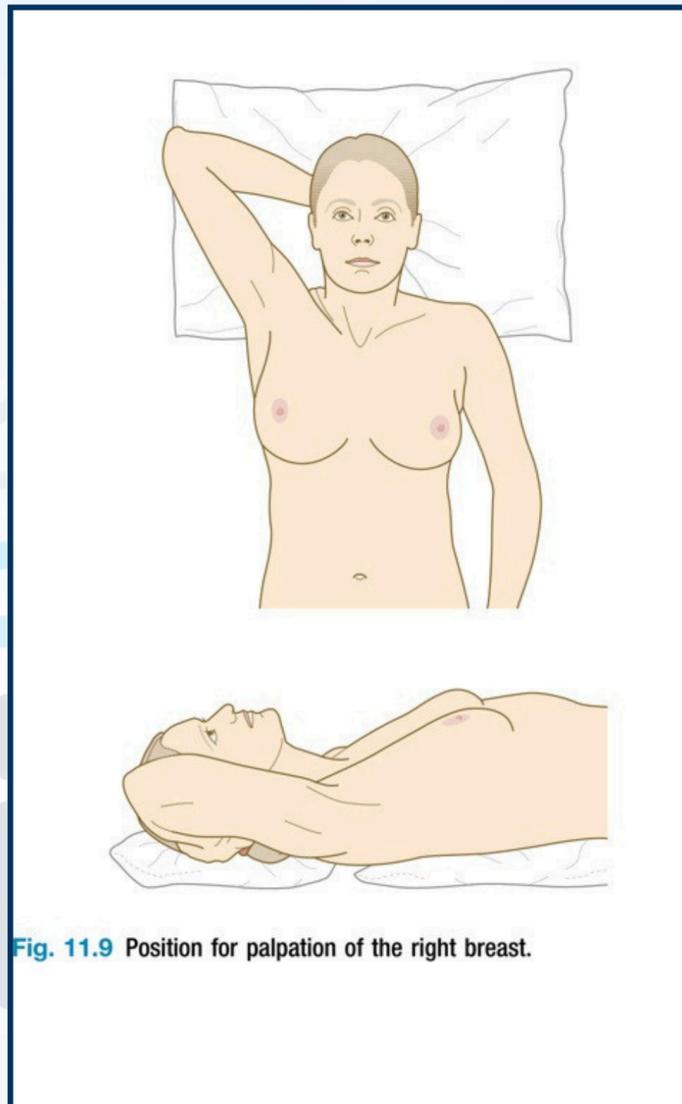
Fig. 11.8 Drug-induced gynaecomastia caused by cimetidine.



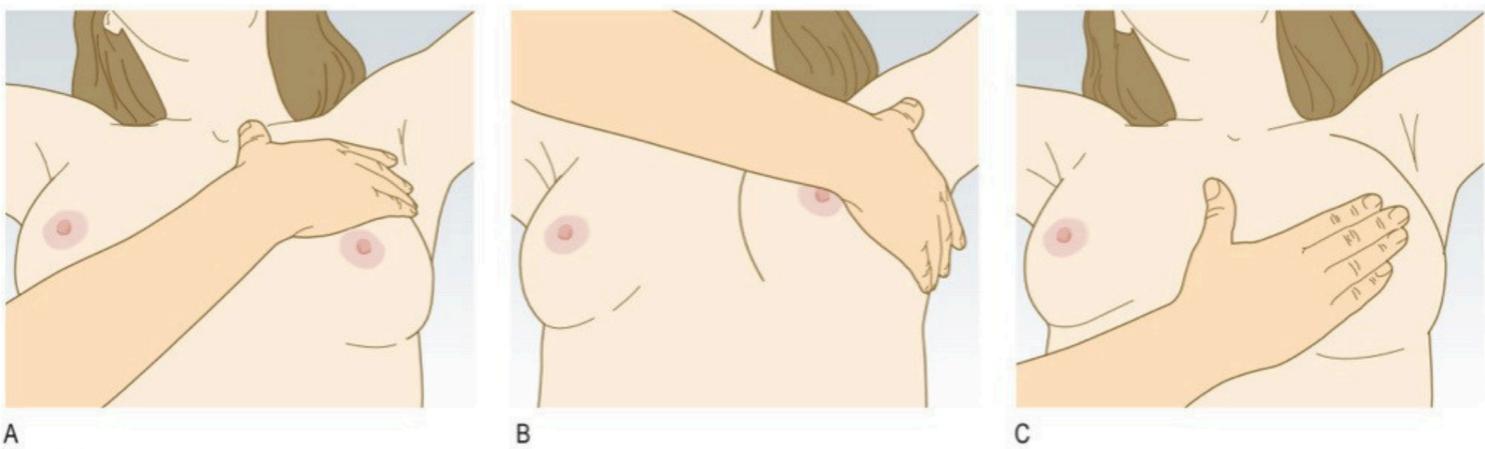
examining the anterior serratus muscle to check the relations of the muscles with the underlying breast disease



**Fig. 11.8** Positions for inspecting the breasts. **A** Hands resting on the thighs. **B** Hands pressed on to the hips. **C** Arms above the head. **D** Leaning forward with the breasts pendulous.



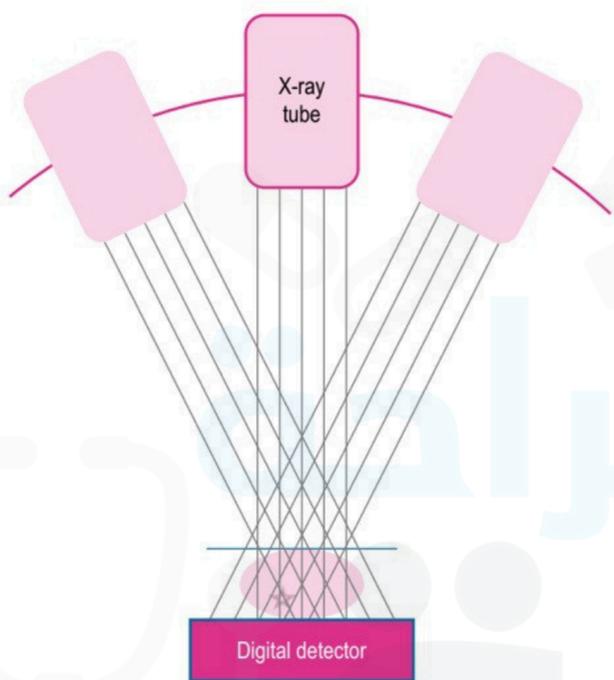
**Fig. 11.9** Position for palpation of the right breast.



**Fig. 11.10** Clinical examination of the breast. Examine each quadrant of the breast systematically, from the outside towards the nipple, including under the nipple.

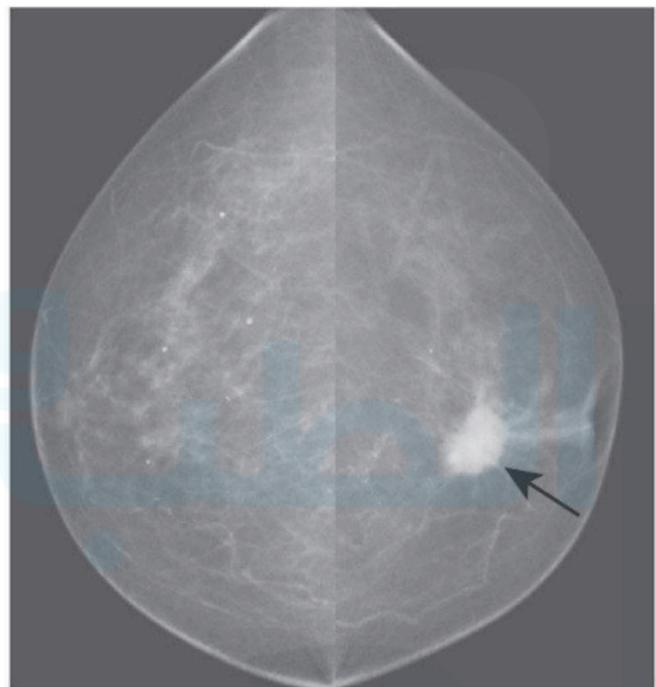


**Fig. 11.13** Ultrasound of a breast cyst. A characteristic smooth-walled, hypoechoic lesion (arrow).

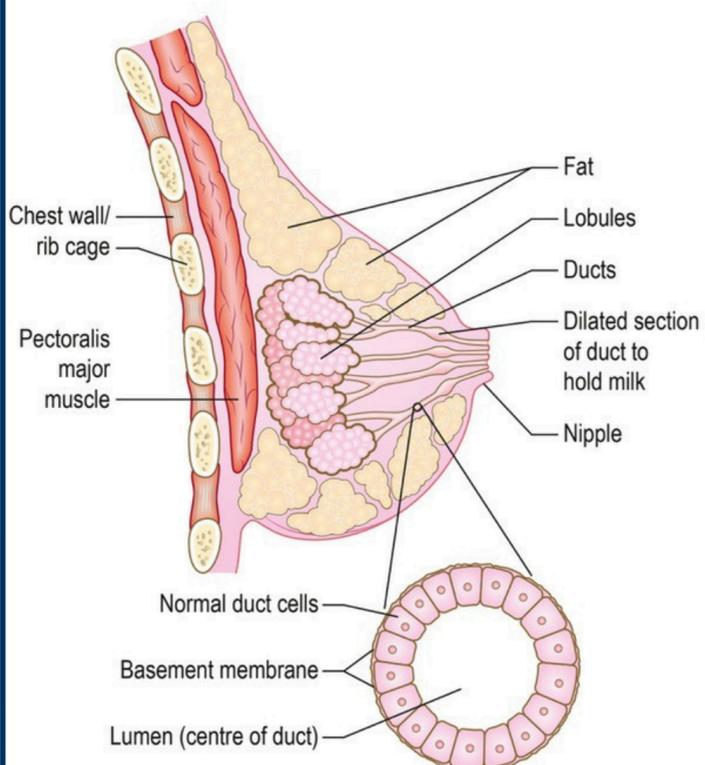


11

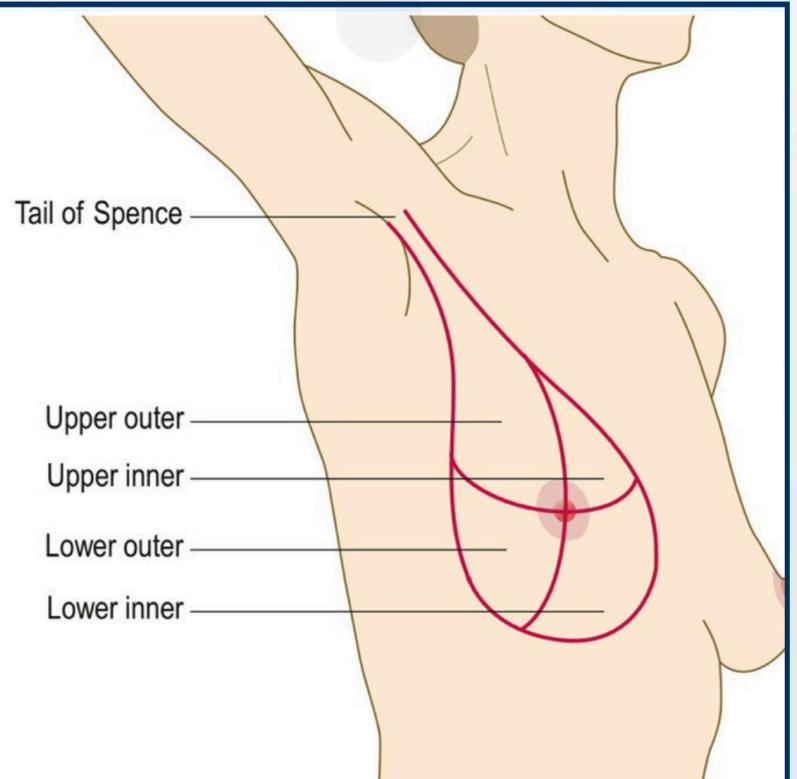
**Fig. 11.14** Digital breast tomosynthesis. The x-ray tube moves along an acquisition angle obtaining projectional images (slices) of the compressed breast. These stacked images are then reconstructed to create three-dimensional images of the breast.



**Fig. 11.12** Digital mammogram. A spiculate opacity characteristic of a cancer (arrow).



**Fig. 11.3** Cross-section of the female breast.



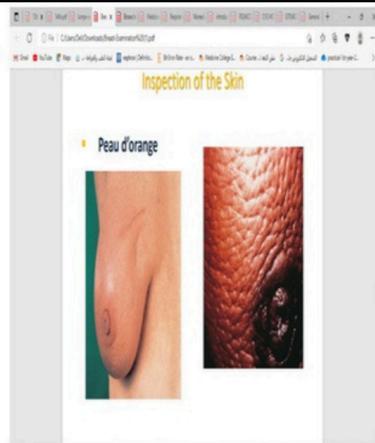
**Fig. 11.1** Adult right breast.

What is the most likely diagnosis ?

- 1)
- 2) Peau d'orange of breast
- 3)
- 4)



2. name :  
Peudo orange



10- what this indicates ?



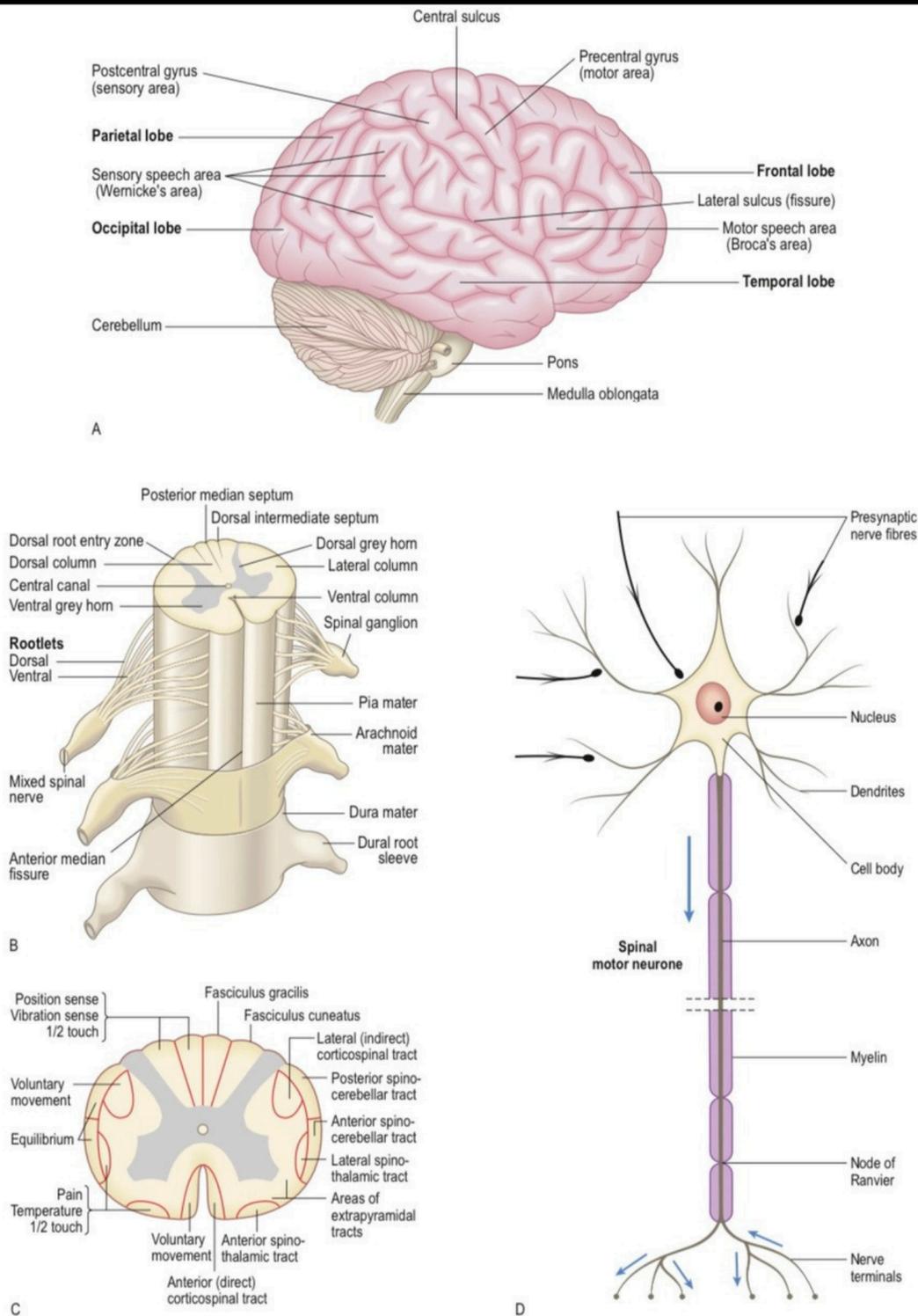
- a. Breast eczema ✓
- b. Breast abscess

# MINI-OSCE MACLEOD

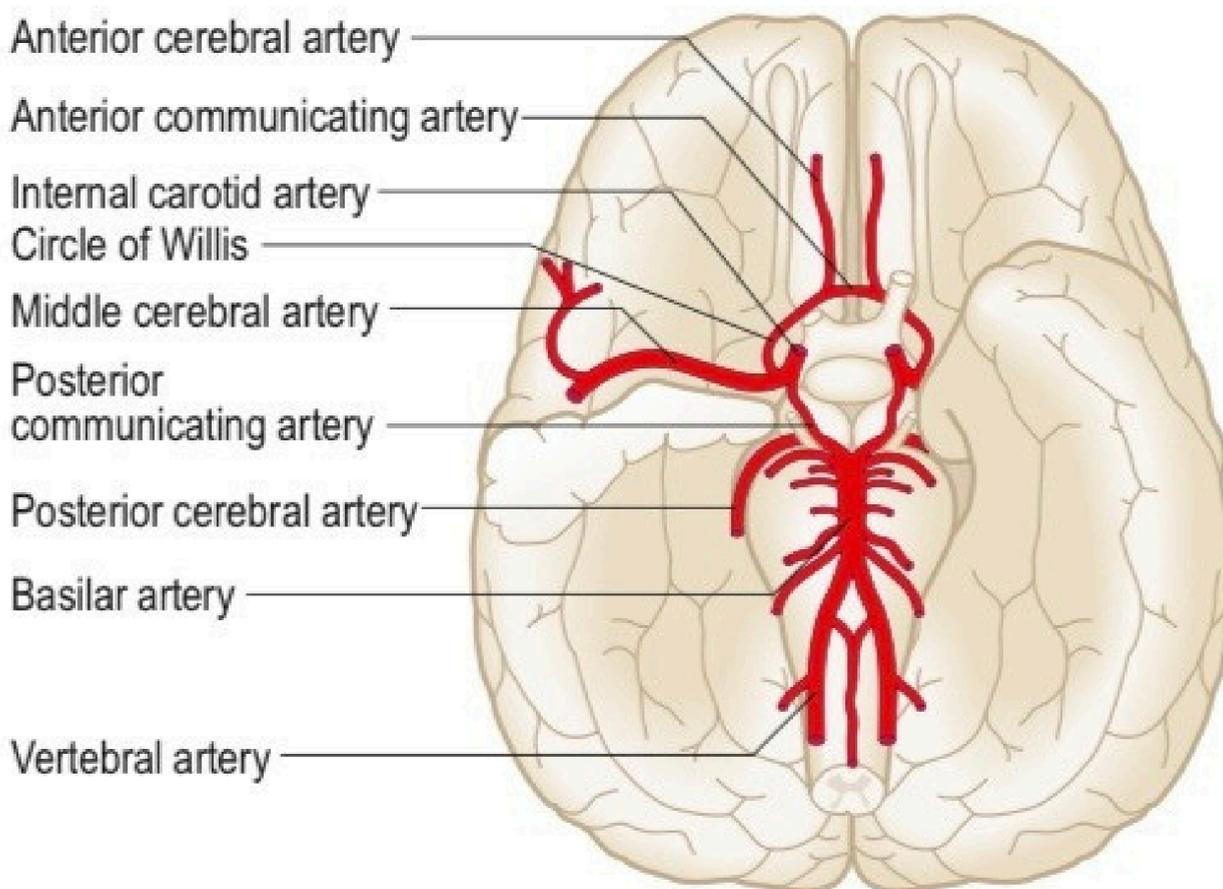
## NERVOUS SYSTEM



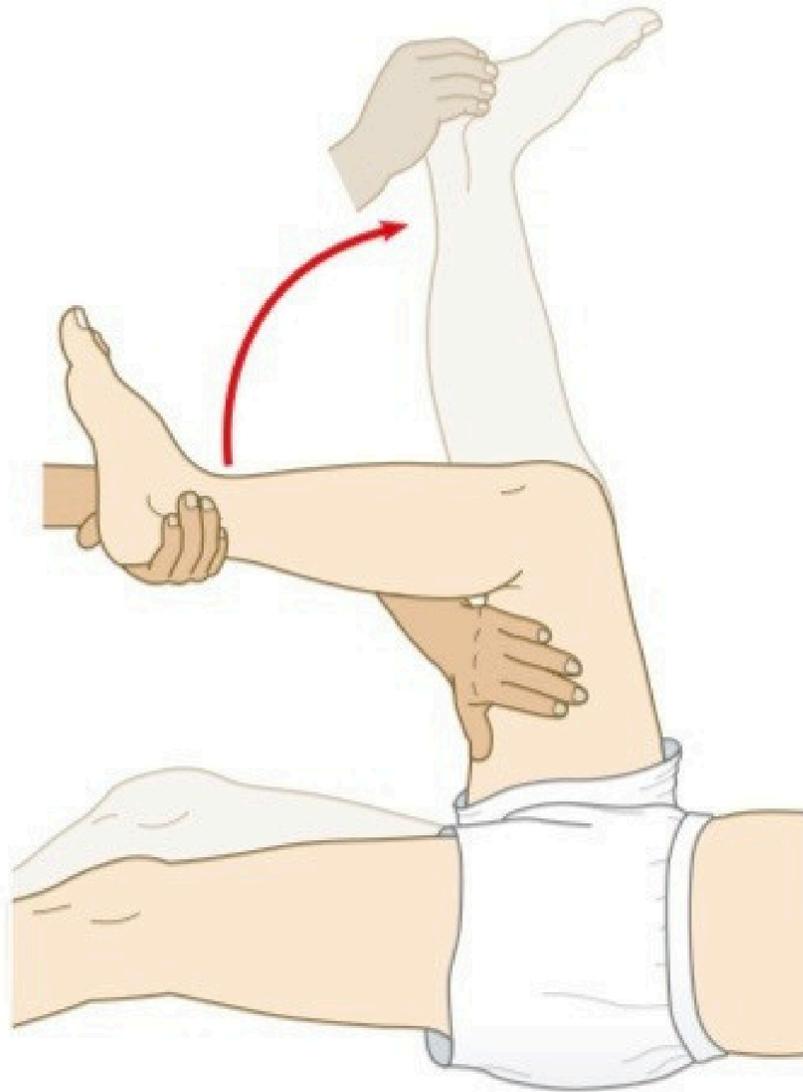
الفريق الأكاديمي  
لجنة الطب والجراحة



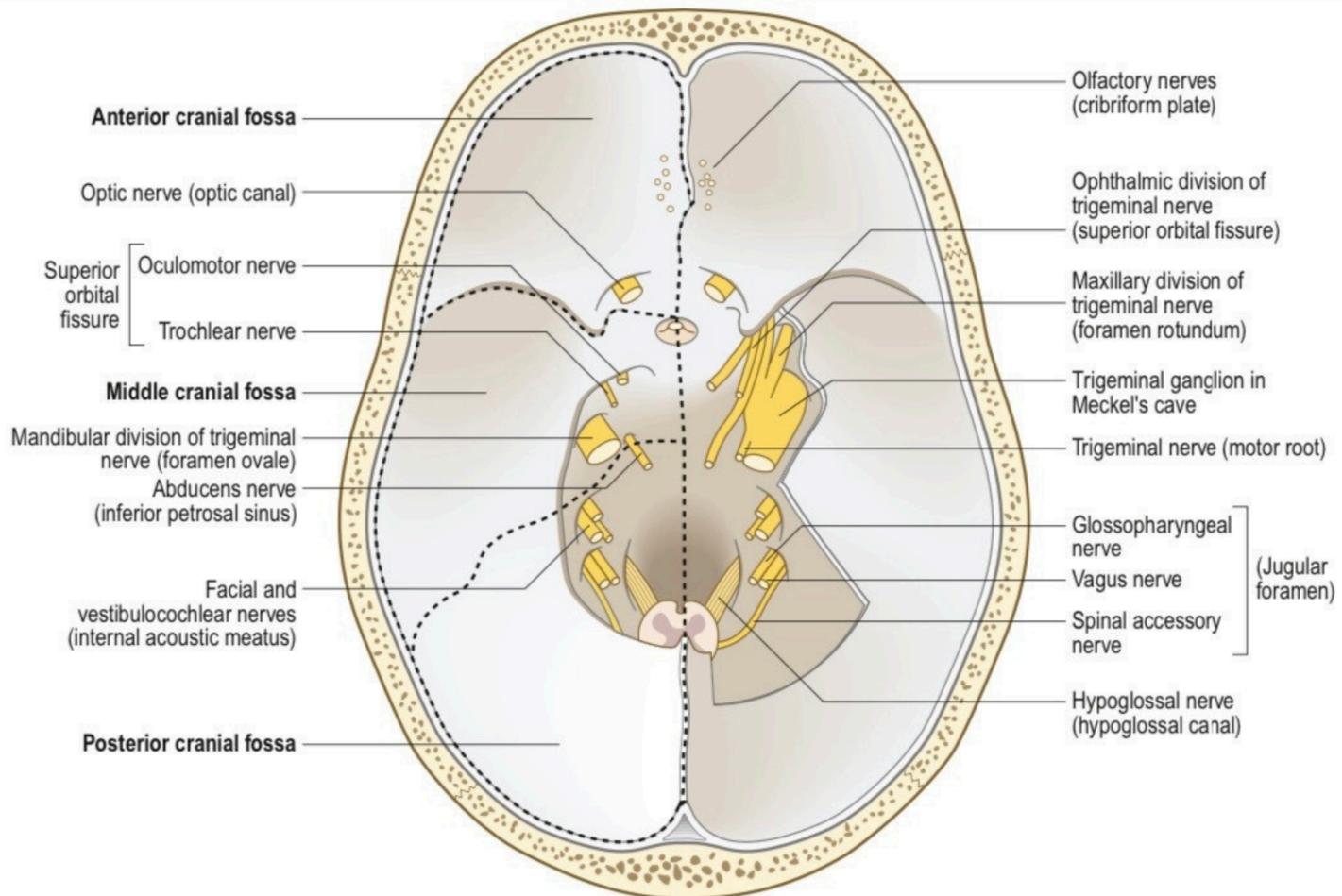
**Fig. 7.1** Anatomy of the central nervous system. **A** Lateral surface of the brain. **B** Spinal cord, nerve roots and meninges. **C** Cross-section of the spinal cord. **D** Spinal motor neuron. The terminals of presynaptic neurons form synapses with the cell body and dendrites of the motor neurons.



**Fig. 7.2** The arterial blood supply of the brain (circle of Willis).



**Fig. 7.3** Testing for meningeal irritation: Kernig's sign.



**Fig. 7.5** Base of the cranial cavity. The dura mater, with the cranial nerves and their exits from the skull. On the right side, part of the tentorium cerebelli and the roof of the trigeminal cave have been removed.

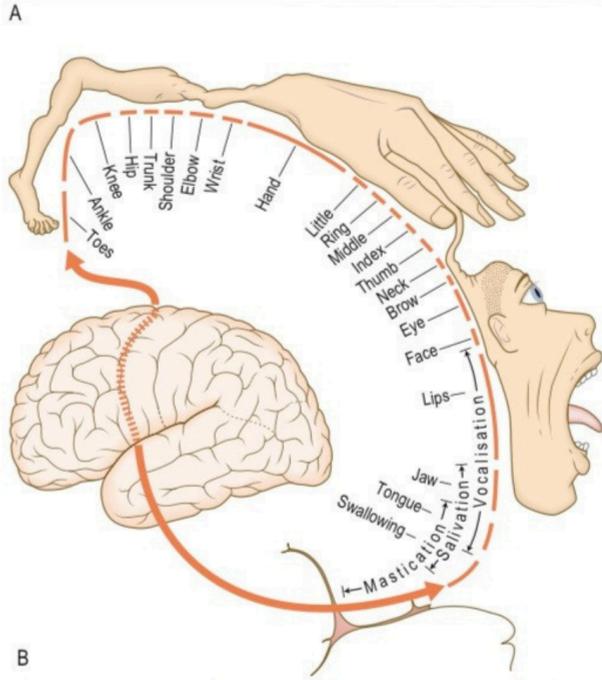
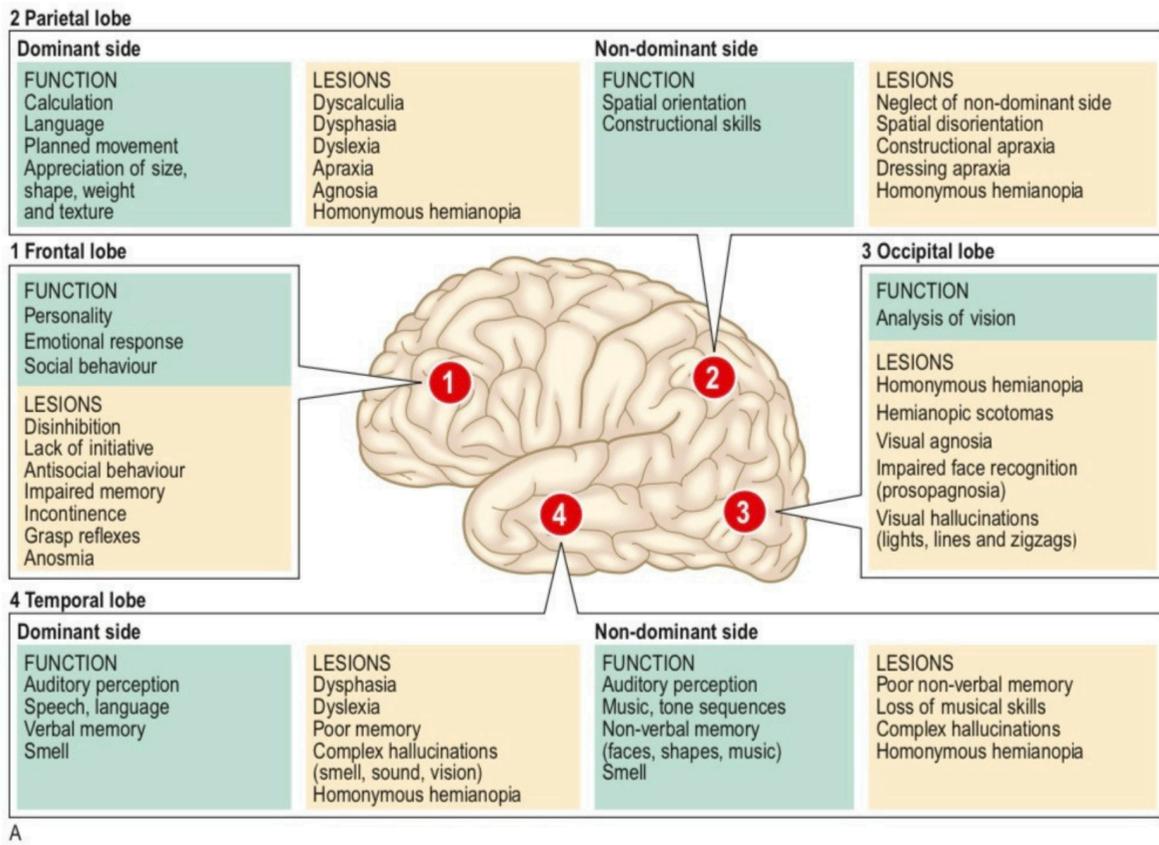


Fig. 7.4 Cortical function. **A** Features of localised cerebral lesions. **B** Somatotopic homunculus.

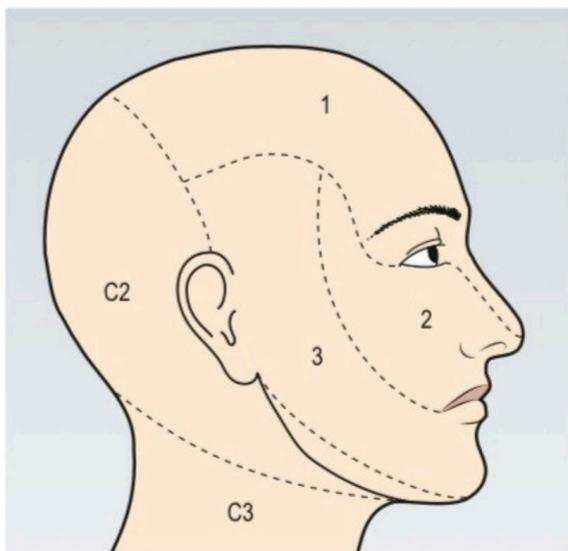


Fig. 7.6 The sensory distribution of the three divisions of the trigeminal nerve. **1**. Ophthalmic division. **2**. Maxillary division. **3**. Mandibular division.

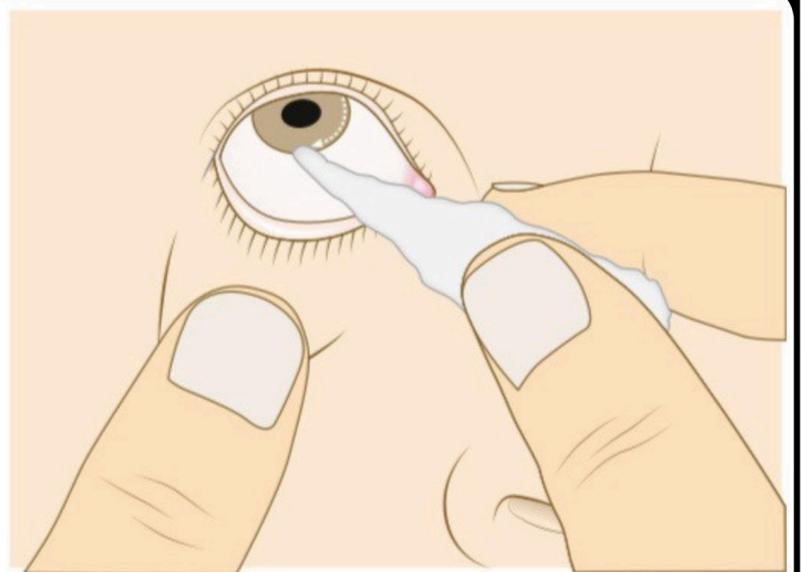


Fig. 7.7 Testing the corneal reflex. The cotton-wool wisp should touch the cornea overlying the iris, not the conjunctiva, and avoid visual stimulus.



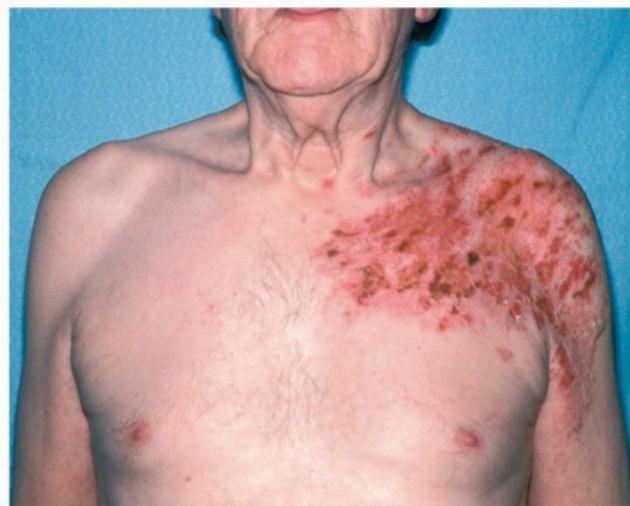
**Fig. 7.8** Eliciting the jaw jerk.



**A**



**B**

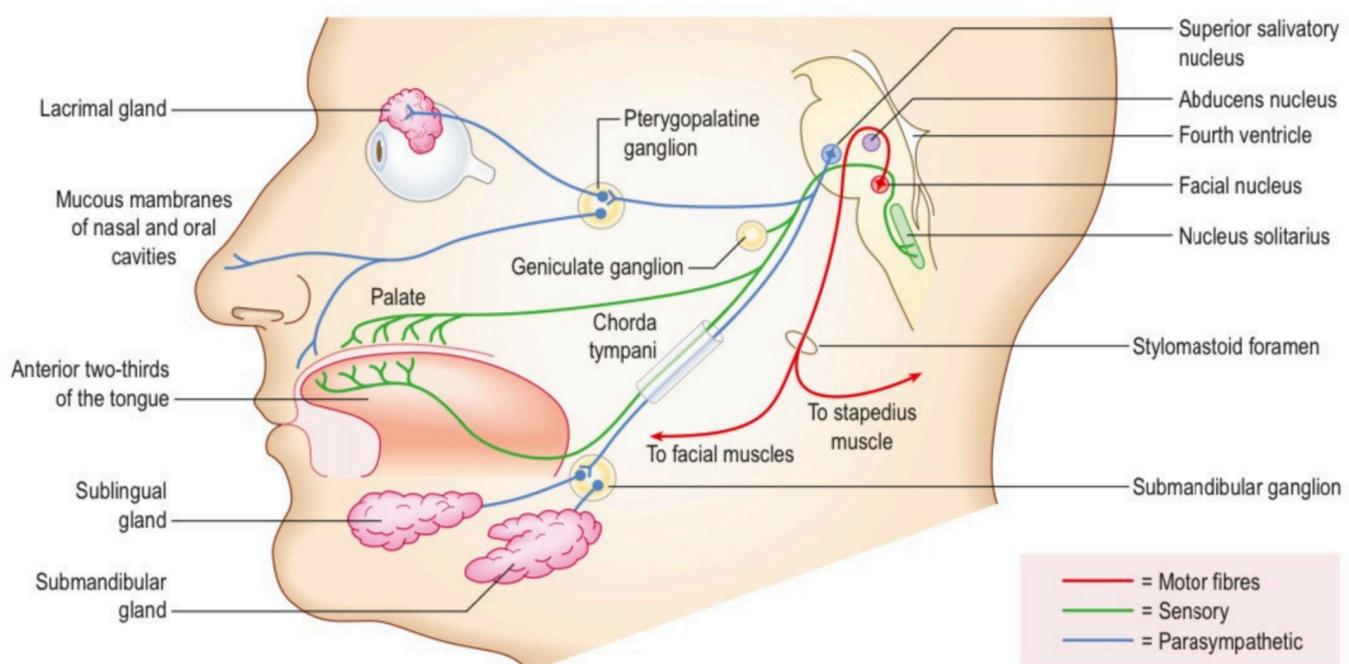


**C**

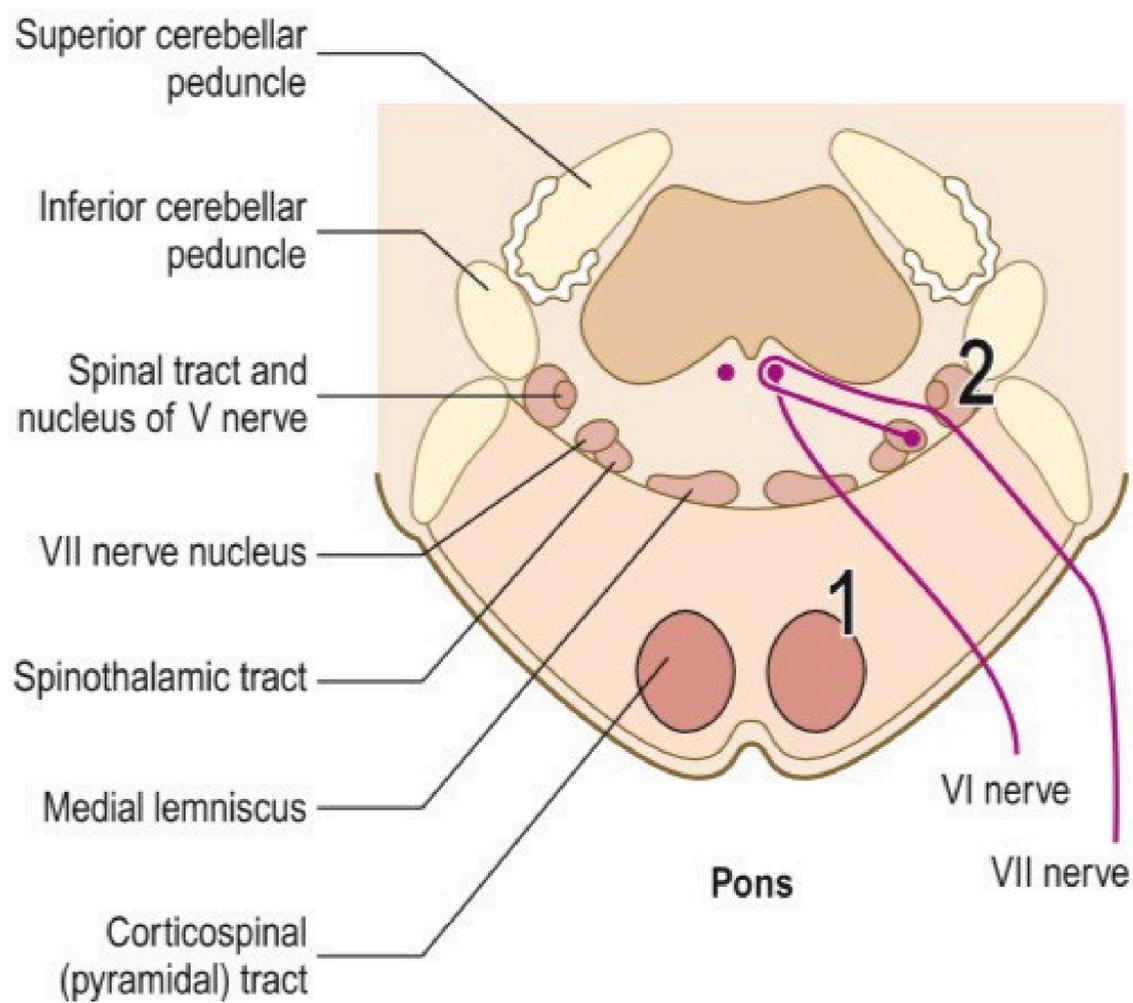


**D**

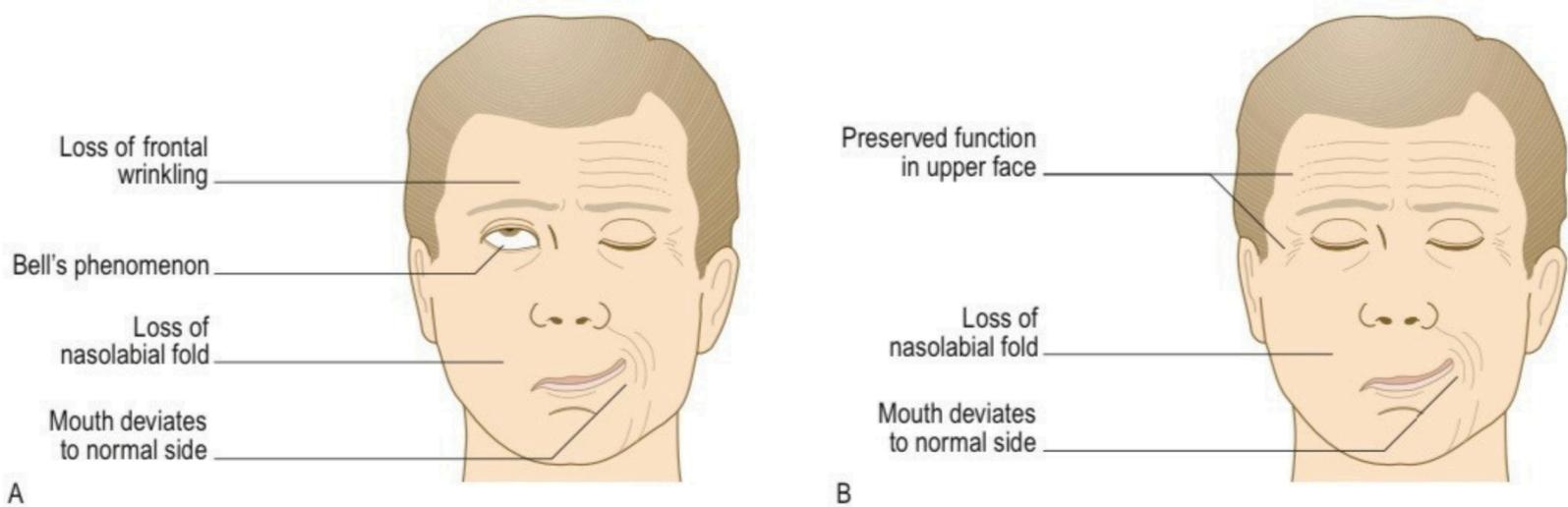
**Fig. 7.9** Herpes zoster. **A** The ophthalmic division of the left trigeminal (V) nerve is involved. **B** The maxillary division of the left V nerve. **C** Cervical spinal root left C4. **D** Thoracic spinal root right T5.



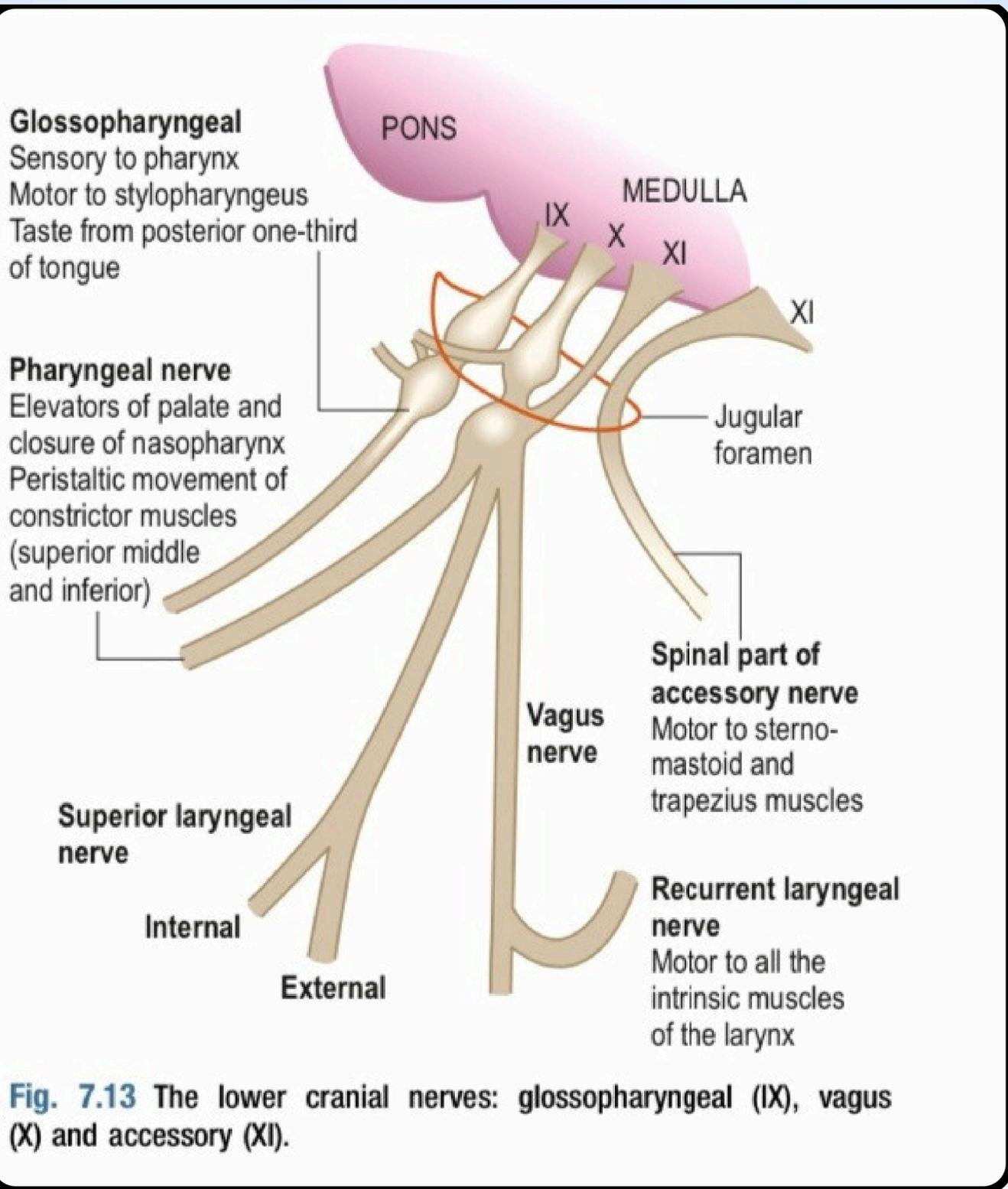
**Fig. 7.10** Component fibres of the facial nerve and their peripheral distribution.



**Fig. 7.11 Lesions of the pons.** Lesions at (1) may result in ipsilateral VI and VII nerve palsies and contralateral hemiplegia. At (2) ipsilateral cerebellar signs and impaired sensation on the ipsilateral side of the face and on the contralateral side of the body may occur.



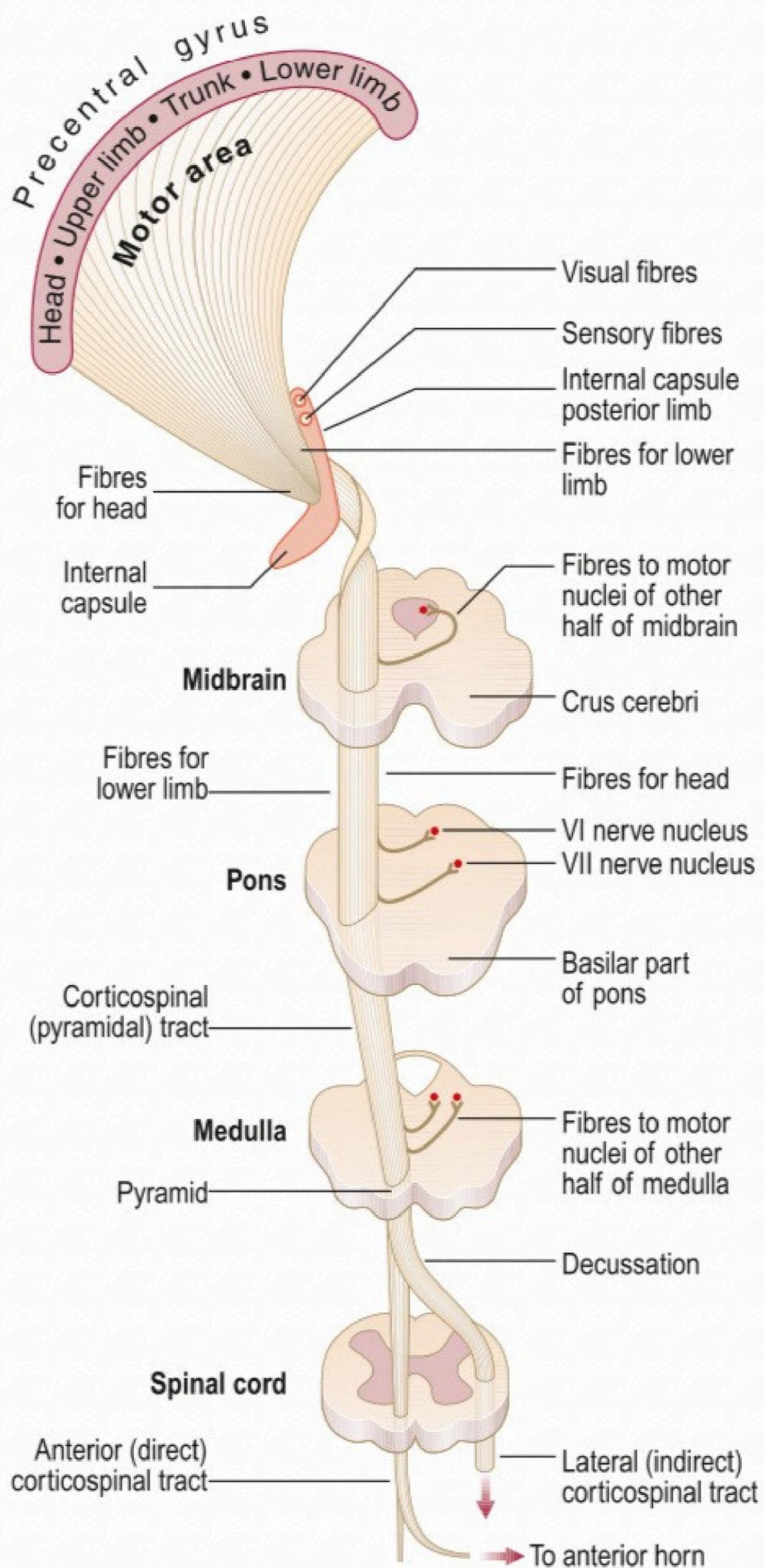
**Fig. 7.12 Types of facial weakness.** **A** Right facial weakness due to right lower motor neurone lesion. **B** Right facial weakness due to left upper motor neurone lesion.



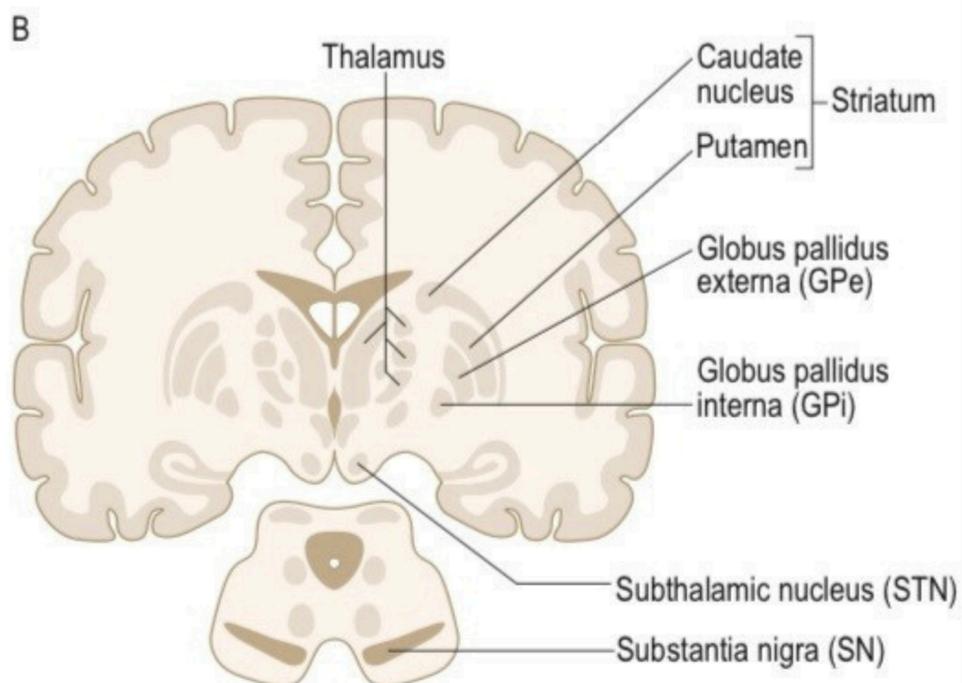
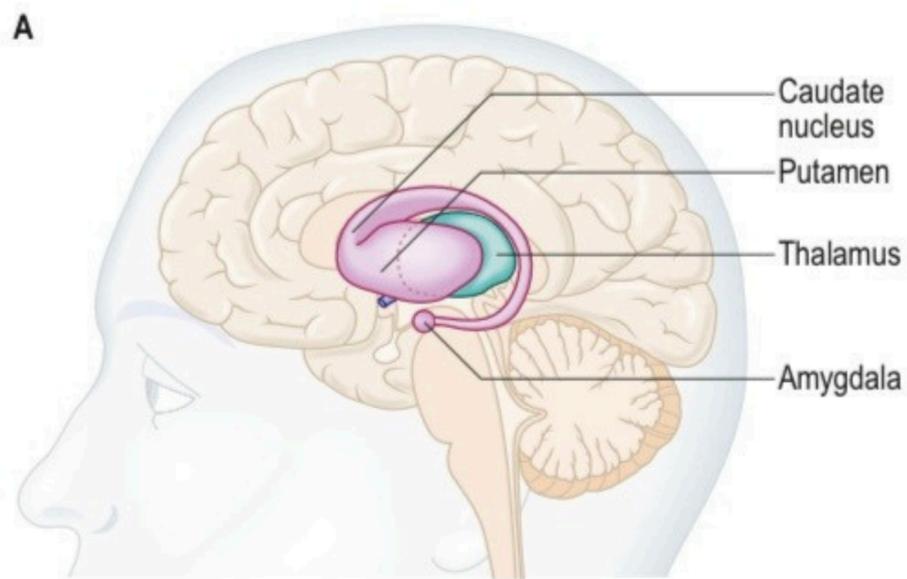
**Fig. 7.13** The lower cranial nerves: glossopharyngeal (IX), vagus (X) and accessory (XI).



**Fig. 7.14** Left hypoglossal nerve lesion. From Epstein O, Perkin GD, de Bono DP, et al. *Clinical Examination*. 2nd ed. London: Mosby; 1997.



**Fig. 7.15** Principal motor pathways.



**Fig. 7.16 Basal ganglia.** **A** Anatomical location. **B** Coronal view.

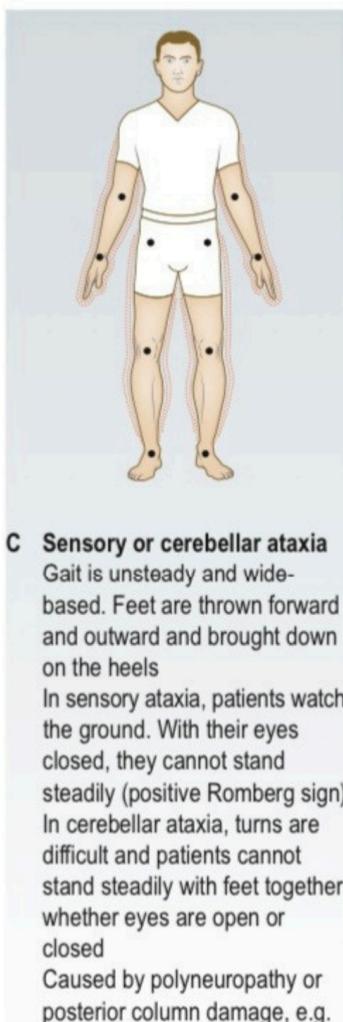
- assessing tone
- testing movement and power
- examining reflexes
- testing coordination.



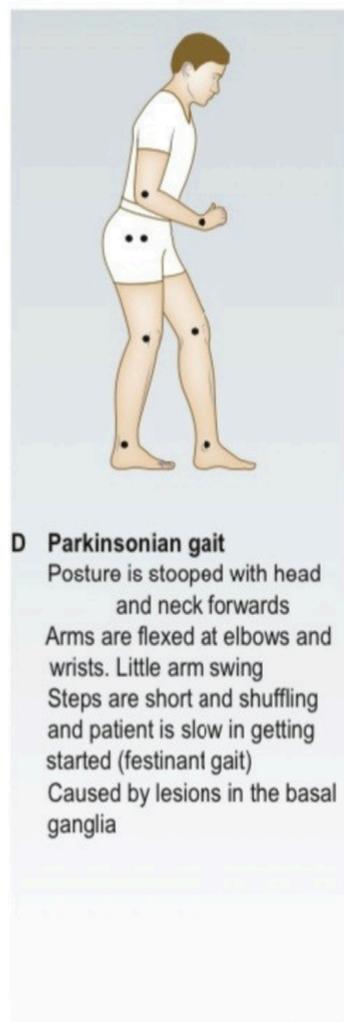
**A Spastic hemiparesis**  
One arm held immobile and close to the side with elbow, wrist and fingers flexed  
Leg extended with plantar flexion of the foot  
On walking, the foot is dragged, scraping the toe in a circle (circumduction)  
Caused by upper motor neurone lesion, e.g. stroke



**B Steppage gait**  
Foot is dragged or lifted high and slapped on to the floor  
Unable to walk on the heels  
Caused by foot drop owing to lower motor neurone lesion



**C Sensory or cerebellar ataxia**  
Gait is unsteady and wide-based. Feet are thrown forward and outward and brought down on the heels  
In sensory ataxia, patients watch the ground. With their eyes closed, they cannot stand steadily (positive Romberg sign)  
In cerebellar ataxia, turns are difficult and patients cannot stand steadily with feet together whether eyes are open or closed  
Caused by polyneuropathy or posterior column damage, e.g. syphilis



**D Parkinsonian gait**  
Posture is stooped with head and neck forwards  
Arms are flexed at elbows and wrists. Little arm swing  
Steps are short and shuffling and patient is slow in getting started (festinant gait)  
Caused by lesions in the basal ganglia

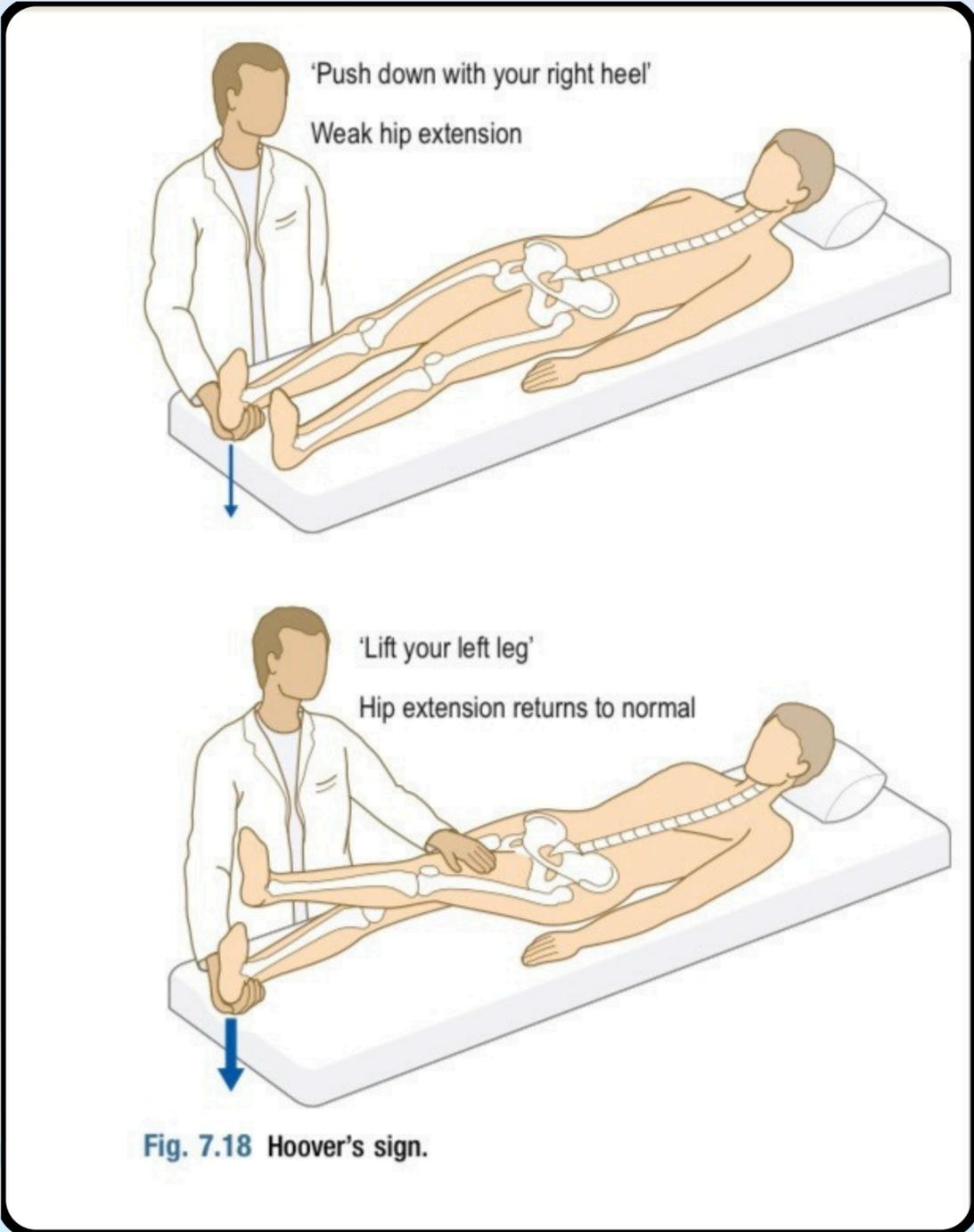


Fig. 7.18 Hoover's sign.

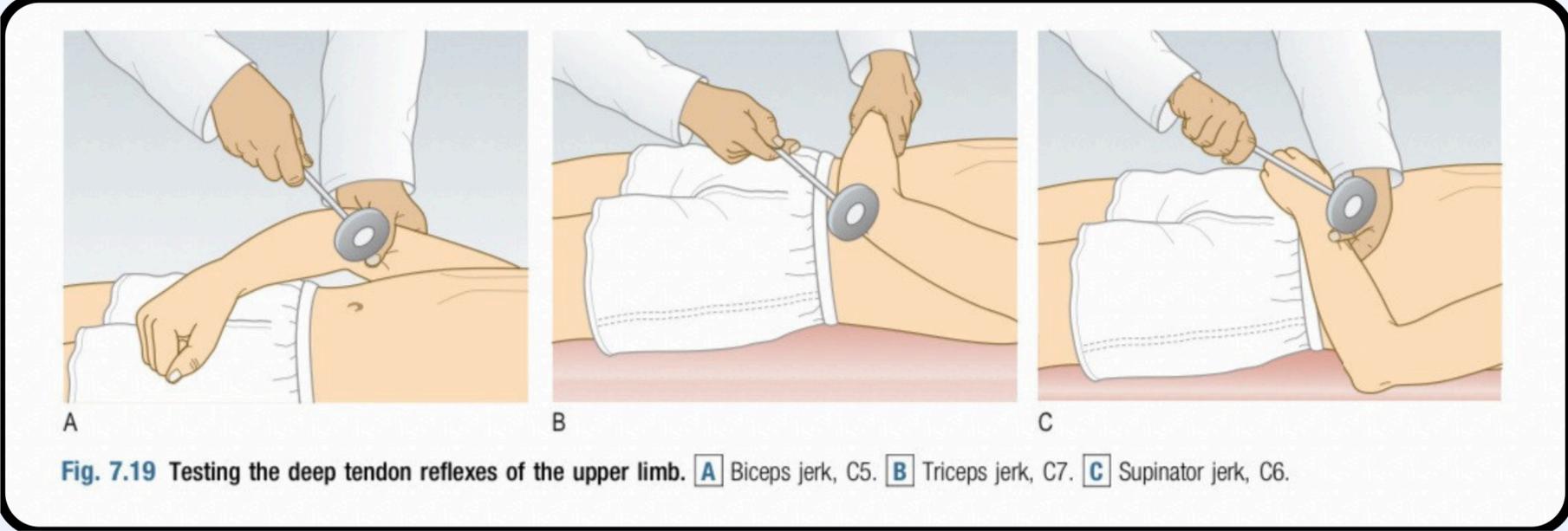


Fig. 7.19 Testing the deep tendon reflexes of the upper limb. **A** Biceps jerk, C5. **B** Triceps jerk, C7. **C** Supinator jerk, C6.

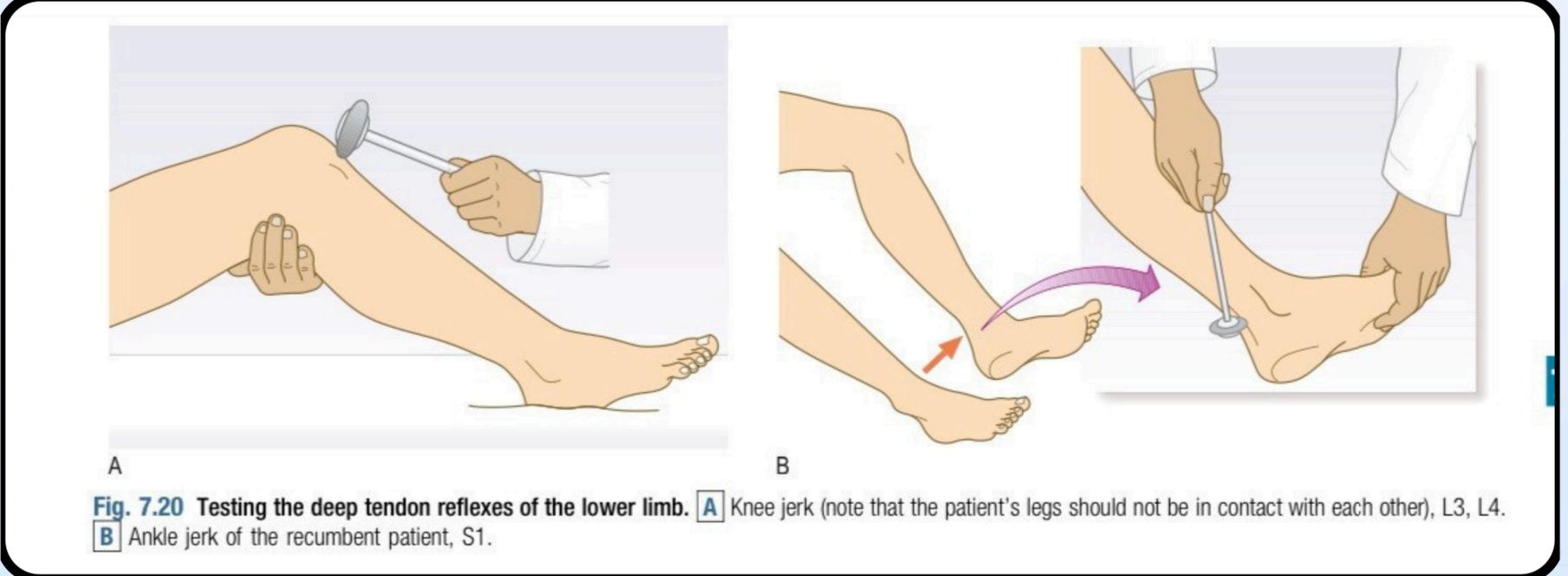
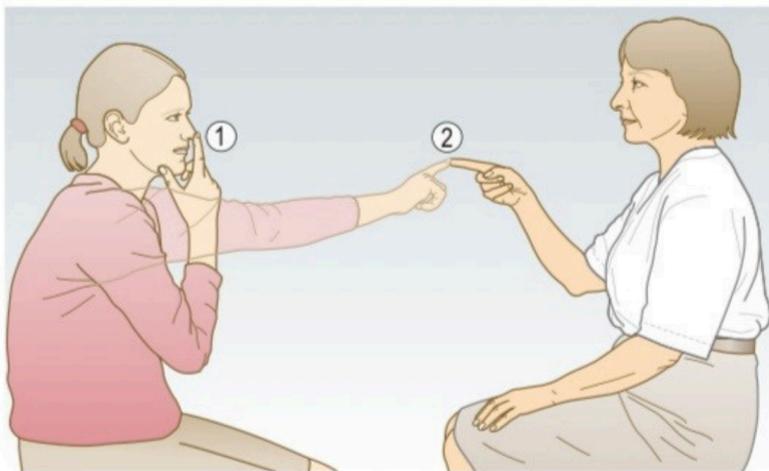


Fig. 7.20 Testing the deep tendon reflexes of the lower limb. **A** Knee jerk (note that the patient's legs should not be in contact with each other), L3, L4. **B** Ankle jerk of the recumbent patient, S1.



**Fig. 7.21** Eliciting the plantar reflex.

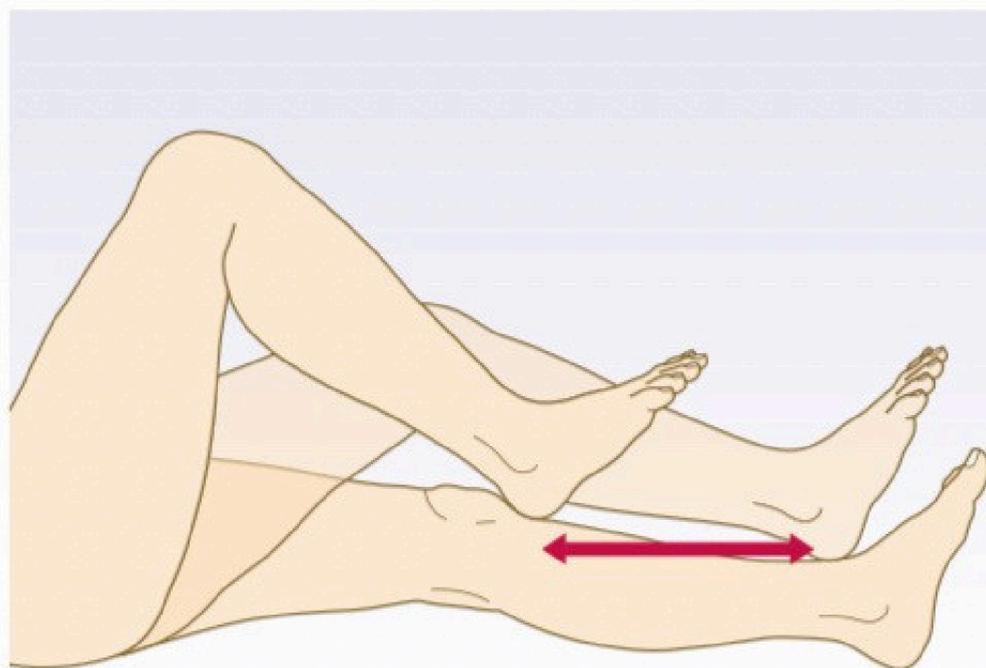


A

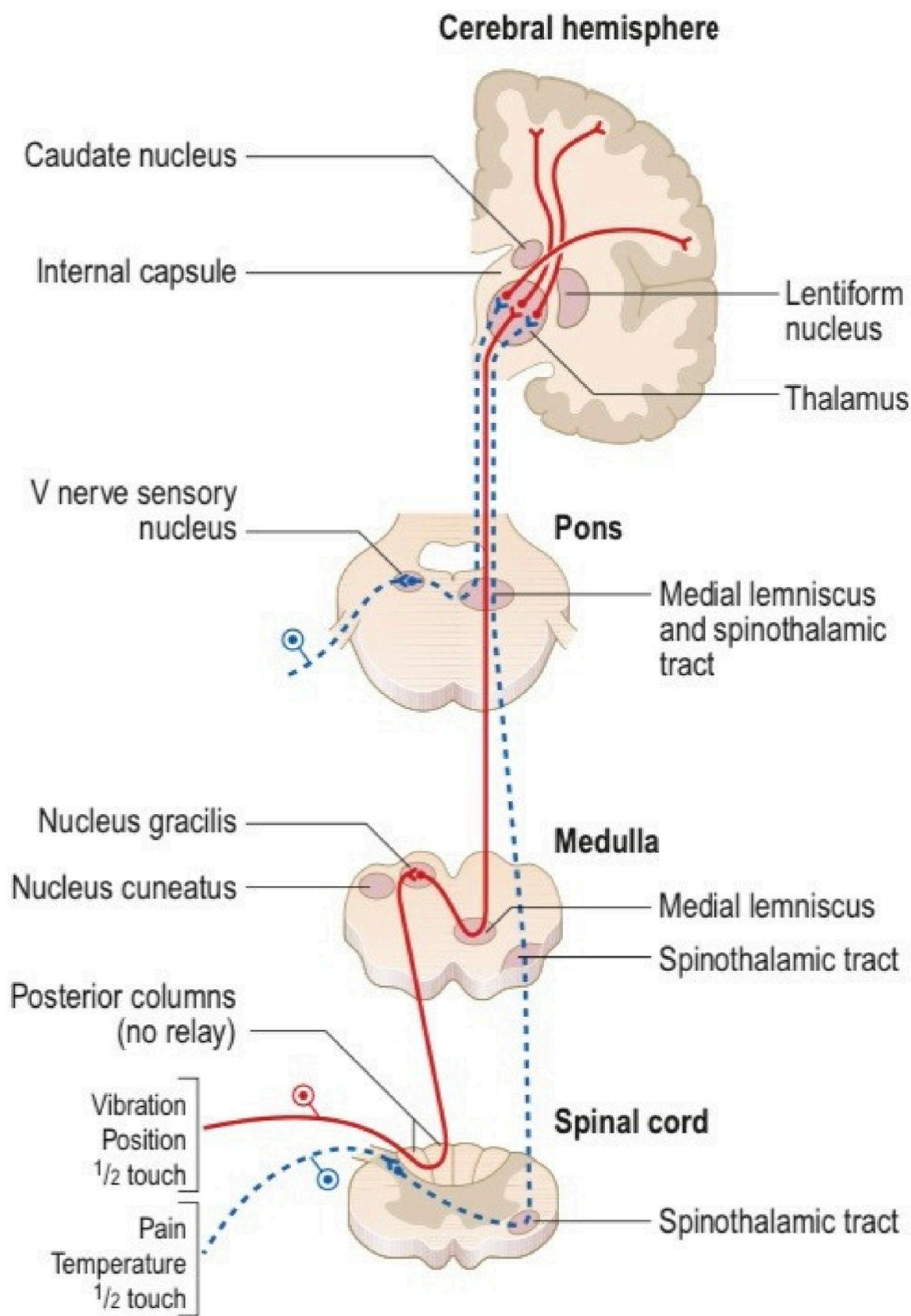


B

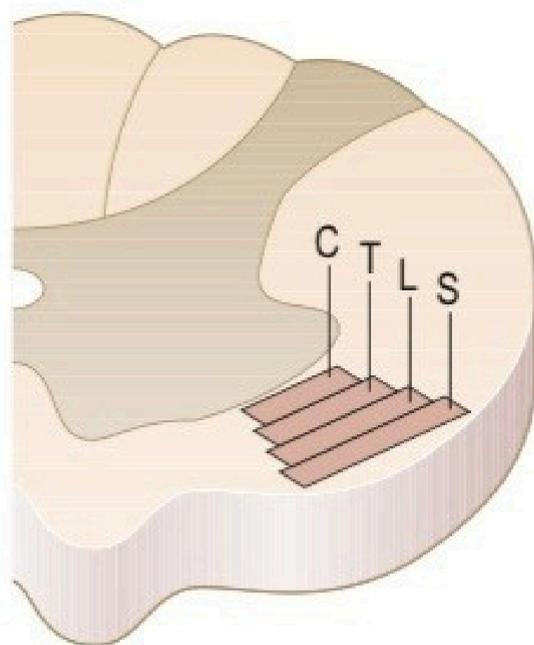
**Fig. 7.22** Finger-to-nose test. **A** Ask the patient to touch the tip of their nose (1) and then your finger (2). **B** Move your finger from one position to another, towards and away from the patient (1), as well as from side to side (2).



**Fig. 7.23** Performing the heel-to-shin test with the right leg.



A



B

**Fig. 7.24 The sensory system.** **A** Main sensory pathways. **B** Spinothalamic tract: layering of the spinothalamic tract in the cervical region. **C** represents fibres from cervical segments, which lie centrally; fibres from thoracic, lumbar and sacral segments (labelled T, L and S, respectively) lie progressively more laterally.

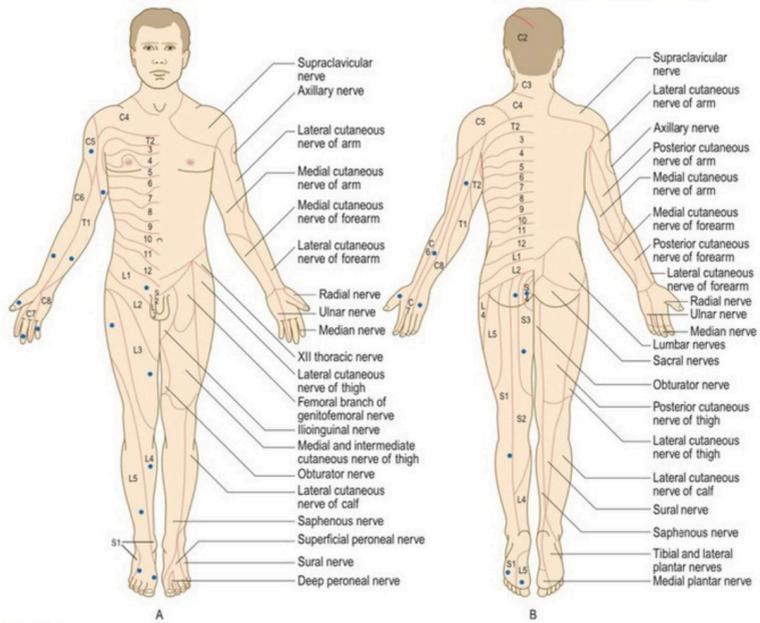


Fig. 7.26 Dermatomal and sensory peripheral map innervation. Points (shown in blue) for testing cutaneous sensation of the limbs. By applying stimuli at the points marked, both the dermatomal and main peripheral nerve distributions are tested simultaneously. [A] Anterior view. [B] Posterior view.

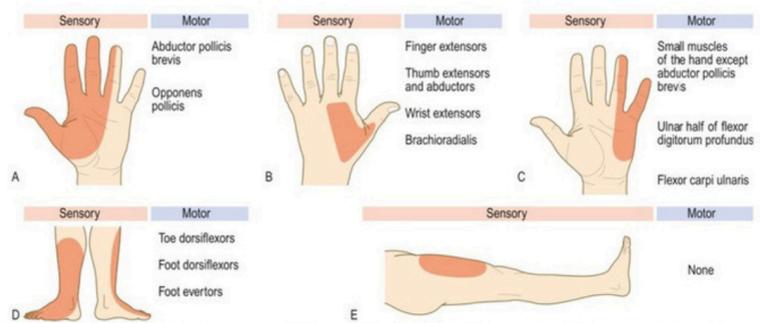


Fig. 7.27 Sensory and motor deficits in nerve lesions. [A] Median. [B] Radial. [C] Ulnar. [D] Common peroneal. [E] Lateral cutaneous of the thigh.

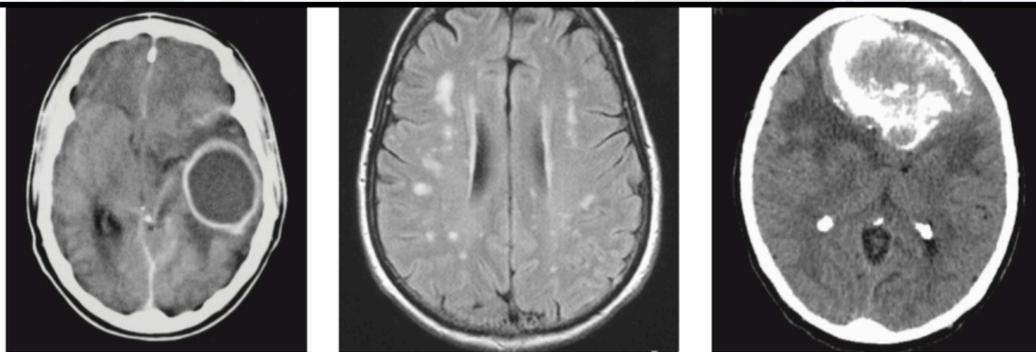


Fig. 7.29 Imaging of the head. [A] Computed tomogram (CT) showing a cerebral abscess. [B] Magnetic resonance scan showing multiple sclerosis with white demyelinating plaques. [C] CT scan showing a large meningioma arising from the olfactory groove.

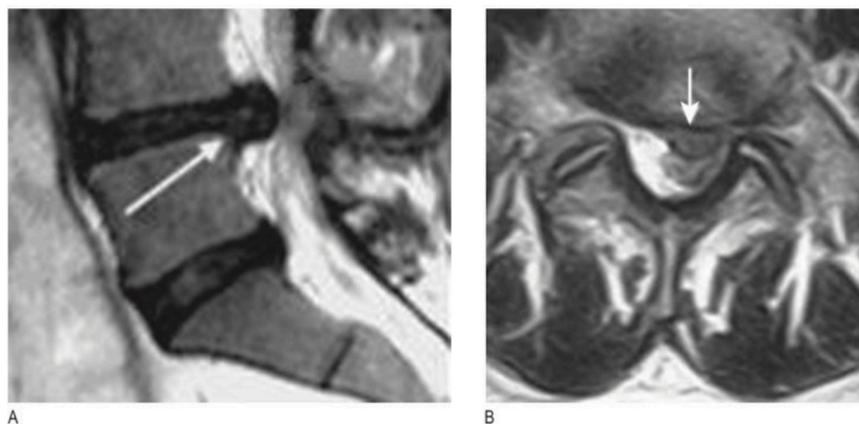


Fig. 7.30 T2 magnetic resonance images showing a large left paracentral L4-5 disc protrusion (arrowed) compressing the L5 nerve root. [A] Sagittal section. [B] Axial section.

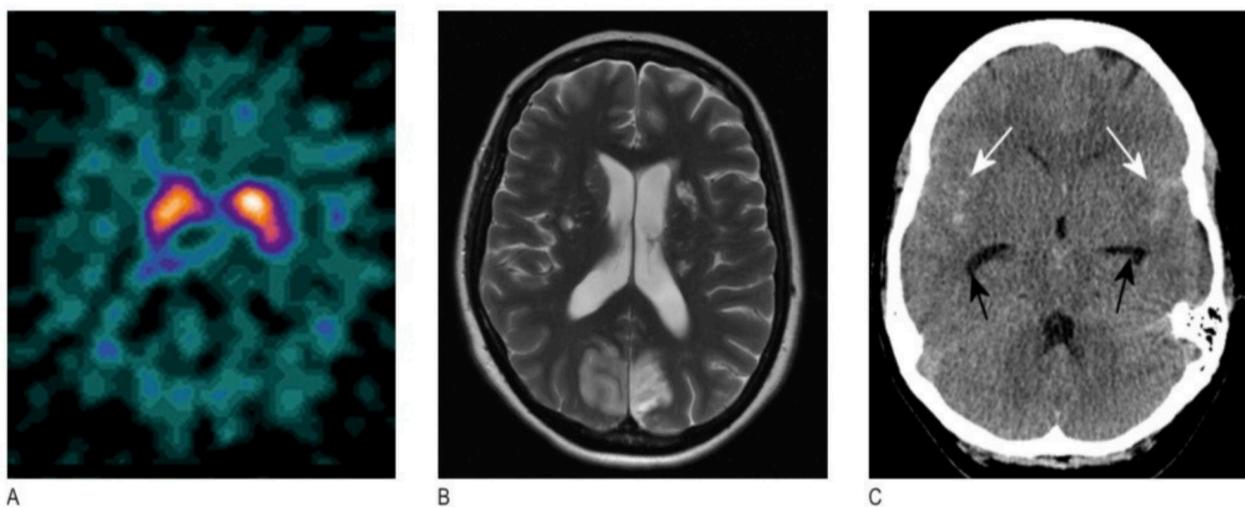


Fig. 7.28 Imaging of the head. [A] DaTscan showing uptake of tracer (dopamine receptors) in the basal ganglia on cross-section of the brain. [B] Magnetic resonance scan showing ischaemic stroke. T2 imaging demonstrates bilateral occipital infarction and bilateral hemisphere lacunar infarction. [C] Unenhanced computed tomogram showing subarachnoid blood in both Sylvian fissures (white arrows) and early hydrocephalus. The temporal horns of the lateral ventricles are visible (black arrows).

1-The confrontation test used for assess of :

- A. Visual acuity .
- B. Visual color .
- C. Ophthalmoplegia
- D. Visual field . XXXX
- E. Accommodation reflex .



3-Which is damaged nerve ?

- A. Left trochlear nerve .
- B. Left oculomotor nerve .
- C. Left optic nerve .
- D. Left abducent nerve . XXXX
- E. Right abducent nerve

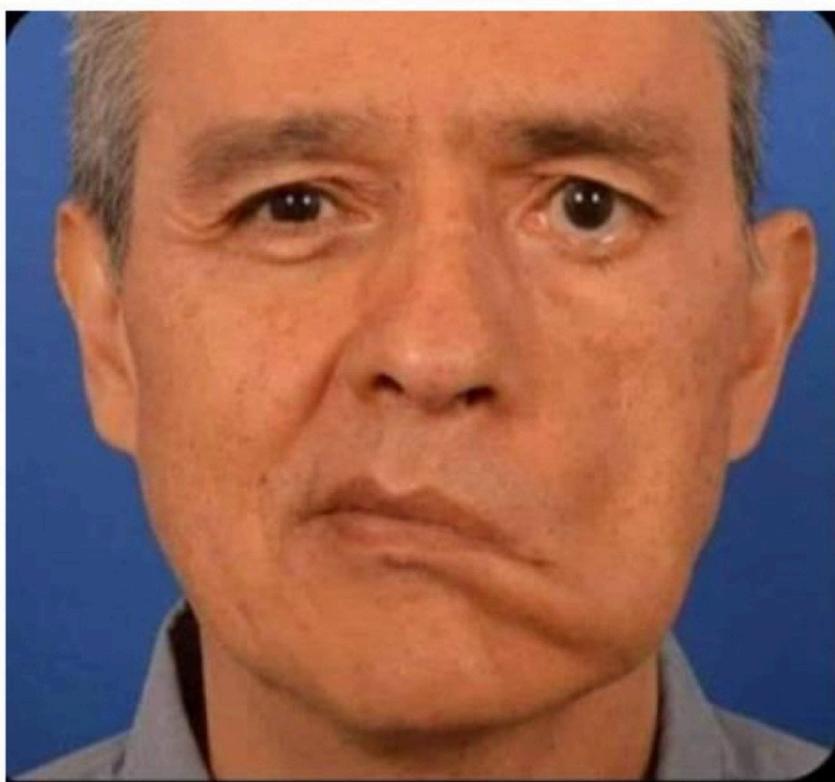


4- All of following are dxs for this sign except ?

- a) Right ventricular failure .
- b) Acute bronchitis .
- c) Mitral stenosis .
- d) Acute thrombophlebitis . XXX ????????
- e) Idiopathic pulmonary fibrosis .

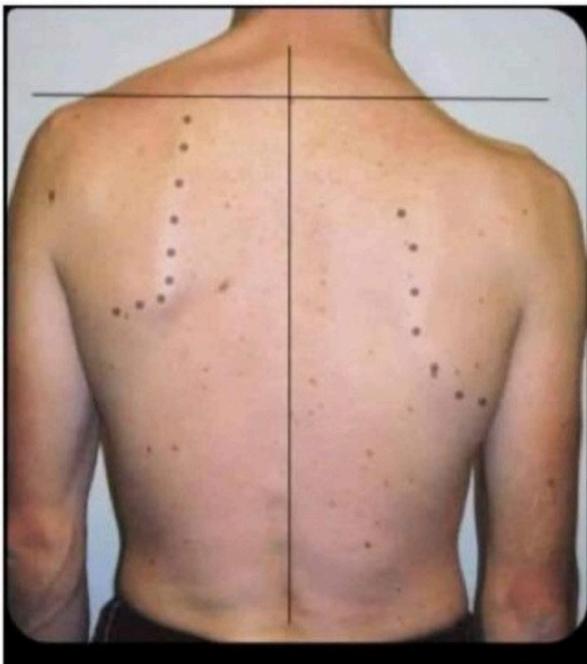
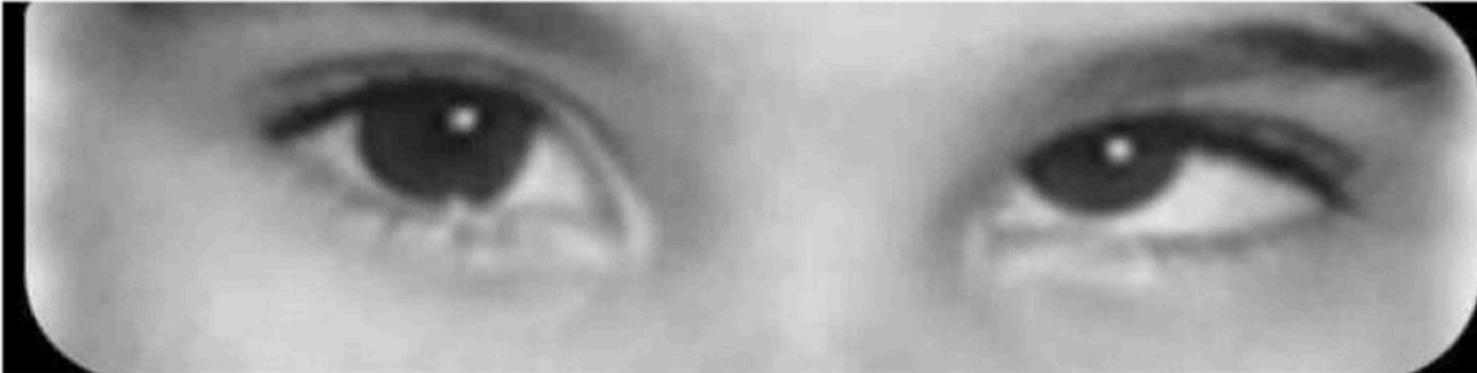
8-Which is damaged cranial nerve

- a. Right hypoglossal nerve .
- b. Left vagus nerve .
- c. Right trigeminal nerve .
- d. Left hypoglossal nerve .
- e. Left trigeminal nerve . XXX



**10-Which is damaged cranial nerve**

- a. Right oculomotor nerve .
- b. Left trochlear nerve . XXXX
- c. Right trochlear nerve .
- d. Left abducent nerve .
- e. Left trigeminal nerve .



- a. Spinal root of accessory nerve . XXX
- b. Thoracodorsal nerve .
- c. Long thoracic nerve .
- d. Axillary nerve .
- e. Glossopharyngeal nerve

**13-Which is damage nerve for this patient ?**



- a. Spinal root of accessory nerve .
- b. Thoracodorsal nerve .
- c. Long thoracic nerve . XXX
- d. Axillary nerve .
- e. Glossopharyngeal nerve .

14- Which is damaged cranial nerve



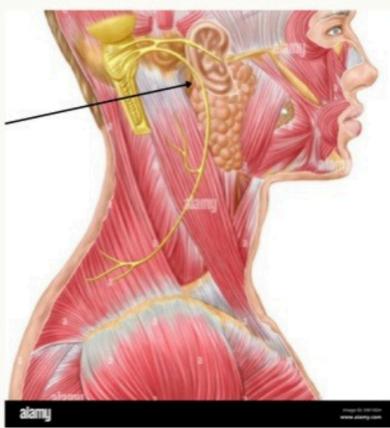
- a. Right hypoglossal nerve .
- b. Left vagus nerve .
- c. Right vagus nerve . XXX
- d. Left hypoglossal nerve .
- e. Left trigeminal nerve .

28-Which correct about this test ?



- a. Indicated lower neuron lesion
- b. associated with sensory ataxia
- c. Indicated upper neuron lesion XXXX
- d. Indicated polyneuropathy .
- e. Abnormal in neonate .

11- what is the name of this nerve ?



- a. Accessory nerve ✓
- b. Vagus nerve
- c. Hypoglossal nerve

مساعدة : بمر على ال sternocleidomastoid muscle

18.



7<sup>th</sup> nerve palsy

Name of the test?

- 1) Two point discrimination (high cortical function)
- 2) pain
- 3) Touch test



Right bells palsy (VII nerve)



# Cortical sensation



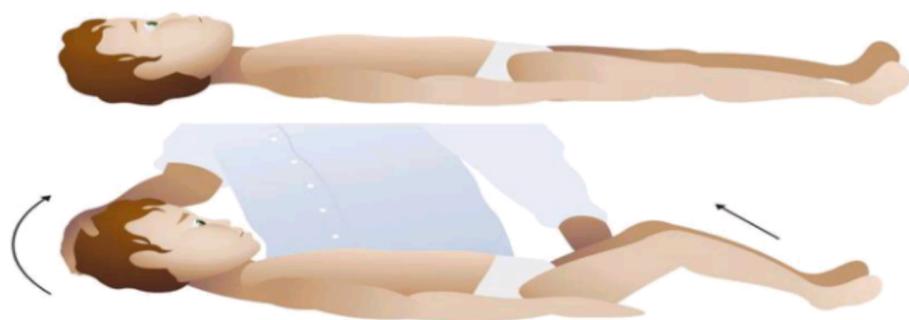
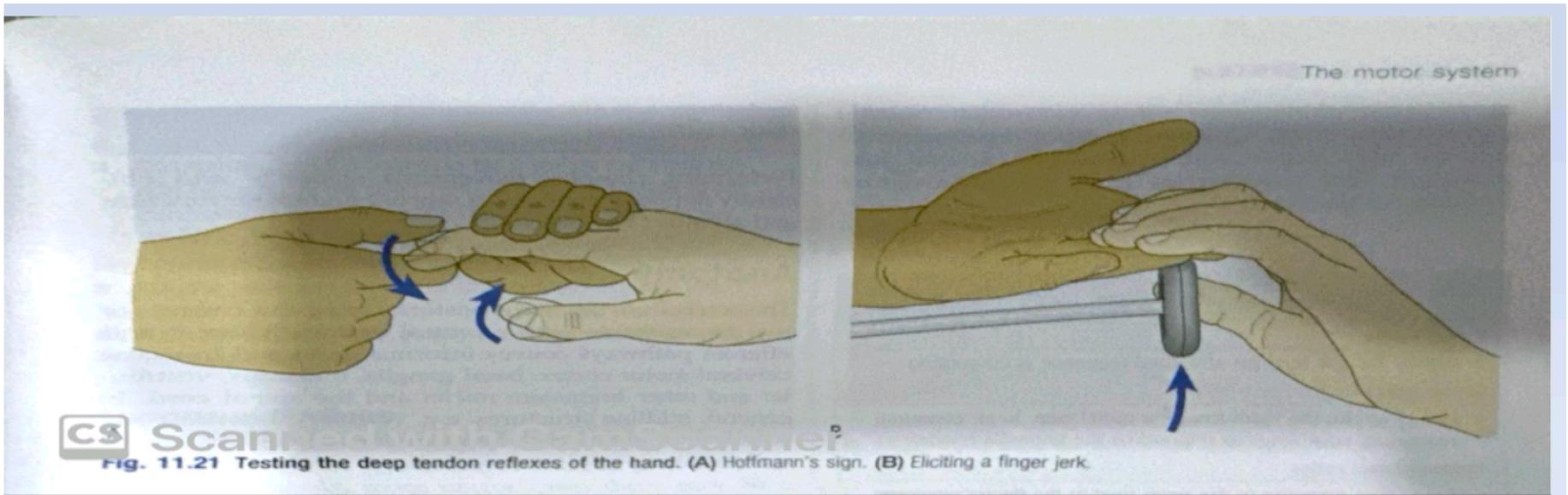
2 Point Discrimination test



Stereognosis test



Graphesthesia test



**Brudzinski's sign:**  
Flexion of the hips and knees in response to neck flexion

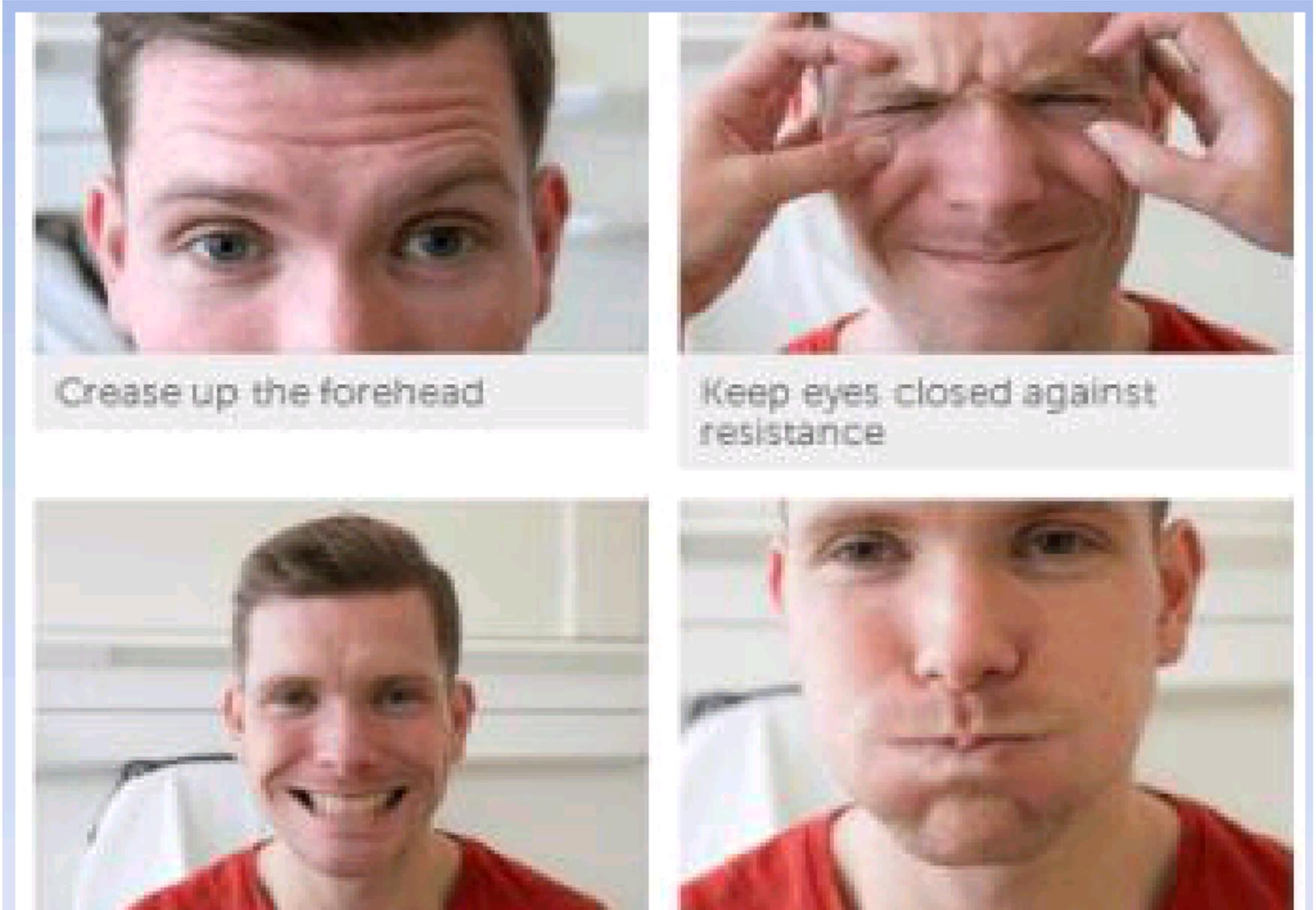


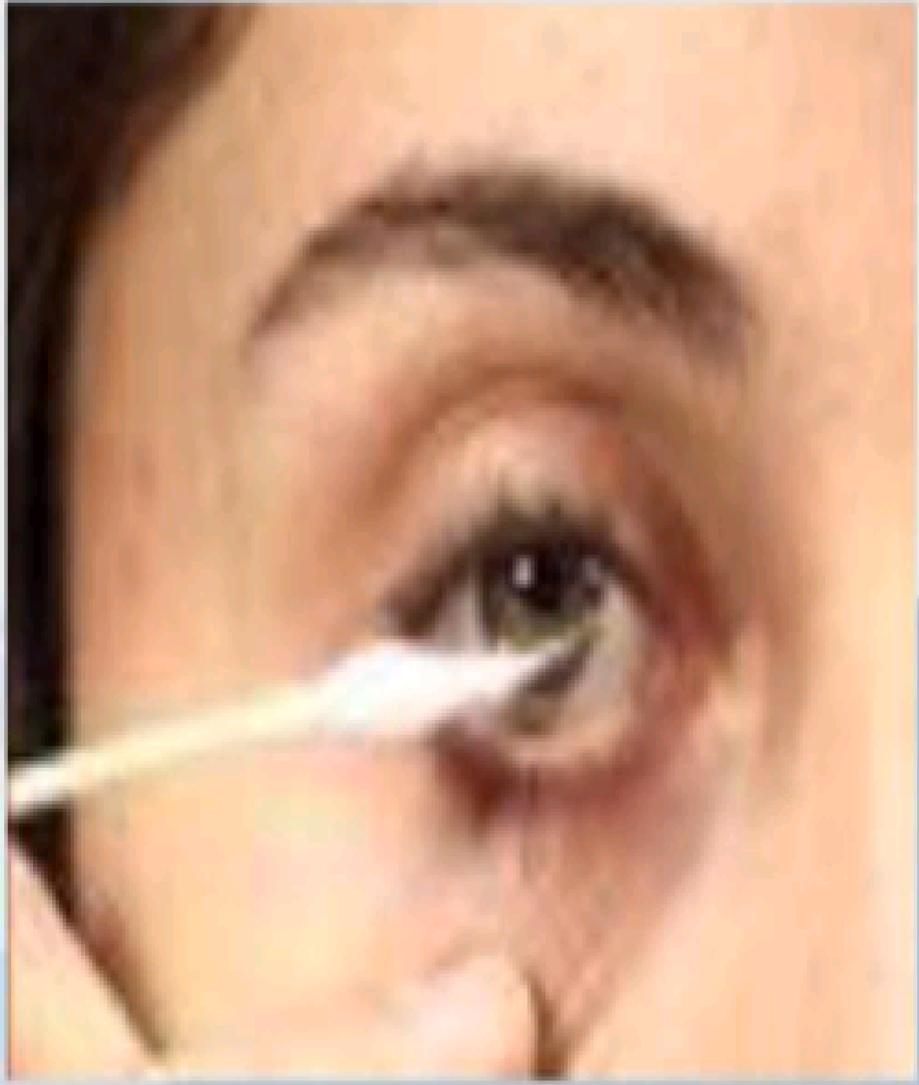
**Kernig's sign:**  
Resistance to extension of leg while the hip is flexed

# accessory nerve



# facial nerve





# trigeminal nerve - corneal reflex



# visual field

## Cranial Nerve V- Trigeminal



- Motor Function
  - Palpate temporal & masseter muscles as patient clenches teeth
  - Try to separate jaw by pushing down on chin

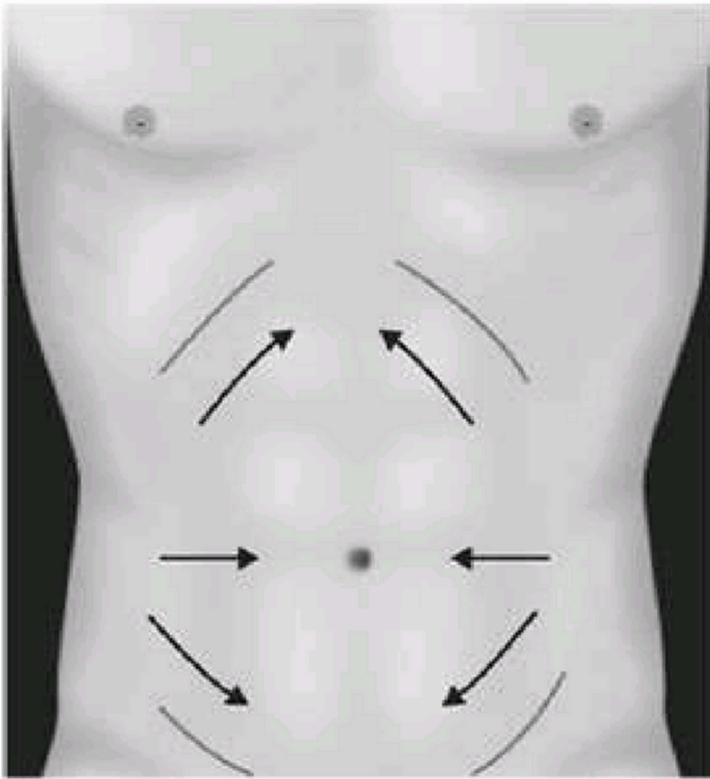
*Jaw strength equal bilaterally*



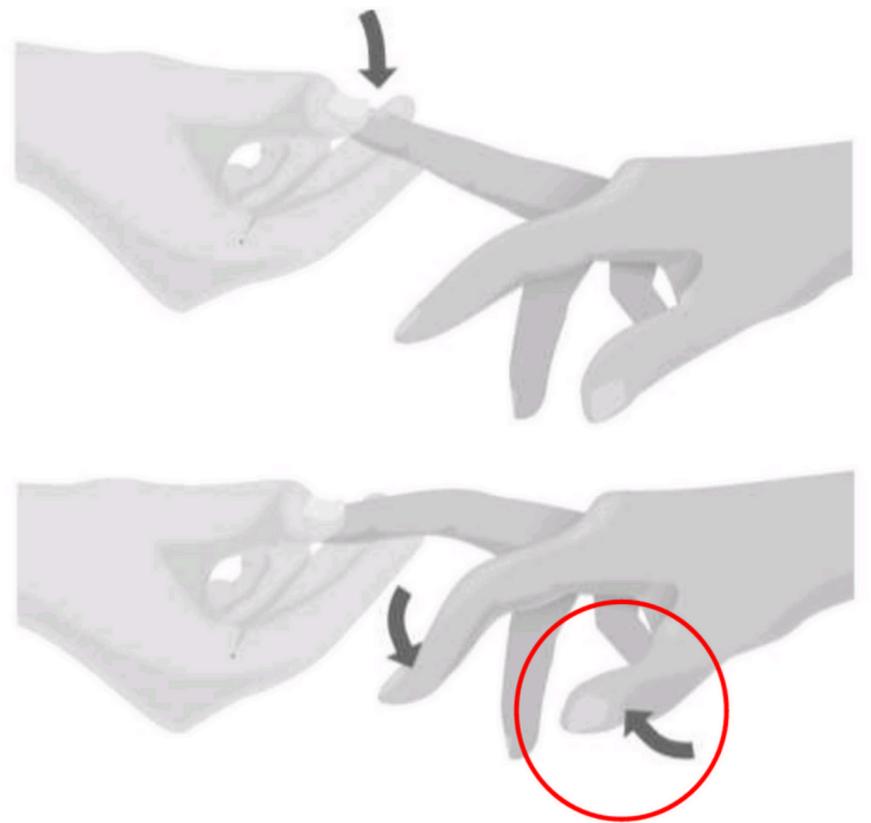
- Sensory Function
  - Test light sensation with cotton ball over
    - Forehead (ophthalmic)
    - Cheeks (maxillary)
    - Chin (mandibular)

*Sensation intact and equal bilaterally*

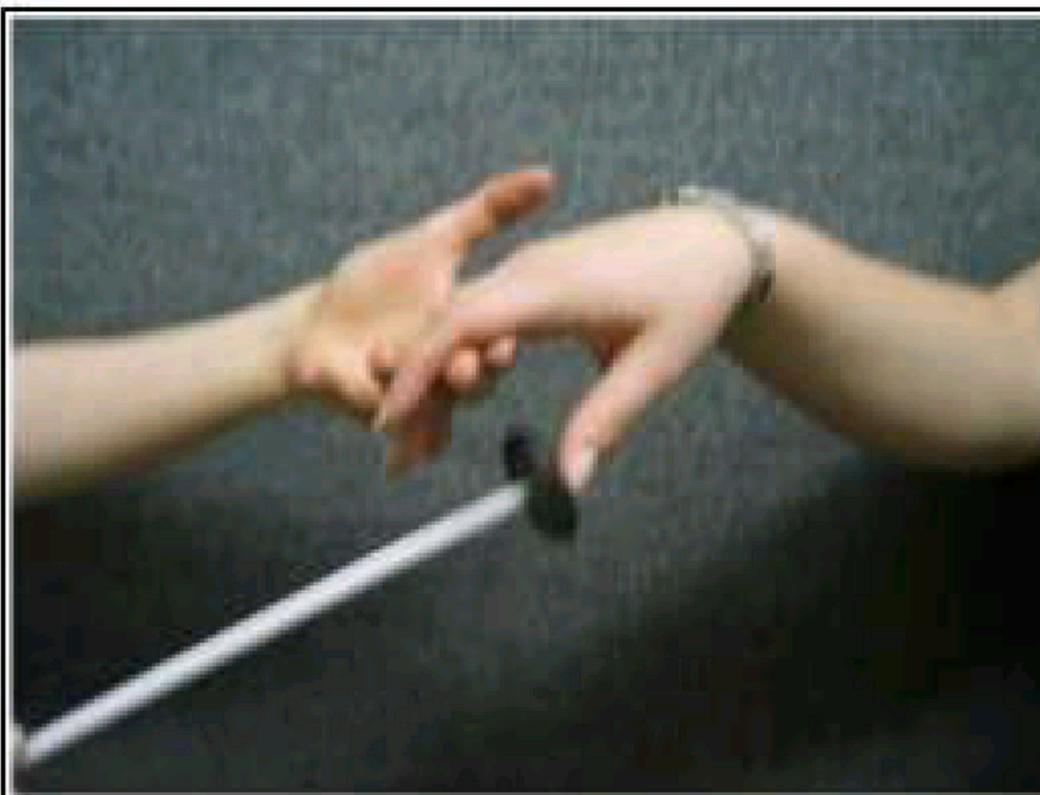
# Abdominal reflexes (T8–12)



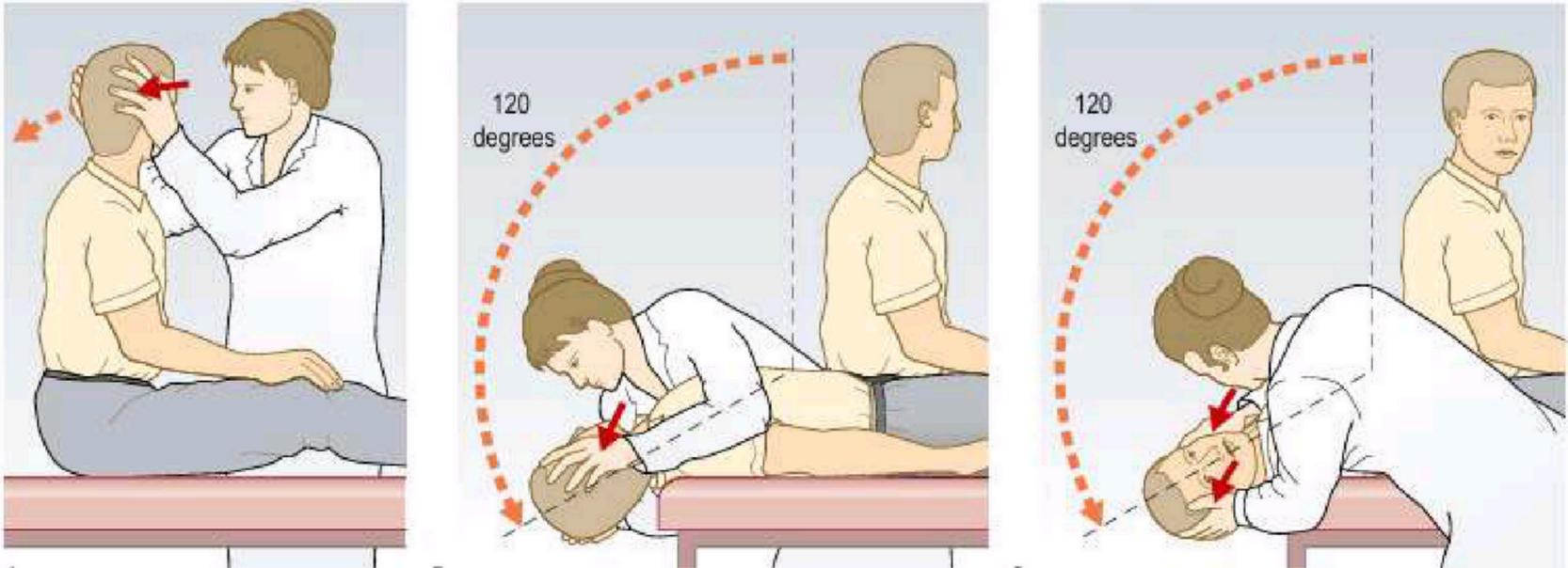
## Hoffman reflex



## Finger jerk (C8)



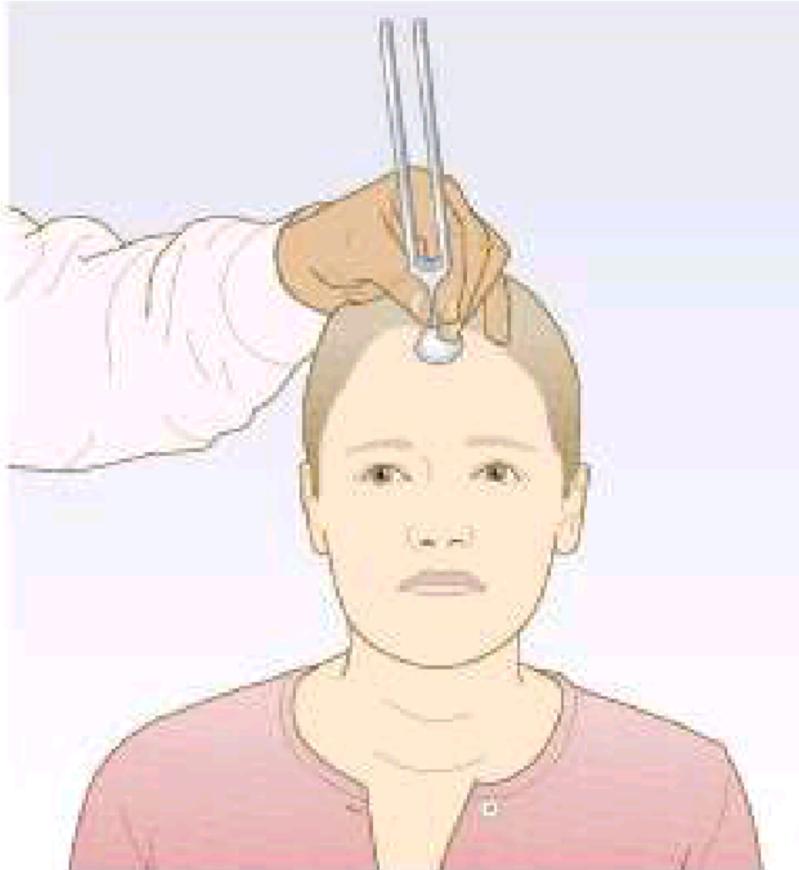
# dix-hallpike positional test



# Rinne's test



# weber's test



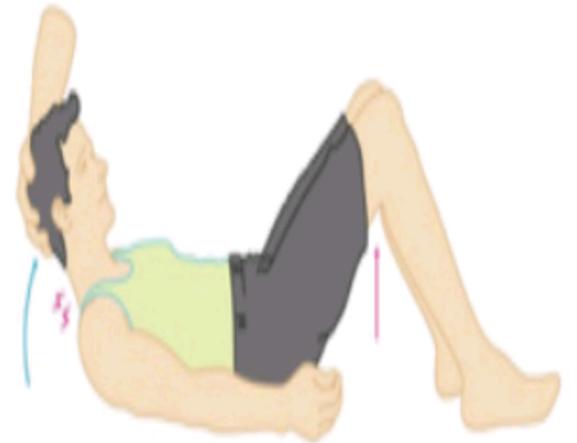
Q35: patient is asked to look to the right , the lesion is in ?

- A. **Right abducent palsy**
- B. Left abducent palsy
- C. Right INO
- D. Left INO
- E. Bilateral INO



Which sign

- **brudinizki**

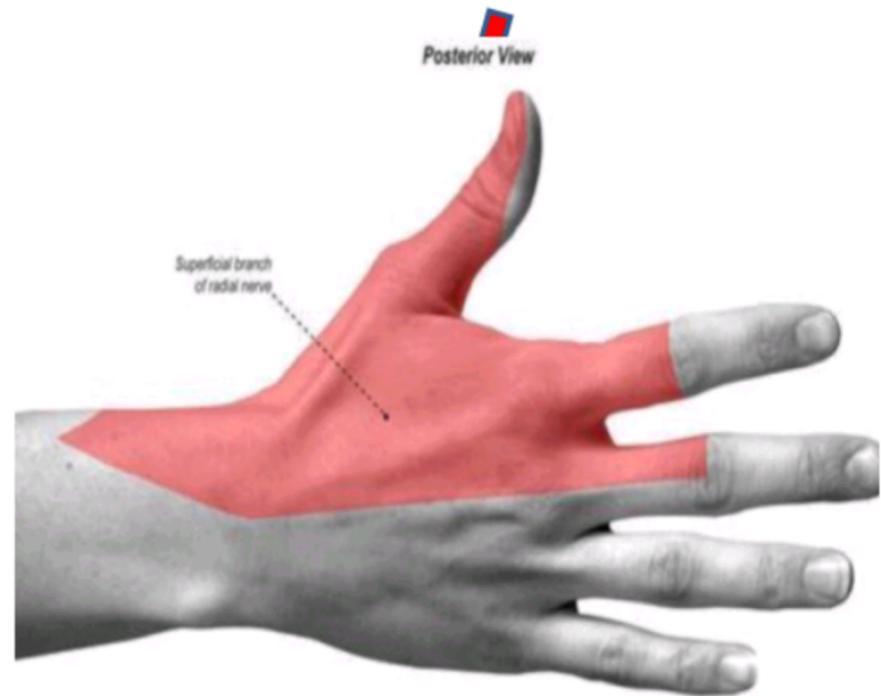


patient in resting position , Which  
**median nerve** nerve is affected?



Q39- Sensation loss over the area shown in the picture, where is the lesion?

- A. Ulnar nerve
- B. Median nerve
- C. **Radial nerve**
- D. Anterior interosseous nerve
- E. C7/T1 disc prolapse



Q40- Which nerve is affected?

- A. **Long thoracic nerve**
- B. Dorsal scapular nerve
- C. Suprascapular nerve
- D. Axillary nerve
- E. Musculocutaneous nerve



Q29- The lesion is may one of the following except?

- A. Right medial rectus
- B. **Left medial rectus**
- C. Myasthenia gravis
- D. Space-occupying lesion
- E. Increased ICP



Q11- All the following conditions are associated with Horner except:

- Cervical spine injury
- Carotid aneurysm
- Tumor in the apex of the lung
- Posterior neck trauma
- Non-reactive pupil**



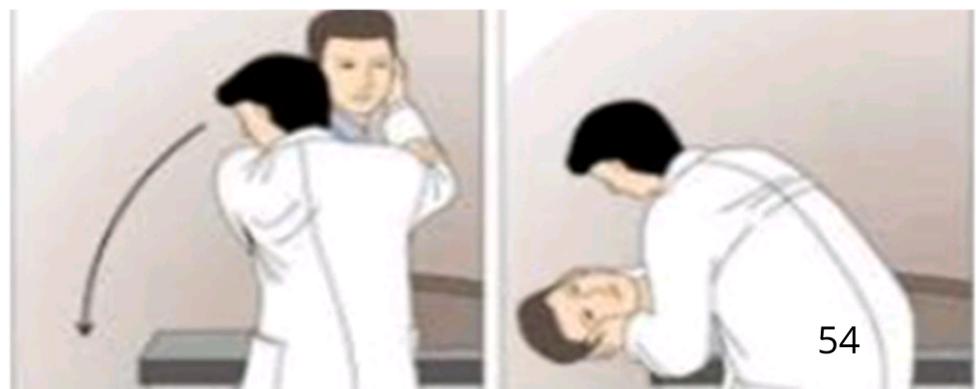
Q27- Which of the following can not be found in this patient:

- a. Hoarseness
- b. Dysphagia
- c. Nasal regurgitation of food
- d. Palate collapse
- e. **Absent jaw reflex**



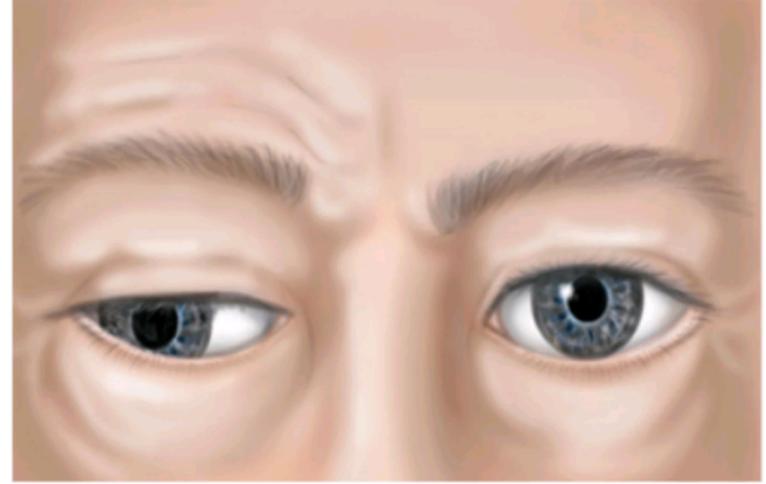
Q15- This test used to diagnose ?

- A. Meniere's disease
- B. **BPPV**
- C. Vestibular neuritis
- D. Acoustic neuroma
- E. Central vertigo



- 40 wrong about this palsy ?

Ptosis due to muller weakness



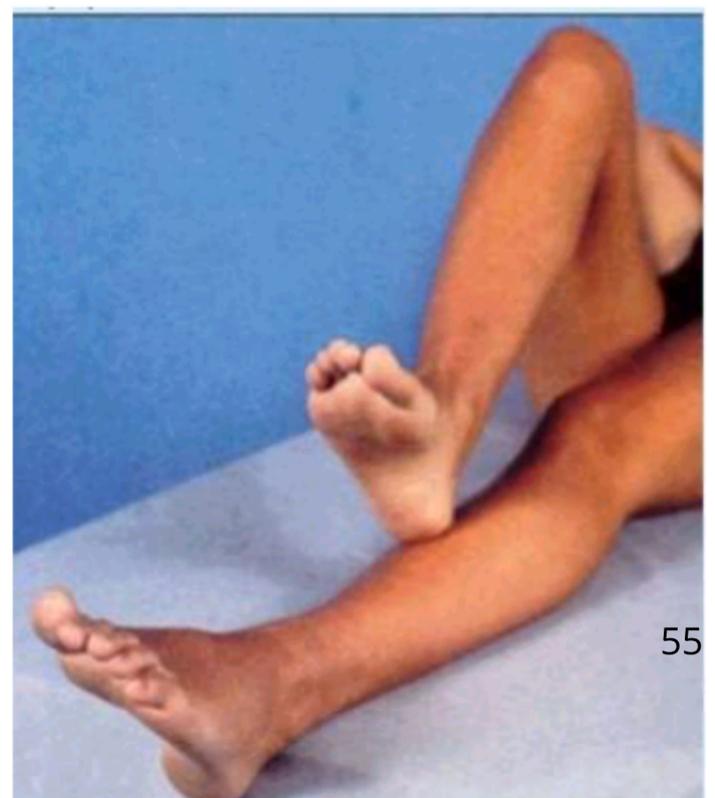
- 26 The patient has fever and nuchal rigidity, what is the name of the test?

- A. Leg raise test
- B. Brudzinski test
- C. **Kernig test**
- D. Babinski test
- E. Hoffman test



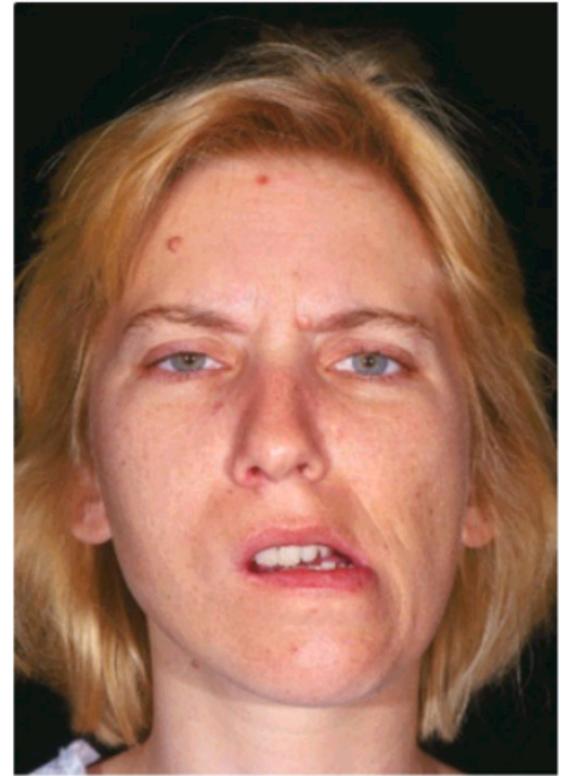
Q3-This test is used for detect the function of:

- A. **Right cerebellum**
- B. Left cerebellum
- C. Right cerebral
- D. Left cerebral
- E. Dorsal columns



7-what is the affected muscle?

- A. **Left pterygoid muscle**
- B. Right pterygoid muscle
- C. Left buccinator
- D. Right buccinator
- E. Left temporalis



5- if this test is positive what does it mean:

Otoliths in **posterior** semicircular canal



• 22 Which of the following can not be found in this patient:

- a. Hoarseness
- b. aphasia
- c. Loss of gag reflex
- d. Palate collapse
- e. **Loss of taste sensation in the posterior 1/3 of the tongue**



What is the name of this case?

Horner syndrome



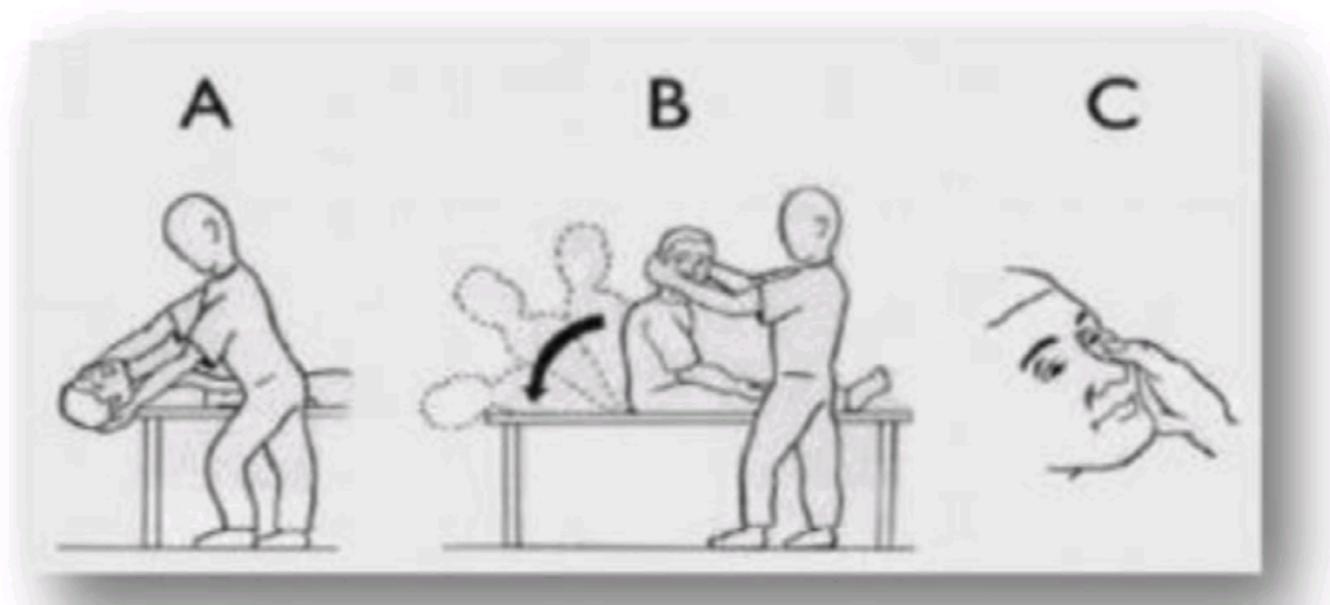
What is the nerve that supplies this area highlighted in (A) ?

Deep peroneal nerve



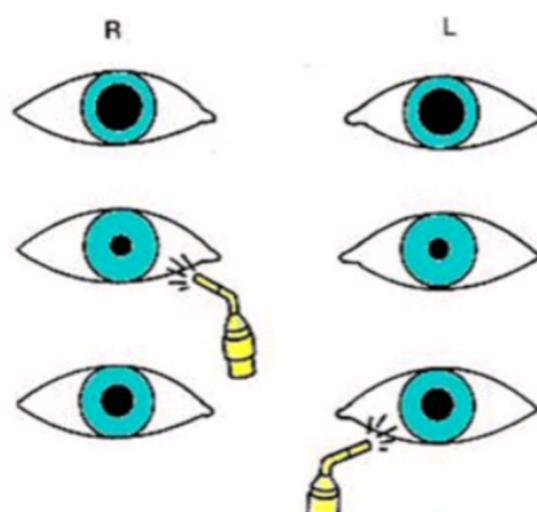
What is the name of test?

Dix-Hallpike maneuver



4-What is the cause for this ?

- A. Right optic neuritis
- B. **Left optic neuritis**
- C. Right oculomotor palsy
- D. Left oculomotor palsy
- E. Horner's syndrome



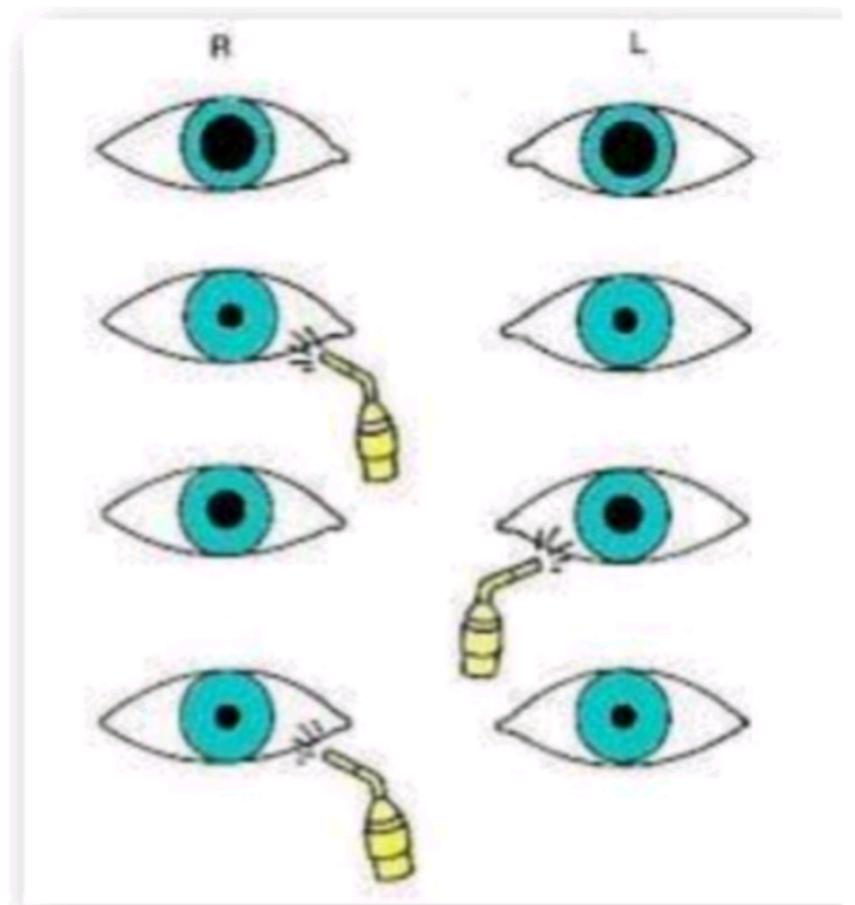
Where is the lesion ?  
Right vagus



All of the followings are true  
except :

- swinging test is more sensitive than direct pupillary reflex
- **Occlomotor lesion cause this , ( مش اكيد , احترنا بين الاجابتين المكتوبات )**

ناسي باقي الخيارات بس كانوا صح



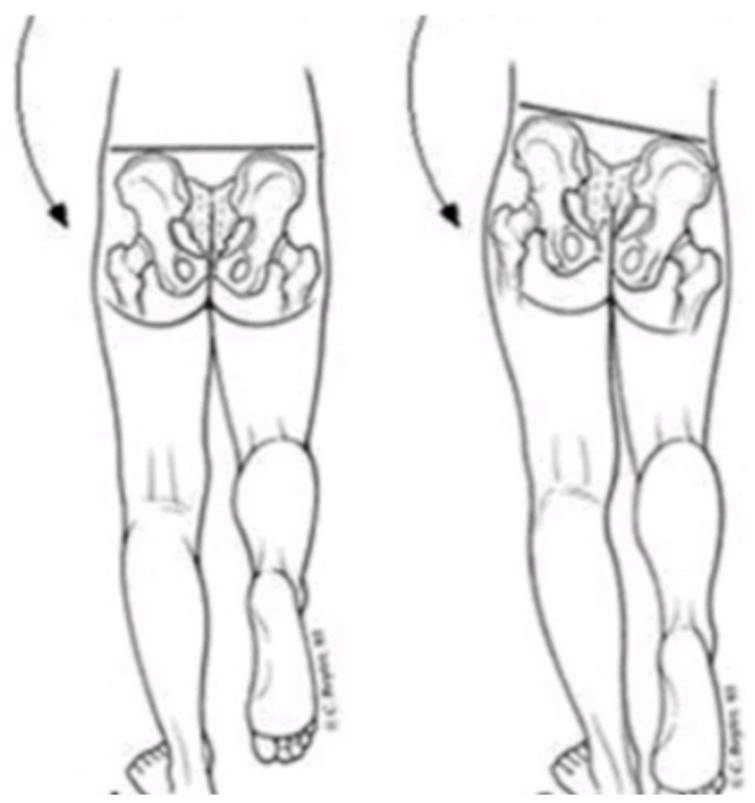
Which nerve is affected?

Abducent nerve



What is the name of test?

Trendelenburg's test



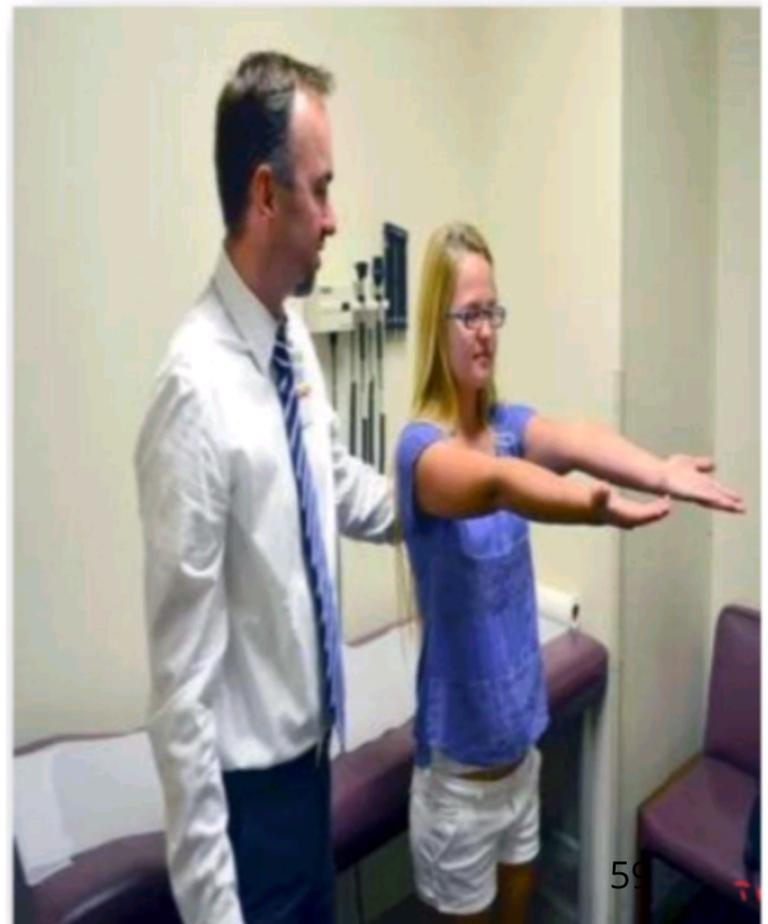
Q5- This test called ?

- A. Tandem test
- B. Romberg's test
- C. Trendelenburg's test
- D. Heel-knee-shin test
- E. Babinski's sign



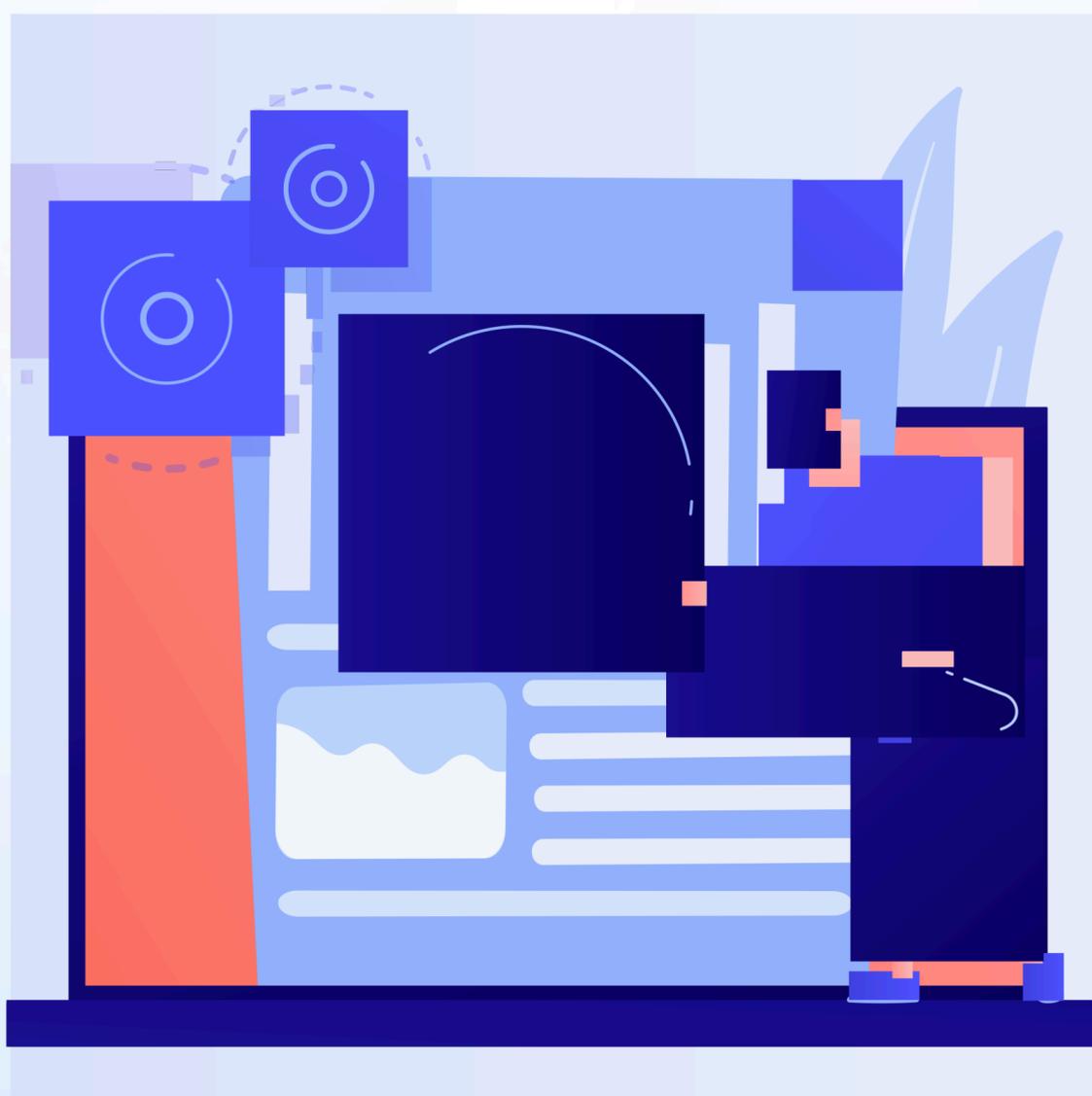
Which of the following is true ?

- the patient lost his balance when closing his eyes after standing ,this is mean positive romberg test



# MINI-OSCE MACLEOD

## ENT



الفريق الأكاديمي  
لجنة الطب والجراحة



**Fig. 9.3** Examination of the ear using an otoscope.

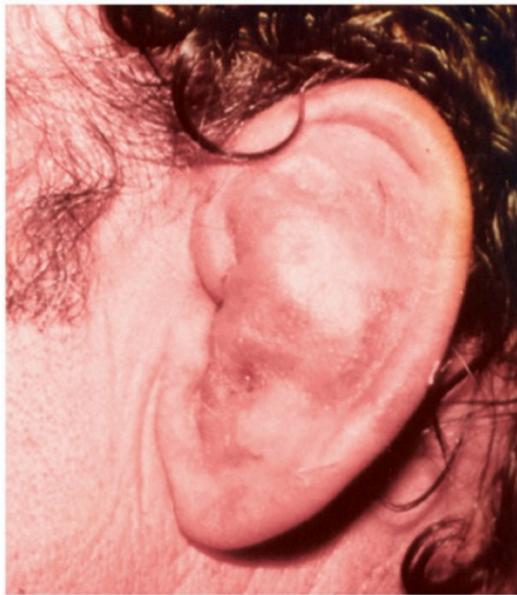


B

**B** Normal tympanic membrane.



A



B



C

**Fig. 9.4** The pinna. **A** Microtia. **B** Haematoma. **C** Squamous cancer (arrow).



A

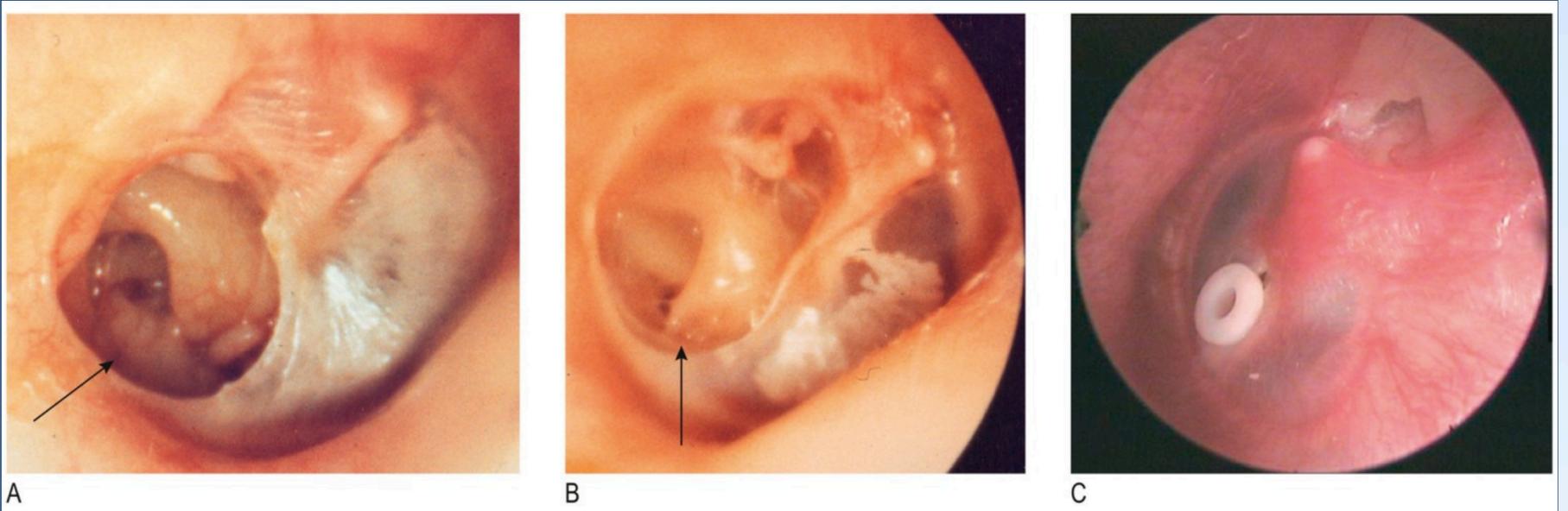


B



C

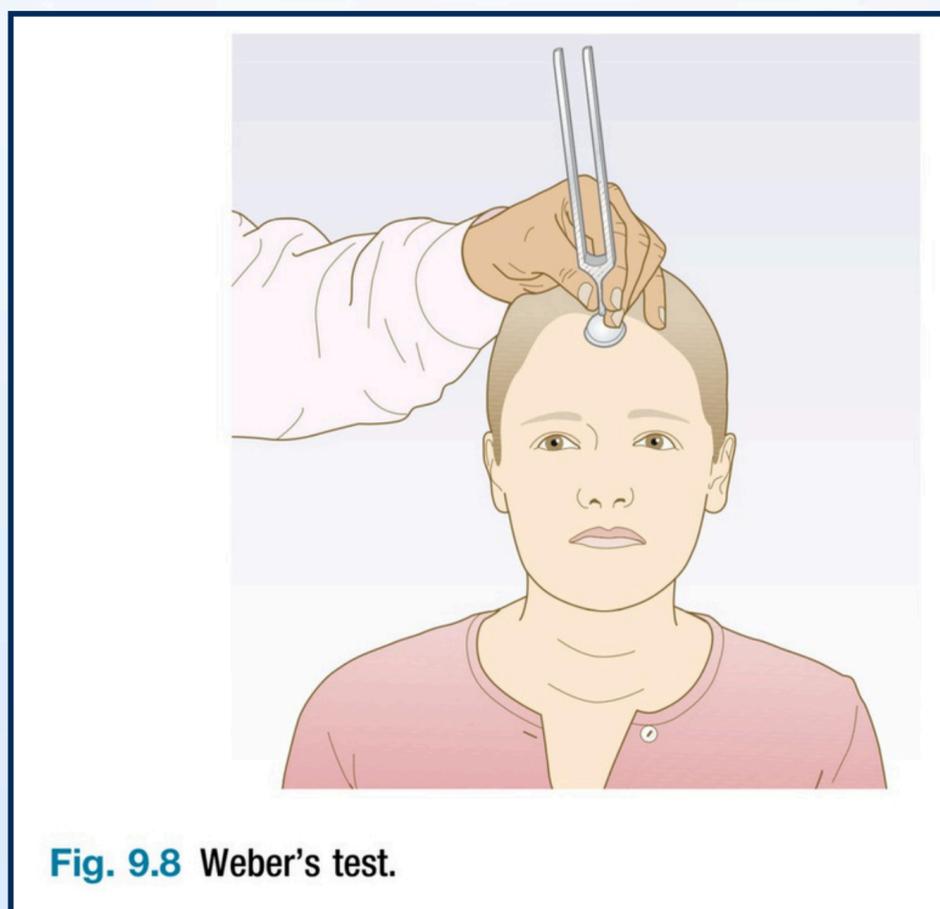
**Fig. 9.5** Auditory canal abnormalities. **A** Otitis externa. **B** Exostosis of the external auditory meatus. **C** Cholesteatoma.



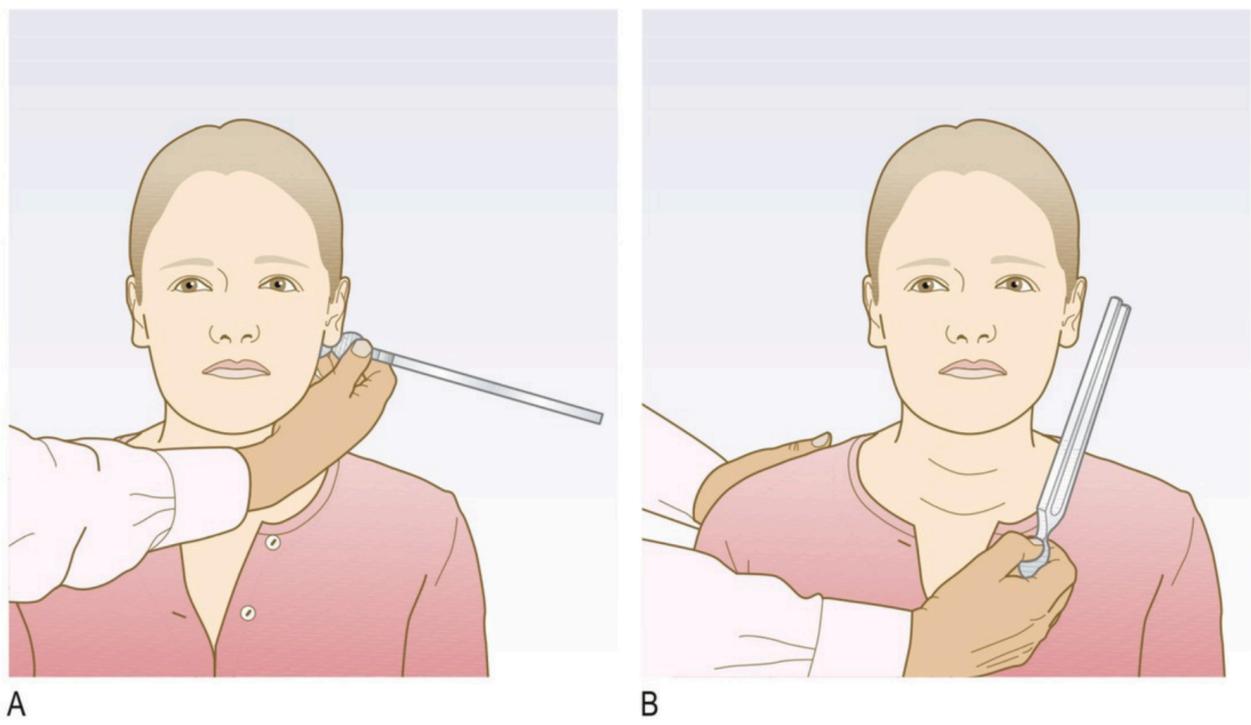
**Fig. 9.6 Tympanic membrane abnormalities.** **A** Tympanic membrane perforation (*arrow*). **B** Retraction pocket of the pars tensa (*arrow*). **C** Grommet in situ.



**Fig. 9.7 Otitis media.** **A** With effusion. **B** Fluid level behind the tympanic membrane (*arrow*). **C** Acute otitis media.



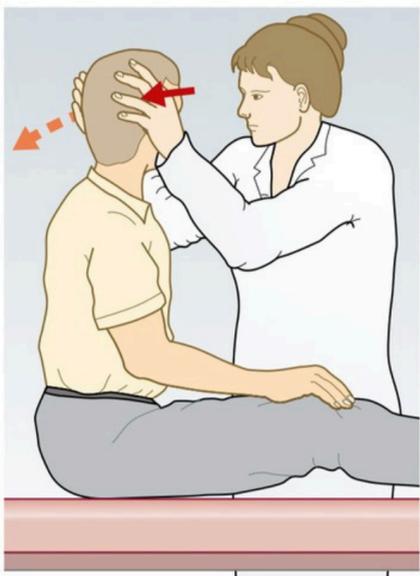
**Fig. 9.8 Weber's test.**



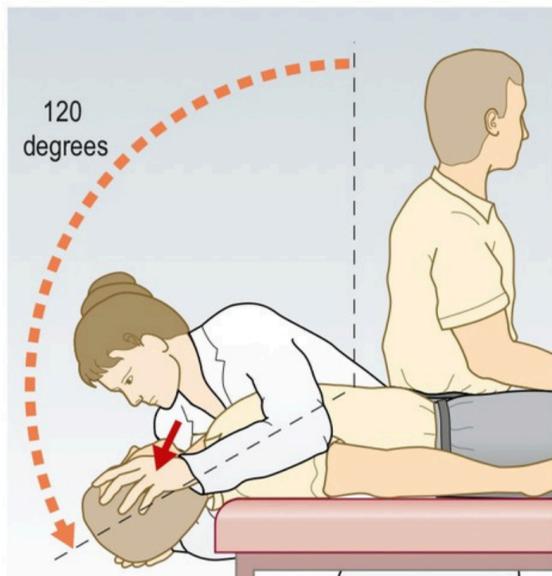
A

B

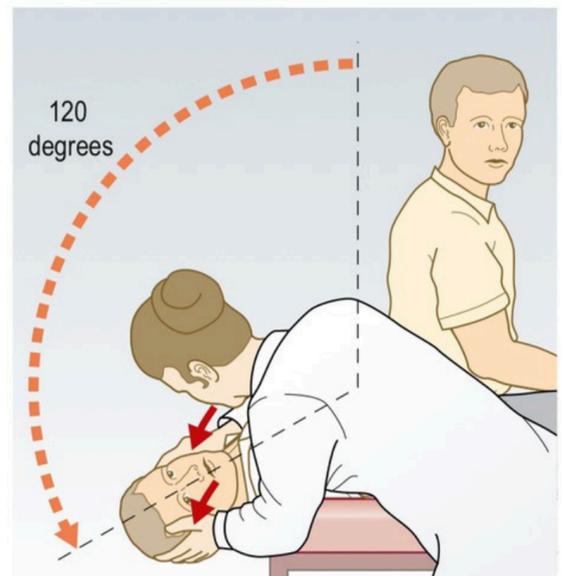
**Fig. 9.9 Rinne's test.** **A** Testing bone conduction. **B** Testing air conduction.



A



B

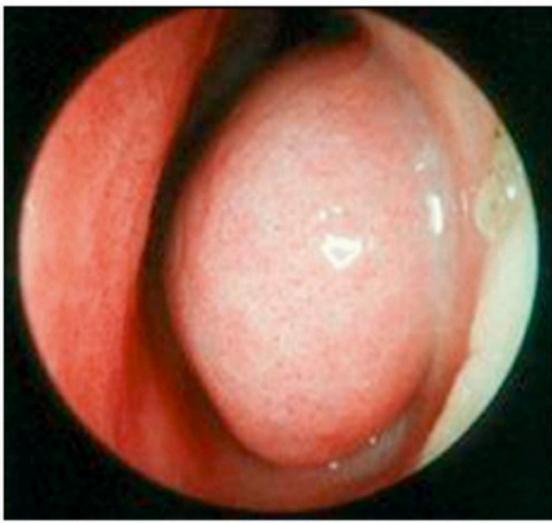


C

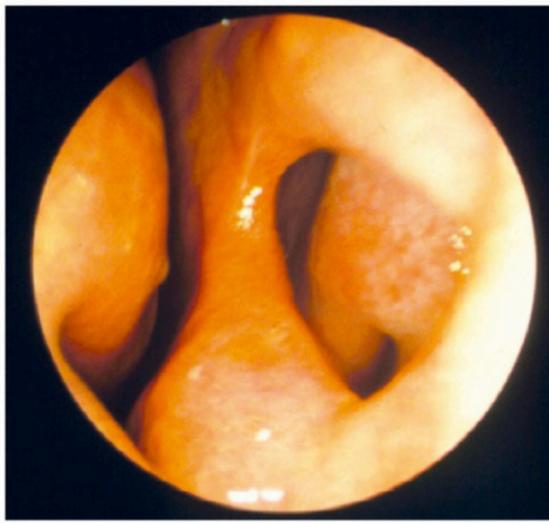
**Fig. 9.10 Dix-Hallpike position test.** The examiner looks for nystagmus (usually accompanied by vertigo). Both nystagmus and vertigo typically decrease (fatigue) on repeat testing. See text for details.



**Fig. 9.11** Magnetic resonance image showing a right acoustic neuroma (*arrow*).



A



B



C

**Fig. 9.14** Nasal abnormalities. **A** Turbinate hypertrophy. **B** Nasal septum perforation post-surgery. **C** Nasal polyps.



**Fig. 9.15** Rhinophyma as a complication of rosacea.

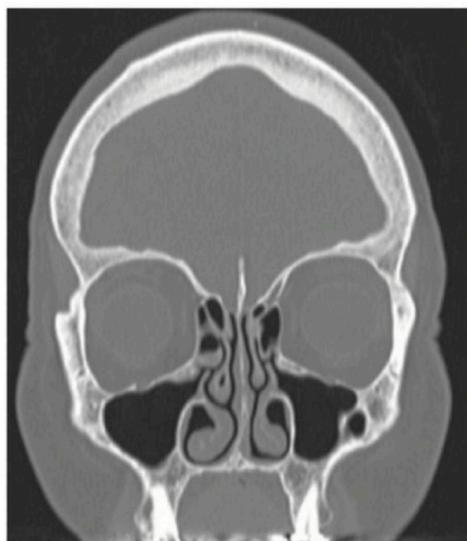


A



B

**Fig. 9.16** Nasal examination. **A** Elevation of the tip of the nose to give a clear view of the anterior nares. **B** Anterior rhinoscopy using an otoscope with a large speculum.

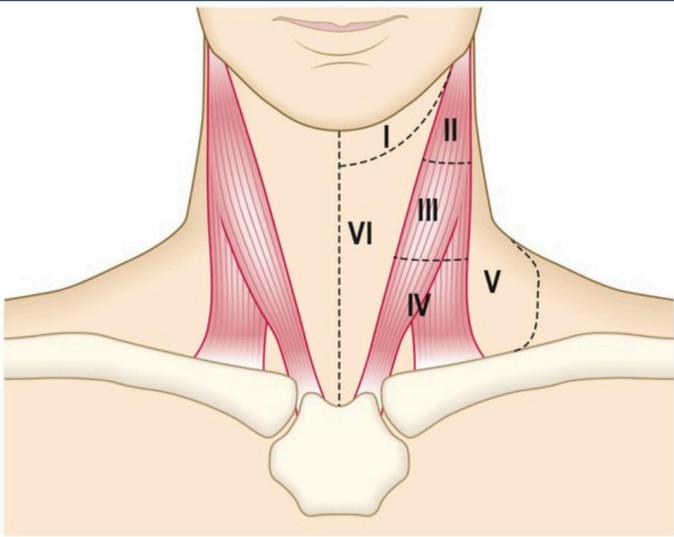


A



B

**Fig. 9.17** Computed tomograms of the paranasal sinuses. **A** Normal scan. **B** Right-sided chronic sinusitis.



- I Submental and submandibular nodes
- II Upper third sternocleidomastoid (SCM) muscle
- III Middle third SCM (between hyoid and cricoid)
- IV Lower third SCM (between cricoid and clavicle)
- V Posterior to SCM (posterior triangle)
- VI Midline from hyoid to manubrium

Fig. 9.22 Cervical lymph node levels.



Fig. 9.24 Pus discharging from the parotid duct.

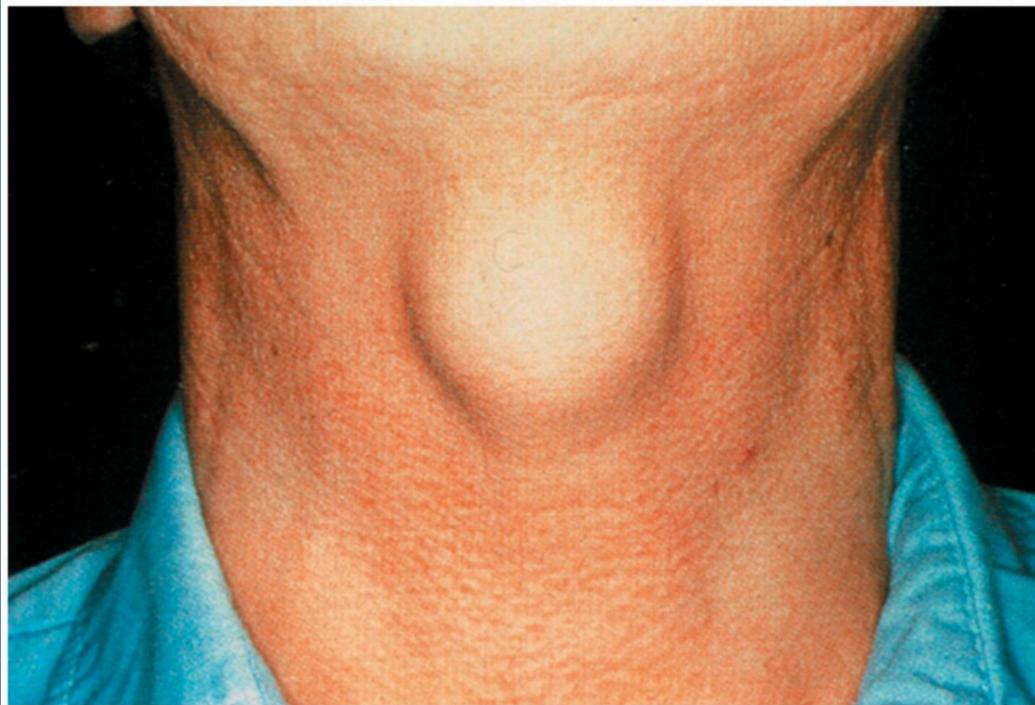
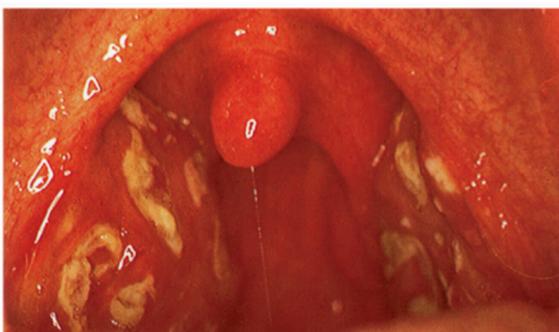


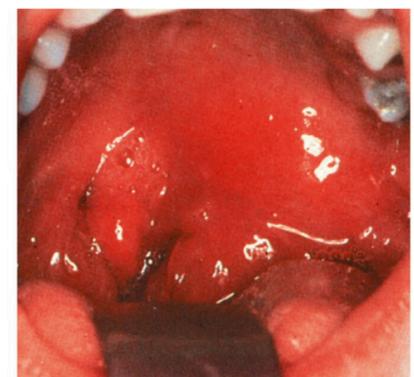
Fig. 9.28 Thyroglossal cyst.



A



B

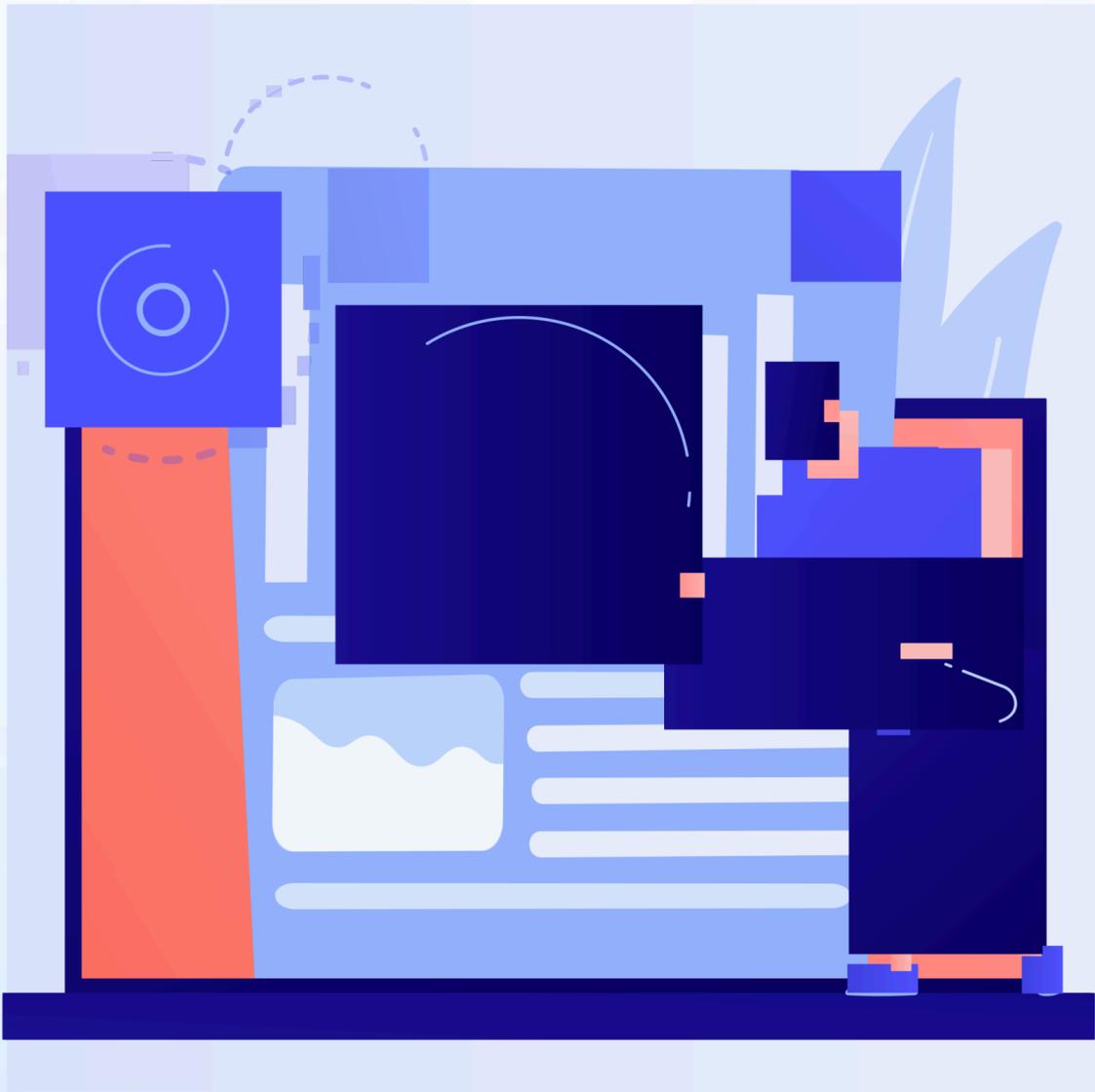


C

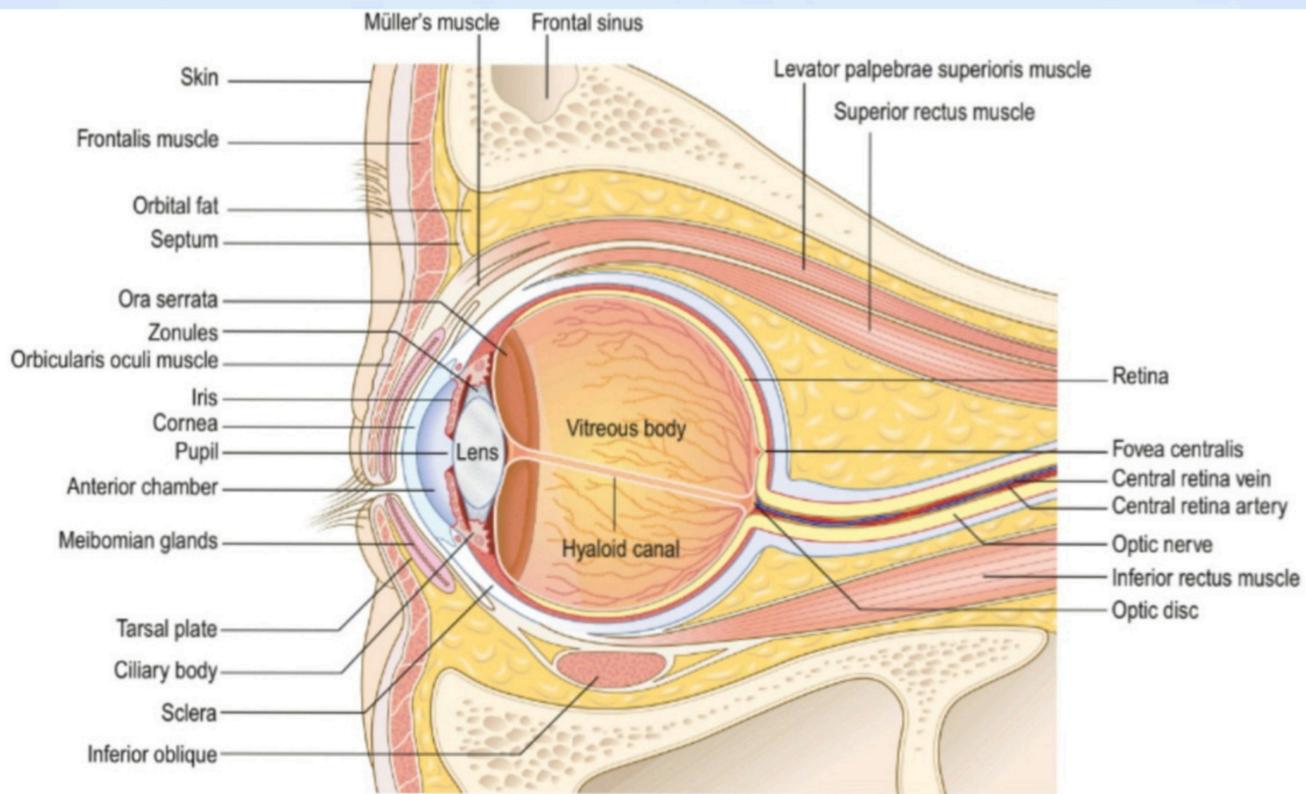
**Fig. 9.23 Sore throat.** **A** Acute tonsillitis. The presence of pus strongly suggests a bacterial (streptococcal) aetiology. **B** Glandular fever showing palatal petechiae. **C** A left peritonsillar abscess. (A) From Bull TR. Color Atlas of ENT Diagnosis. 3rd edn. London: Mosby–Wolfe; 1995.

# MINI-OSCE MACLEOD

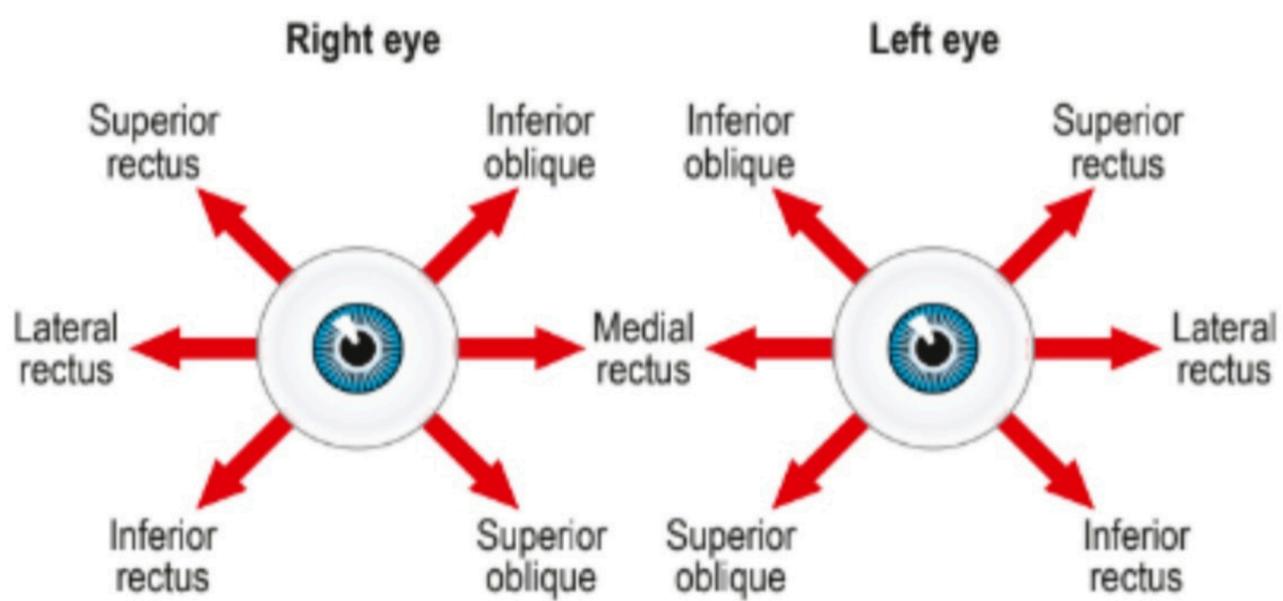
## Ophthalmology



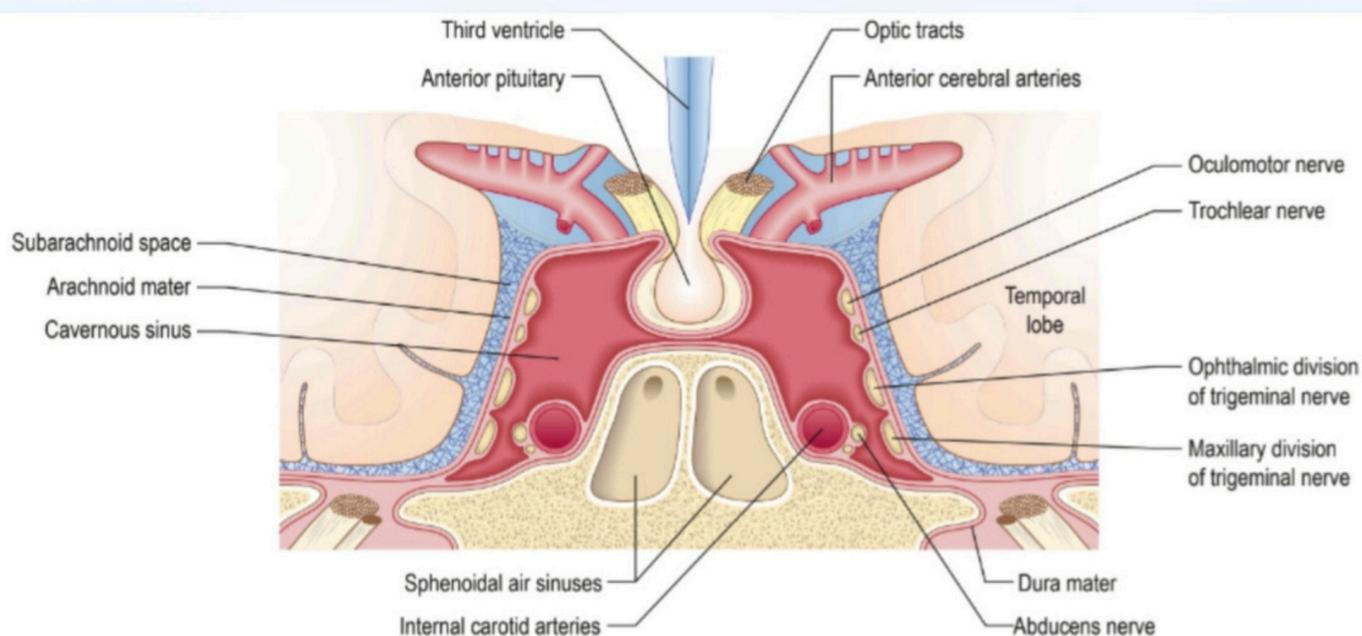
الفريق الأكاديمي  
لجنة الطب والجراحة



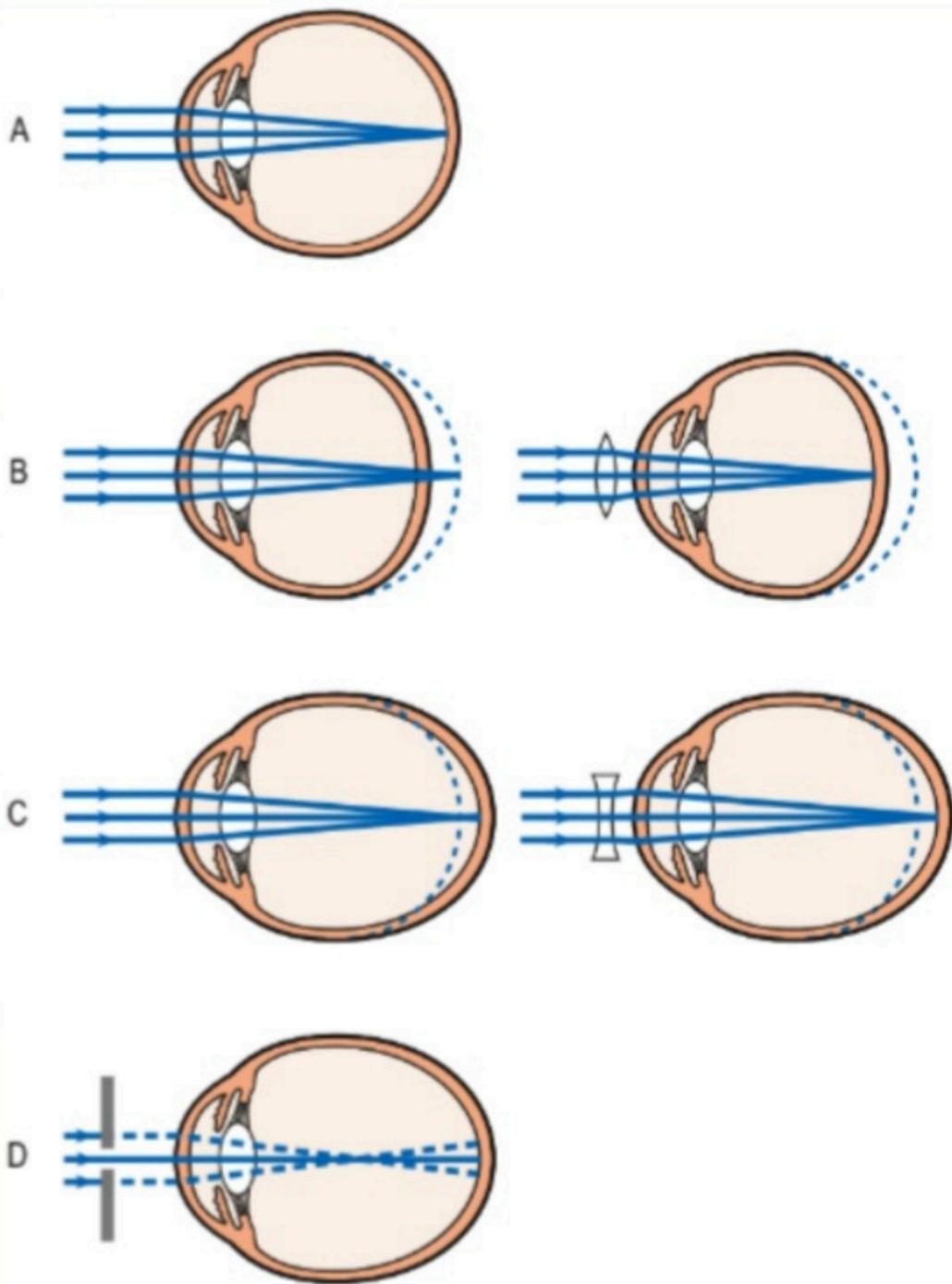
**Fig. 8.1** Cross-section of the eye and orbit (sagittal view).



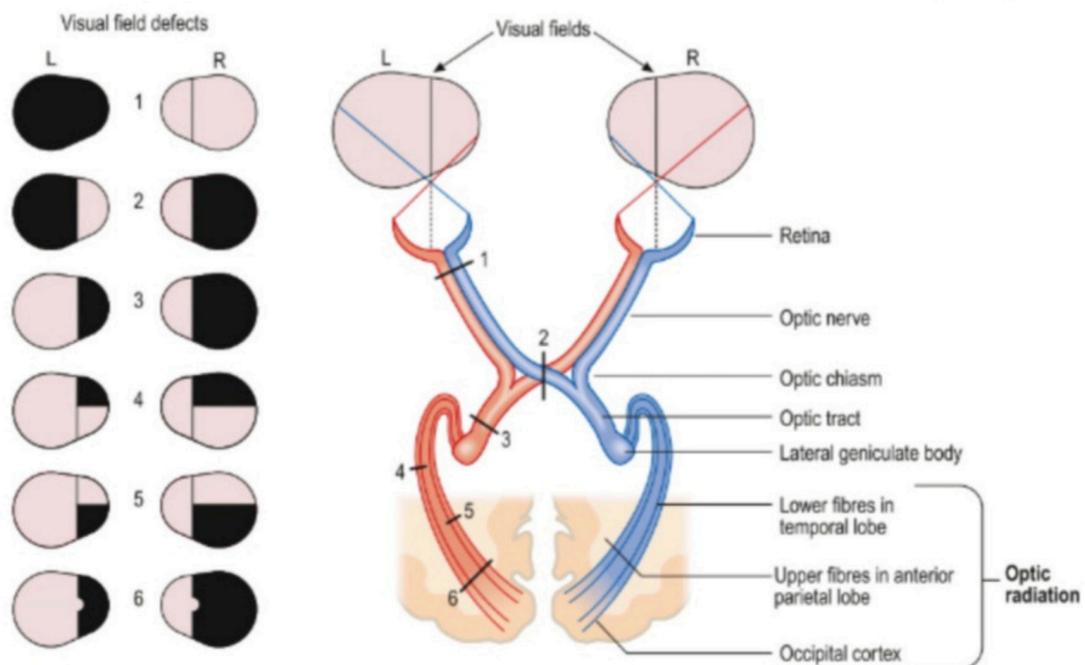
**Fig. 8.2** Control of eye movements. The direction of displacement of the pupil by normal contraction of a particular muscle can be used to work out which eye muscle is paretic.



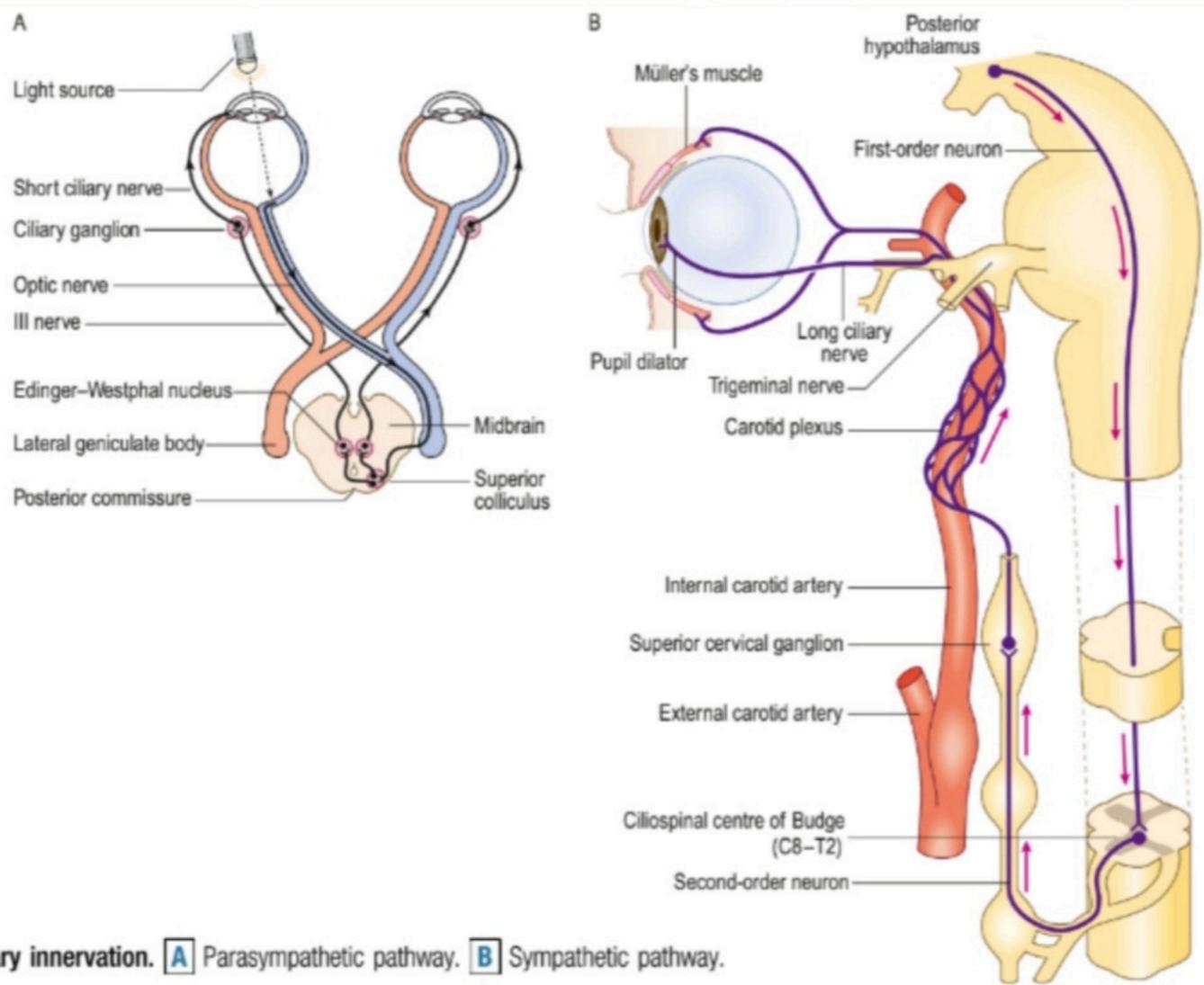
**Fig. 8.3** Cavernous sinus (coronal view). Neuroanatomy of cranial nerves III, IV and VI.



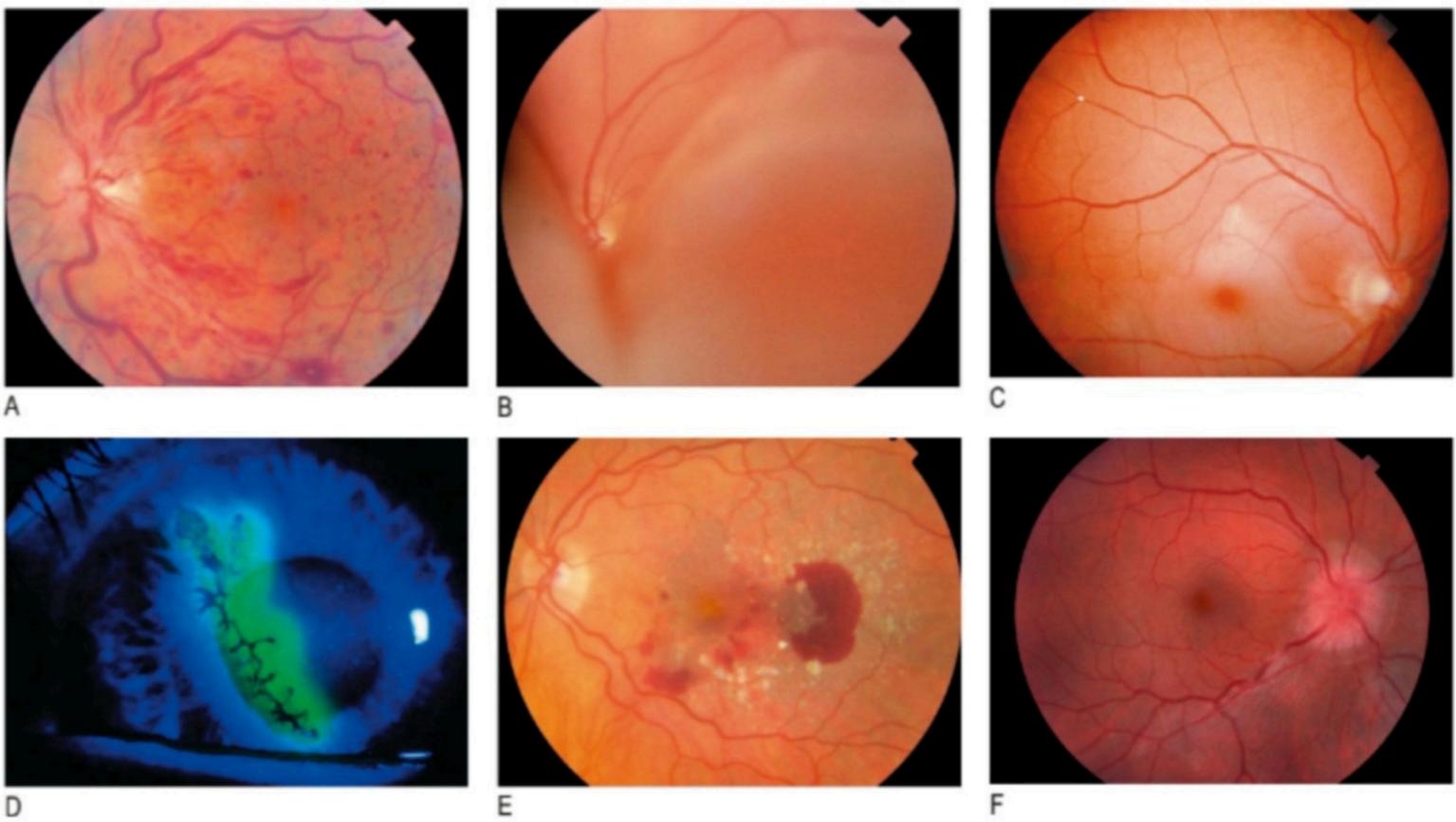
**Fig. 8.4 Normal and abnormal refraction by the cornea and lens.** **A** Emmetropia (normal refraction). Cornea and lens focus light on the retina. **B** Hypermetropia (long-sightedness). The eye is too short and the image focuses behind the retina. A convex (plus) lens focuses the image on the retina. **C** Myopia (short-sightedness). The eye is too long and the image focuses in front of the retina. A concave (minus) lens focuses the image on the retina. **D** Myopia corrected using a pinhole, which allows only rays not requiring refraction to pass to the retina.



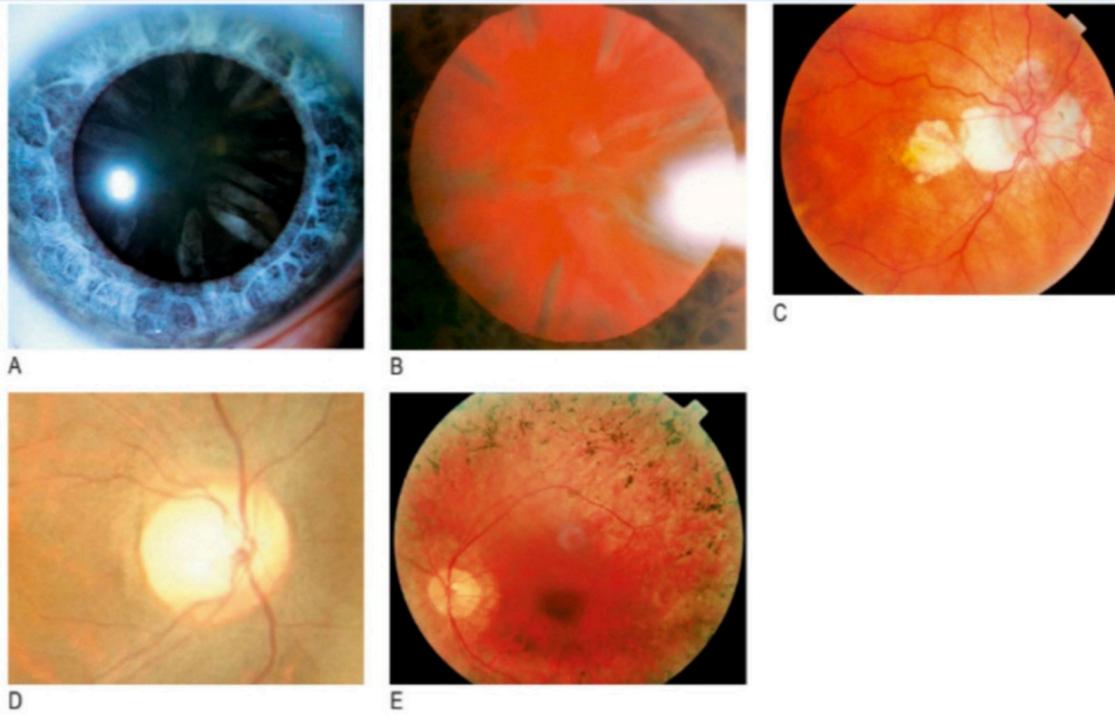
**Fig. 8.5 Visual field defects.** **1.** Total loss of vision in one eye because of a lesion of the optic nerve. **2.** Bitemporal hemianopia due to compression of the optic chiasm. **3.** Right homonymous hemianopia from a lesion of the optic tract. **4.** Upper right quadrantanopia from a lesion of the lower fibres of the optic radiation in the temporal lobe. **5.** Lower quadrantanopia from a lesion of the upper fibres of the optic radiation in the anterior part of the parietal lobe. **6.** Right homonymous hemianopia with sparing of the macula due to a lesion of the optic radiation in the occipital lobe.



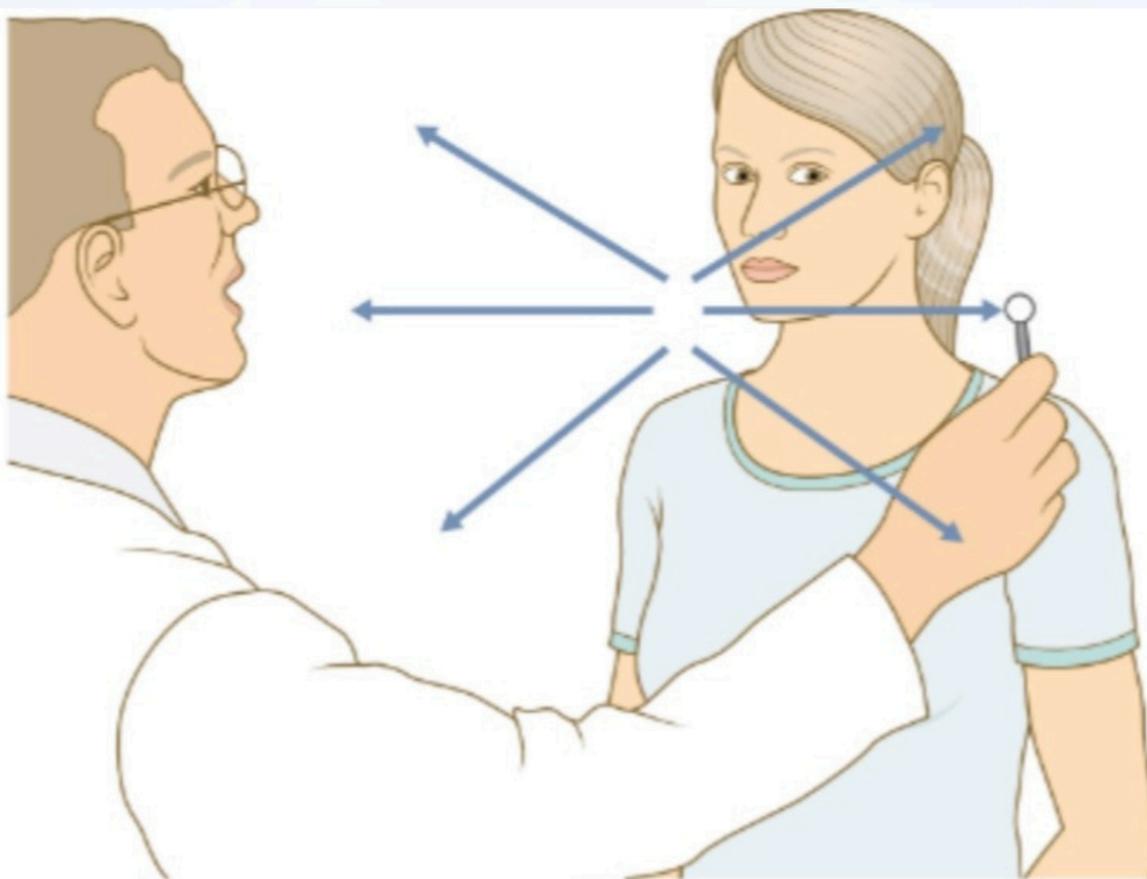
**Fig. 8.6** Pupillary innervation. **A** Parasympathetic pathway. **B** Sympathetic pathway.



**Fig. 8.7** Common causes of an acute change in vision. **A** Central retinal vein occlusion. **B** Retinal detachment. Elevation of the retina around the 'attached' optic disc; the retina may even be visible on viewing the red reflex. **C** Central retinal arterial occlusion. **D** Herpes simplex virus keratitis. **E** Wet age-related macular degeneration. **F** Swollen optic nerve head in acute optic neuritis.



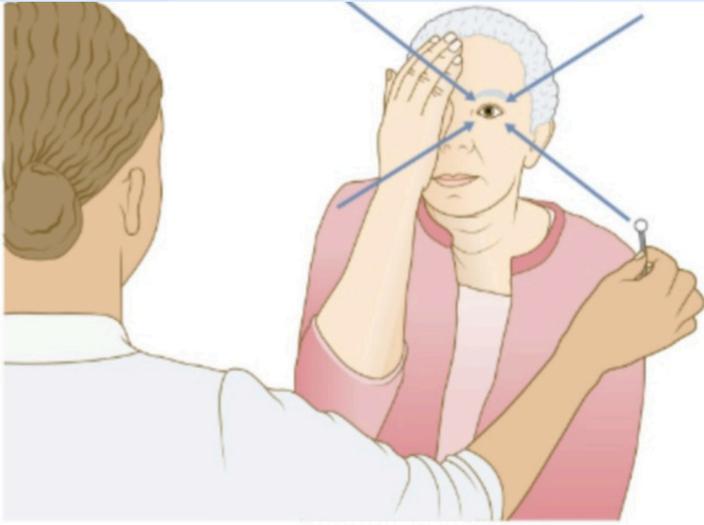
**Fig. 8.8 Common causes of a gradual loss of vision.** **A** Cataract. **B** Altered red reflex in cataract. **C** Dry age-related macular degeneration. **D** Compressive optic neuropathy. Optic nerve sheath meningioma causing optic disc pallor and increased disc cupping with sparing of the outer optic nerve rim. **E** Retinitis pigmentosa: a triad of optic atrophy, attenuated retinal vessels and pigmentary changes. The latter typically start peripherally with an associated ring scotoma and symptoms of night blindness.



**Fig. 8.9 Testing the six positions of gaze.** Sit facing the patient, 1 metre away. Perform the test with both eyes open. Hold a pen torch or target in front of the patient and move it to the six positions of gaze (*blue arrows*). Ask if they see the target as double.



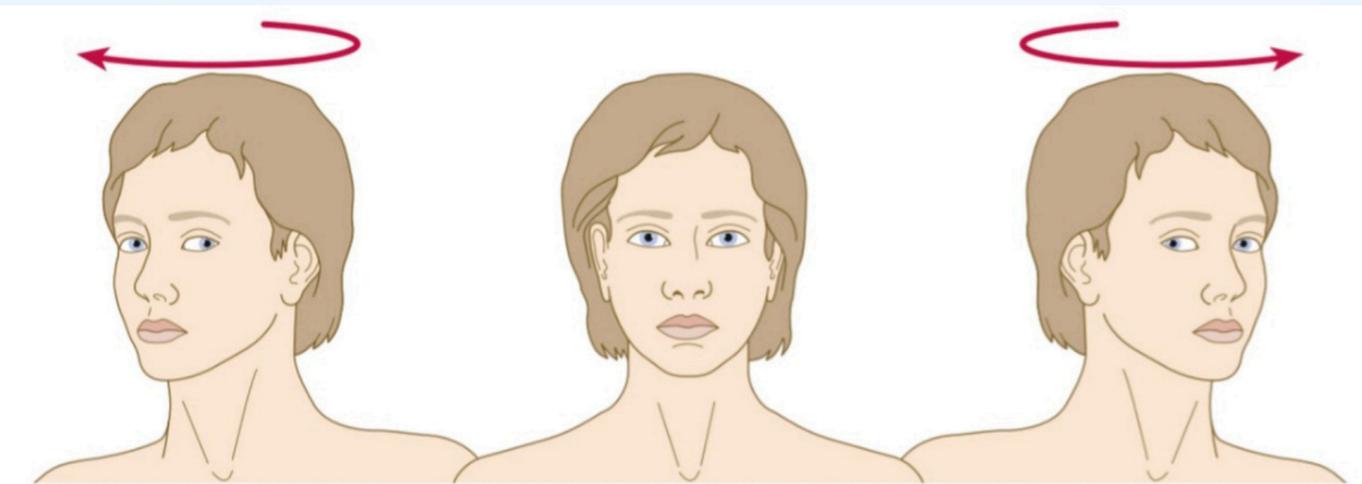
**Fig. 8.10 L sided sixth nerve palsy causing weakness of the lateral rectus.** The patient is attempting to look left.



**Fig. 8.12 Confrontation visual field testing.** Sit facing the patient, 1 metre away. To compare your visual field (assumed normal) with the patient's, present a white target or your fingers at a point equidistant between yourself and the patient in the periphery. Bring the target inwards in the direction of the blue arrows, asking the patient to alert you when they first see it. Test each eye separately.



**Fig. 8.13 Testing the central visual field.** Sit facing the patient, 1 metre away. Present a red target at a point equidistant between yourself and the patient in the periphery, starting when you can first see the target as red. Bring the target inwards in the direction of the blue arrows, asking the patient to alert you when they first see the target as red. Test each eye separately.



**Fig. 8.14 Oculocephalic reflex.** Move the head in the horizontal plane. Note that the eyes move in the opposite direction to head movement.



**Fig. 8.15 Ophthalmoscopy.** Ask the patient to focus on a distant target. To examine the left eye, use your left eye to look through the ophthalmoscope and left hand to hold it, index finger on the wheel. Hold the patient's head with your free hand. Gradually move in to visualise the optic disc. Rotate the wheel to obtain a clear, focused image.

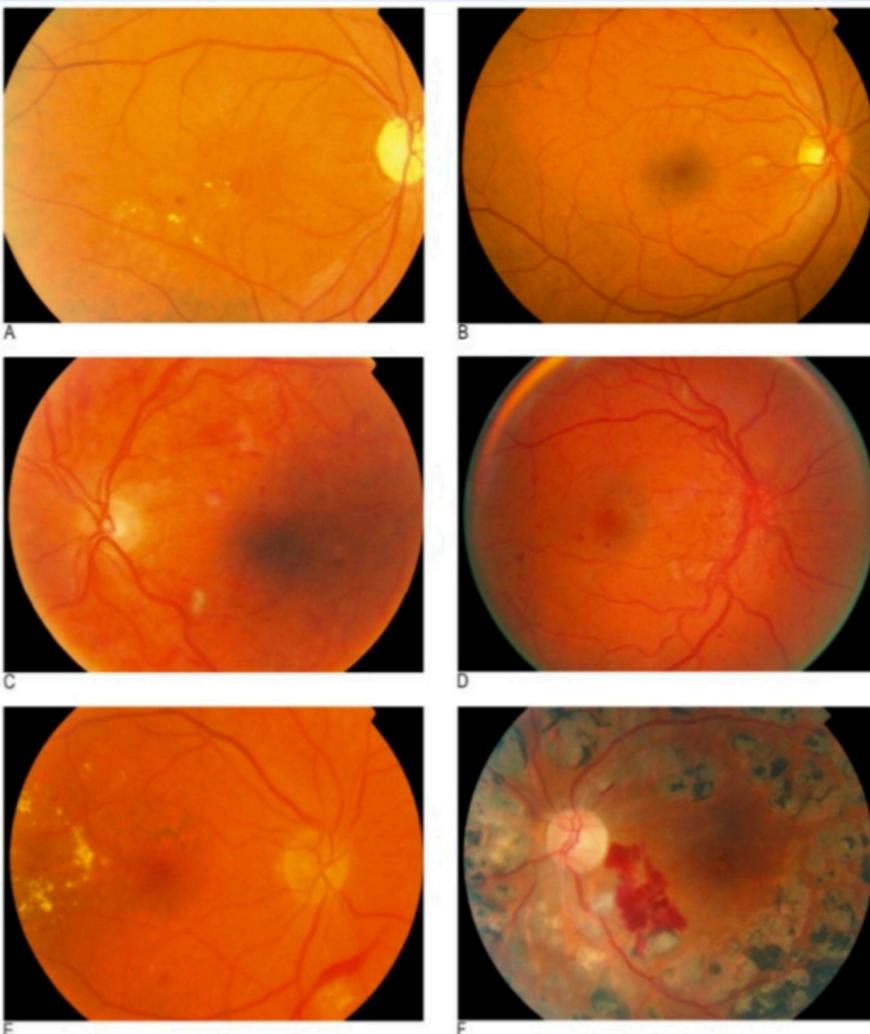


A

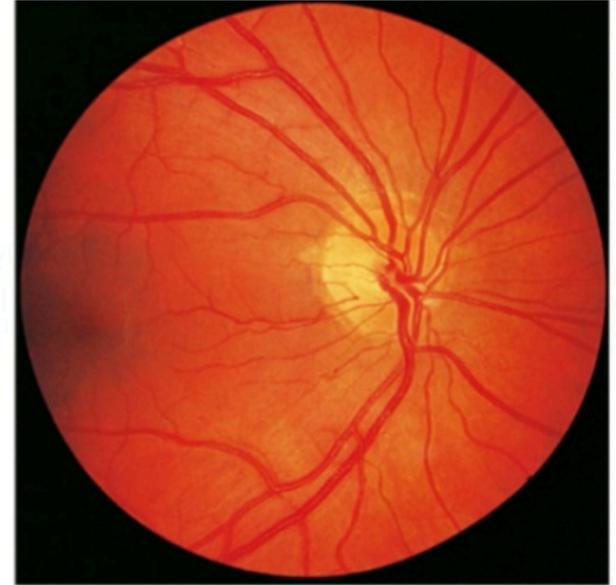


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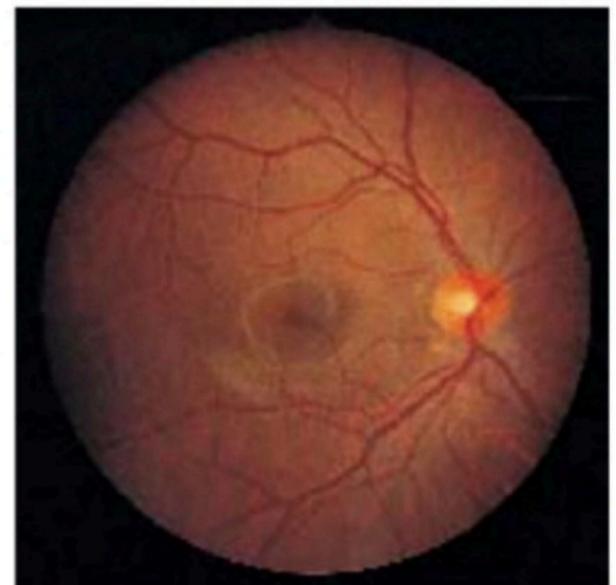
**Fig. 8.11 Third nerve palsy.** **A** Complete ptosis in R third nerve palsy. **B** The same patient looking down and left. The affected R eye is unable to adduct or depress and remains slightly abducted due to unopposed action of the lateral rectus. *From Forbes CD, Jackson WF. Color Atlas of Clinical Medicine. 3rd ed, Edinburgh: Mosby; 2003.*



**Fig. 8.17 Retinal abnormalities in diabetes mellitus.** **A** Diabetic maculopathy with yellowish hard exudates near the fovea and macular blot hemorrhages. **B** Background diabetic retinopathy: dot and blot hemorrhages and a cotton wool spot in the macula. **C** Severe non-proliferative diabetic retinopathy: dot and blot hemorrhages in all quadrants, intraretinal microvascular abnormalities superotemporally and scattered cotton wool spots. **D** Proliferative diabetic retinopathy with extensive neovascularisation at the disc. **E** Proliferative diabetic retinopathy: vitreous haemorrhage and circinate hard exudates in the macula. **F** Treated proliferative diabetic retinopathy: pigmented scars from panretinal laser photocoagulation and persistent haemorrhage in a regressed neovascular complex inferotemporally.

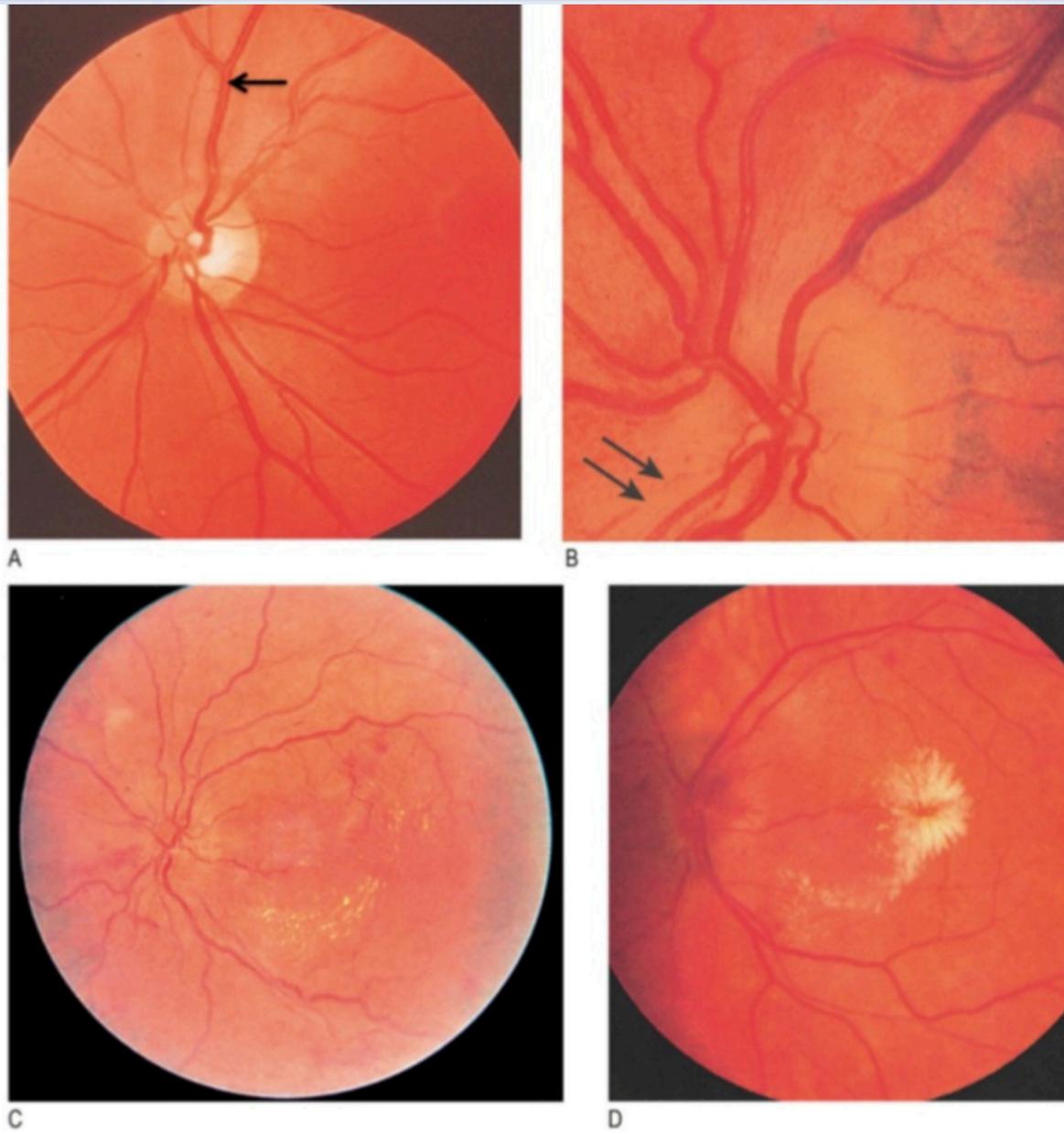


A



B

**Fig. 8.16 The normal fundus.** **A** Caucasian. **B** Asian.



**Fig. 8.18 Hypertensive retinopathy.** **A** Increased reflectance, giving a silver wiring appearance to the arteriole (*arrow*). **B** Focal arteriolar narrowing (*double arrows*) seen in grade 2 disease. **C** Exudates and flame haemorrhages in grade 3 retinopathy. **D** Signs of malignant hypertension in grade 4 disease with a swollen optic disc and macular exudate.



cataract



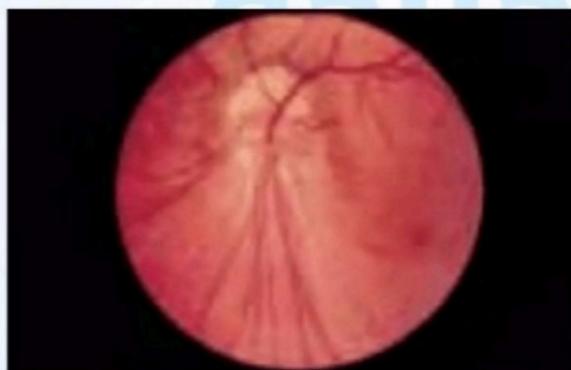
trachoma



Exudative maculopathy  
with new vessels



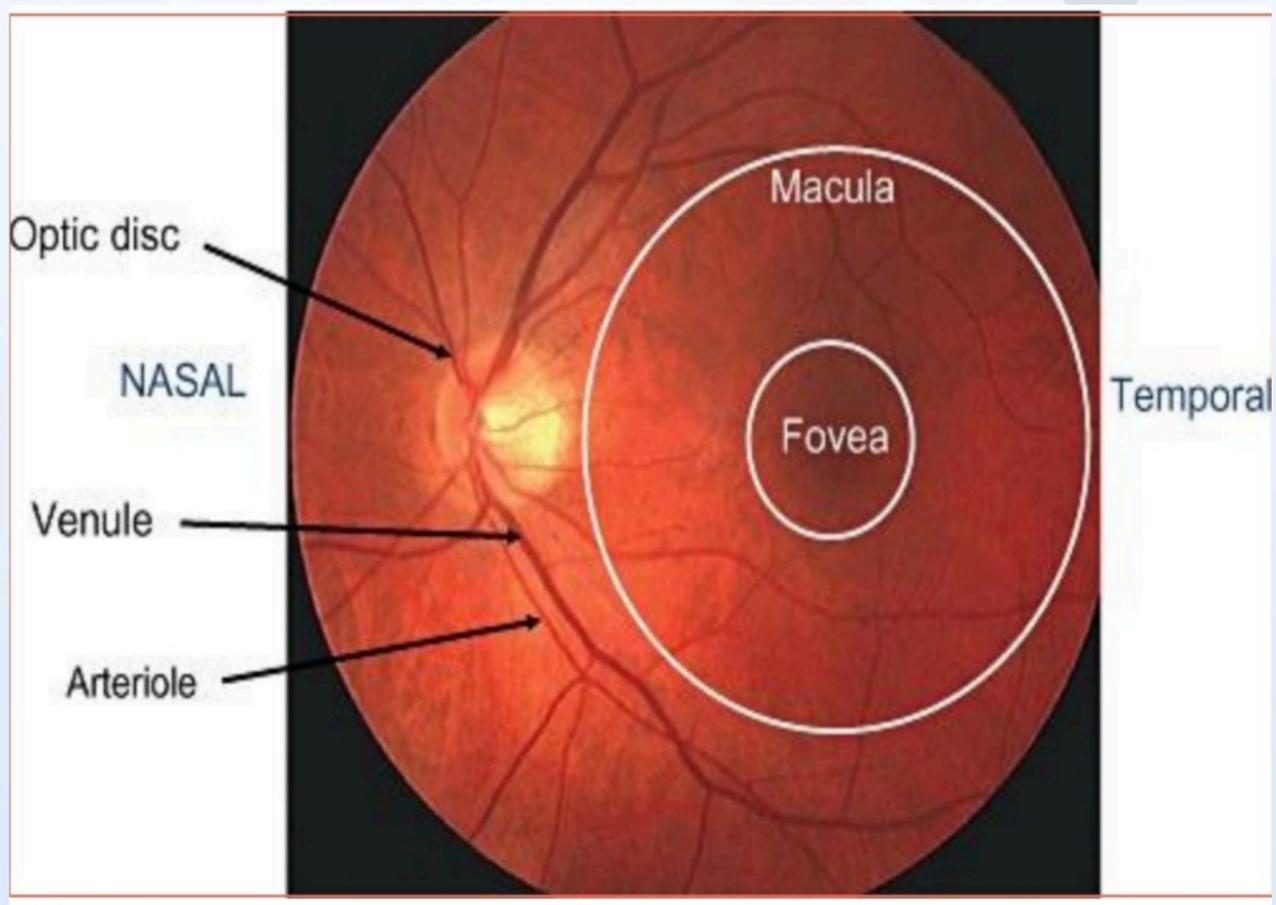
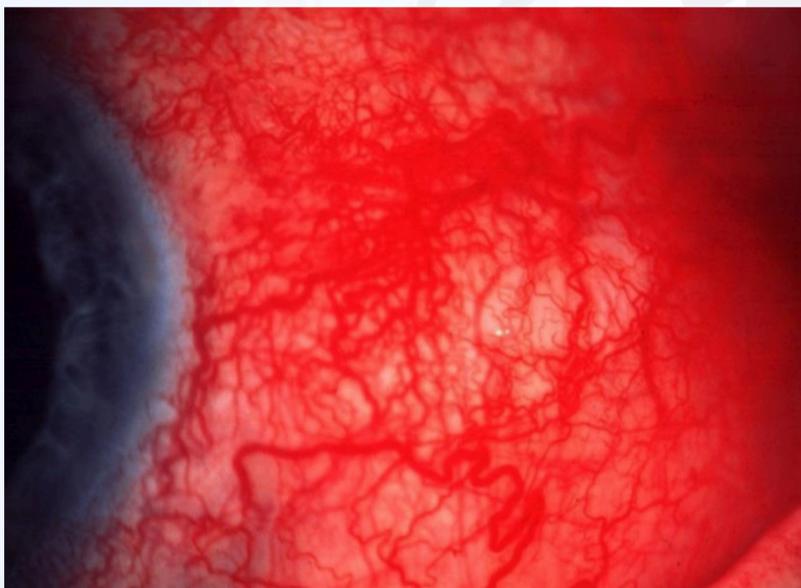
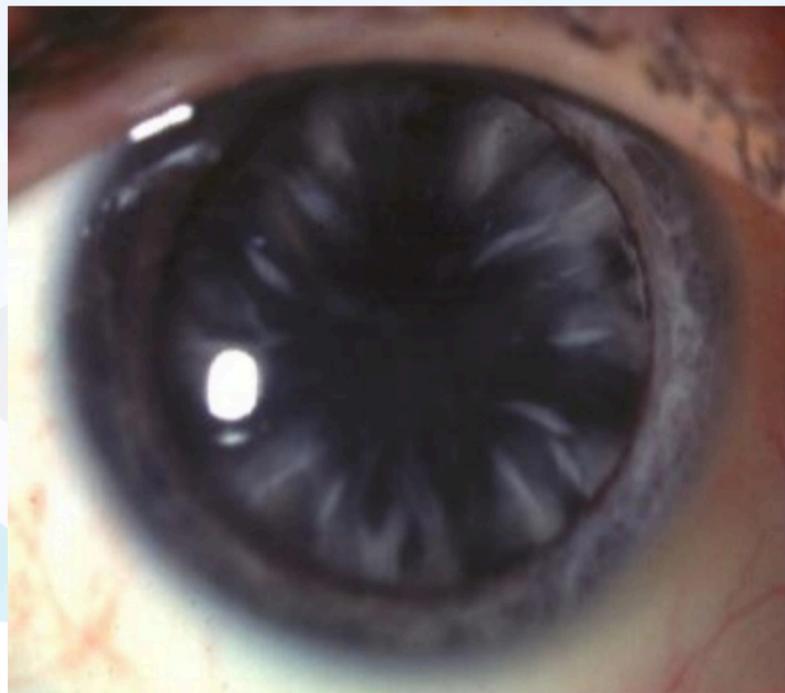
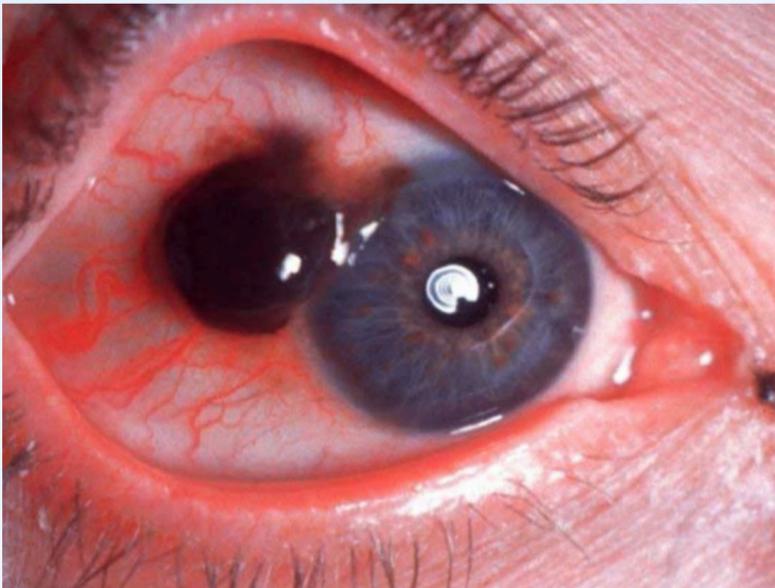
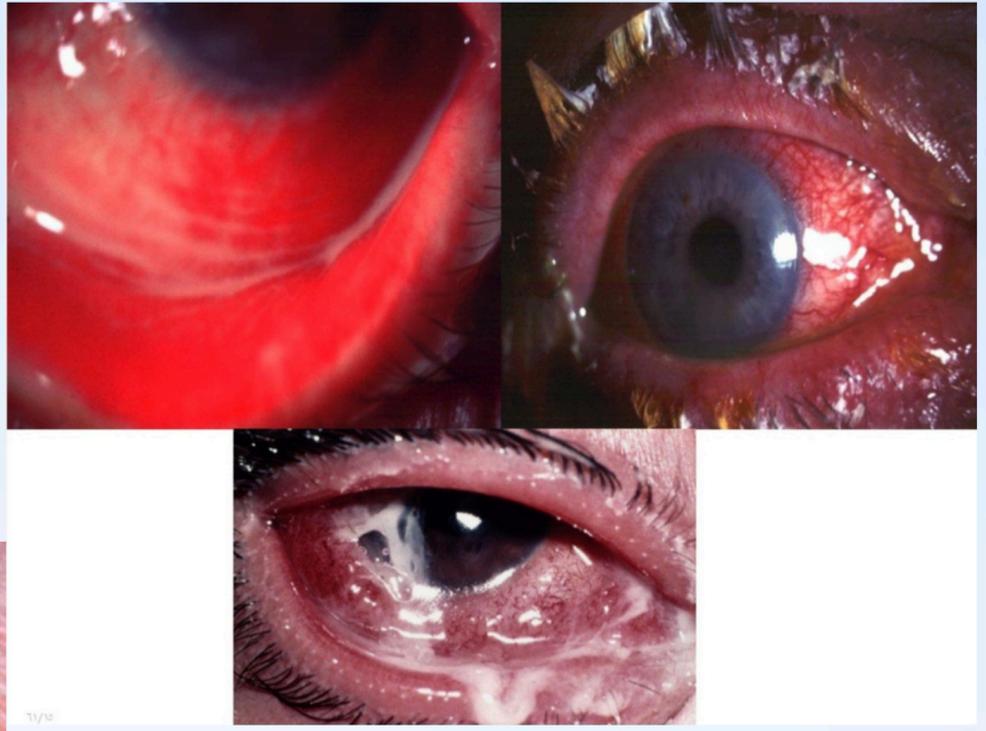
trachoma



Tractional retinal  
detachment

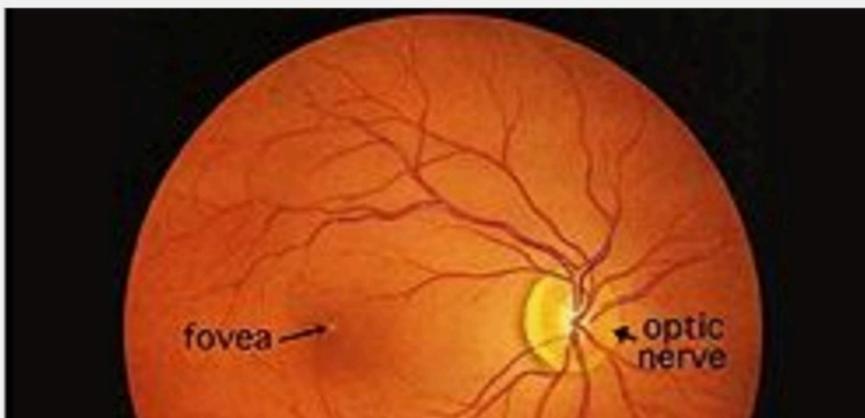
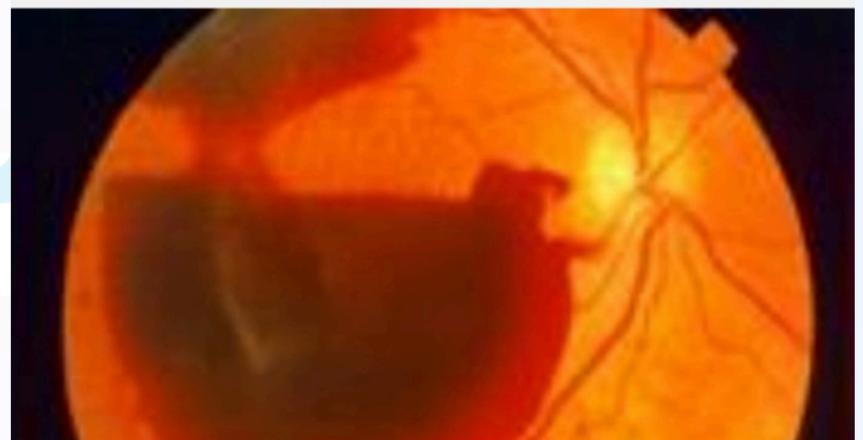
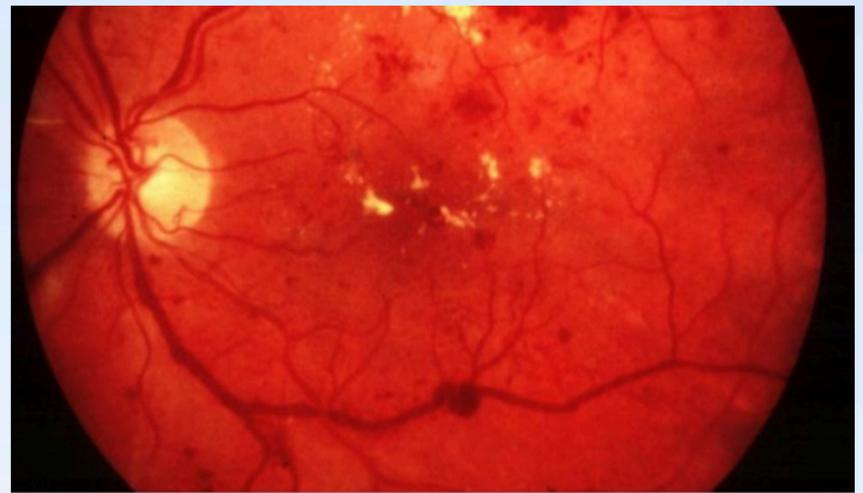
**Pain with redness:**

- ▣ **Acute angle closure Glaucoma**
- ▣ **Uveitis**
- ▣ **Scleritis ( red, painful eye with movement)**
- ▣ **Conjunctivitis**

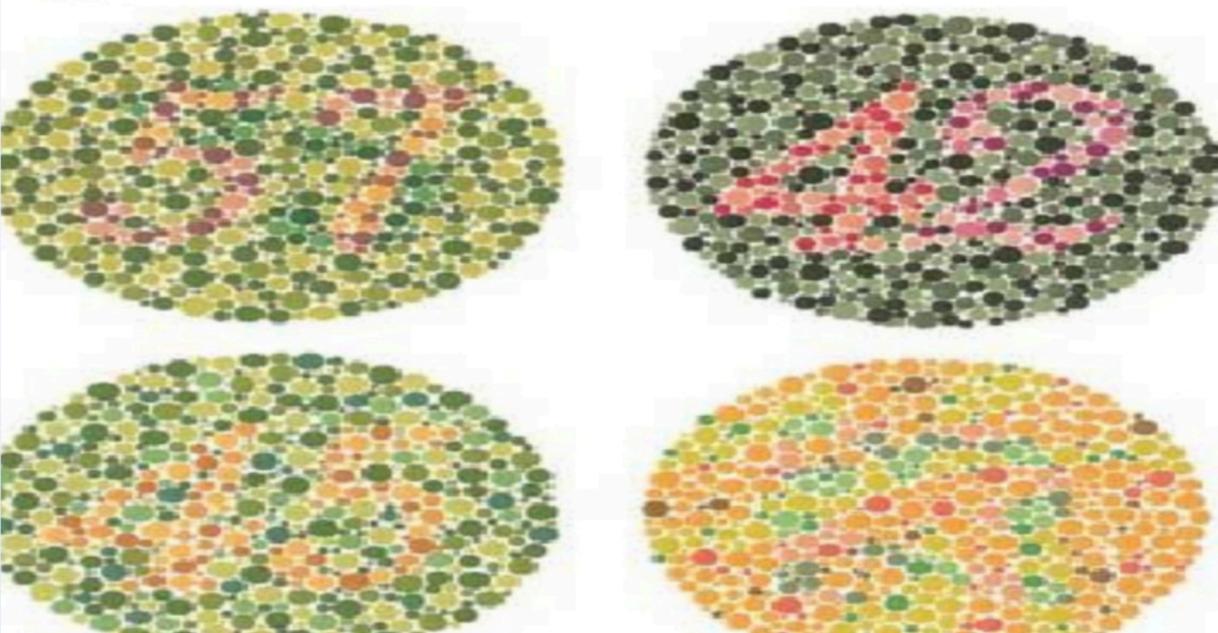


## Fundoscopy

- Direct and Indirect ophthalmoscopes
- Technique of exam
- Direct ophthalmoscope :
  - 2D
  - linear magnification = 15
  - Portable
  - Illumination less
  - Smaller feild



## Color vision



## Special Tests

- Proptosis : Hertle exophthalmometry  
Ruler

Gonio lenses

Retinoscopy

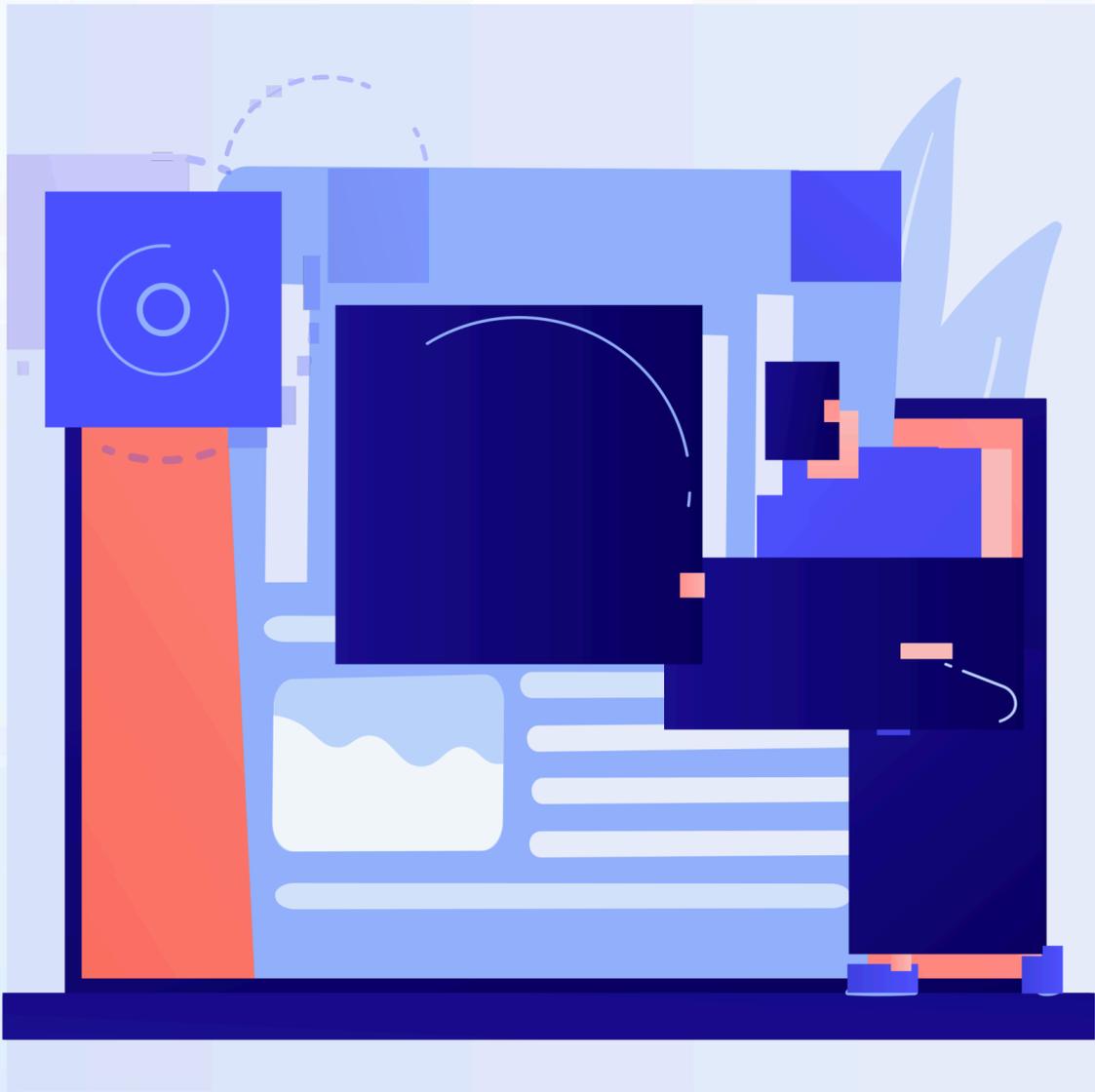
Keratometry

11/21

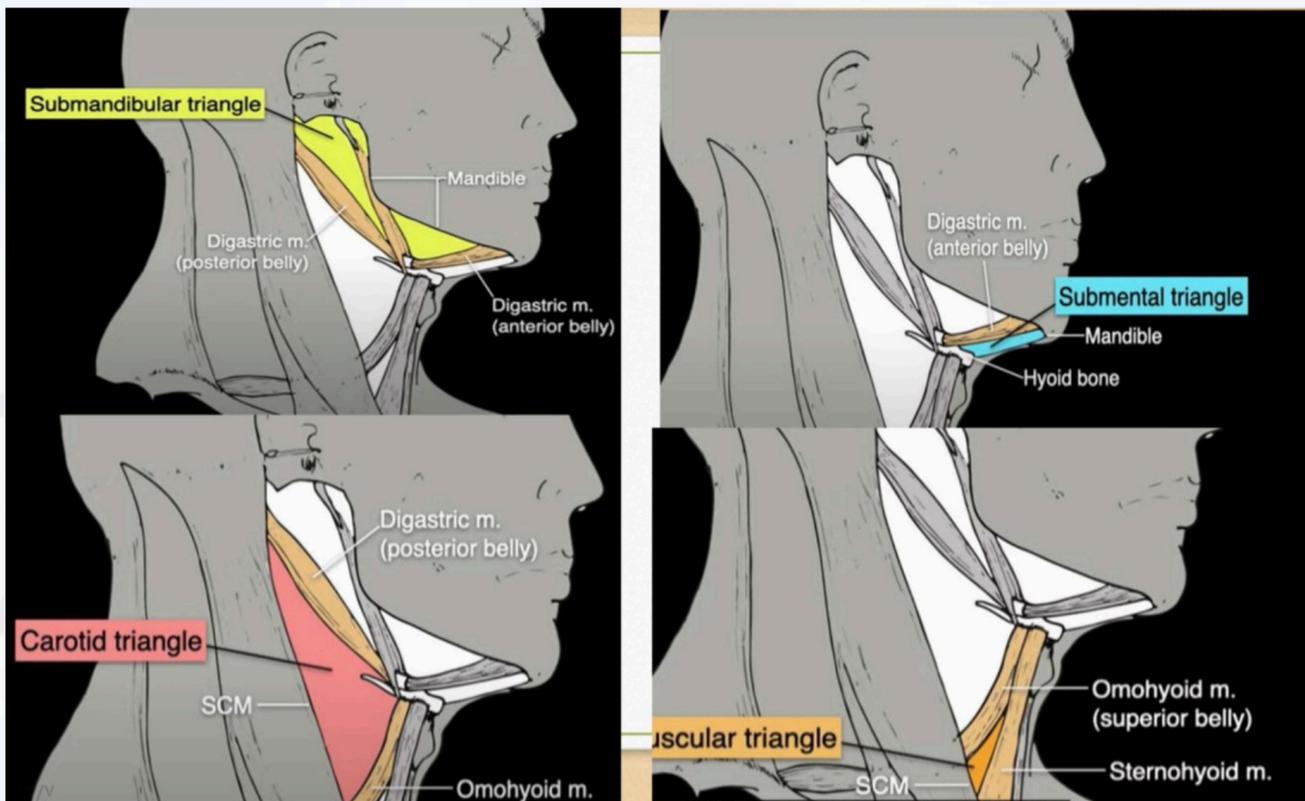
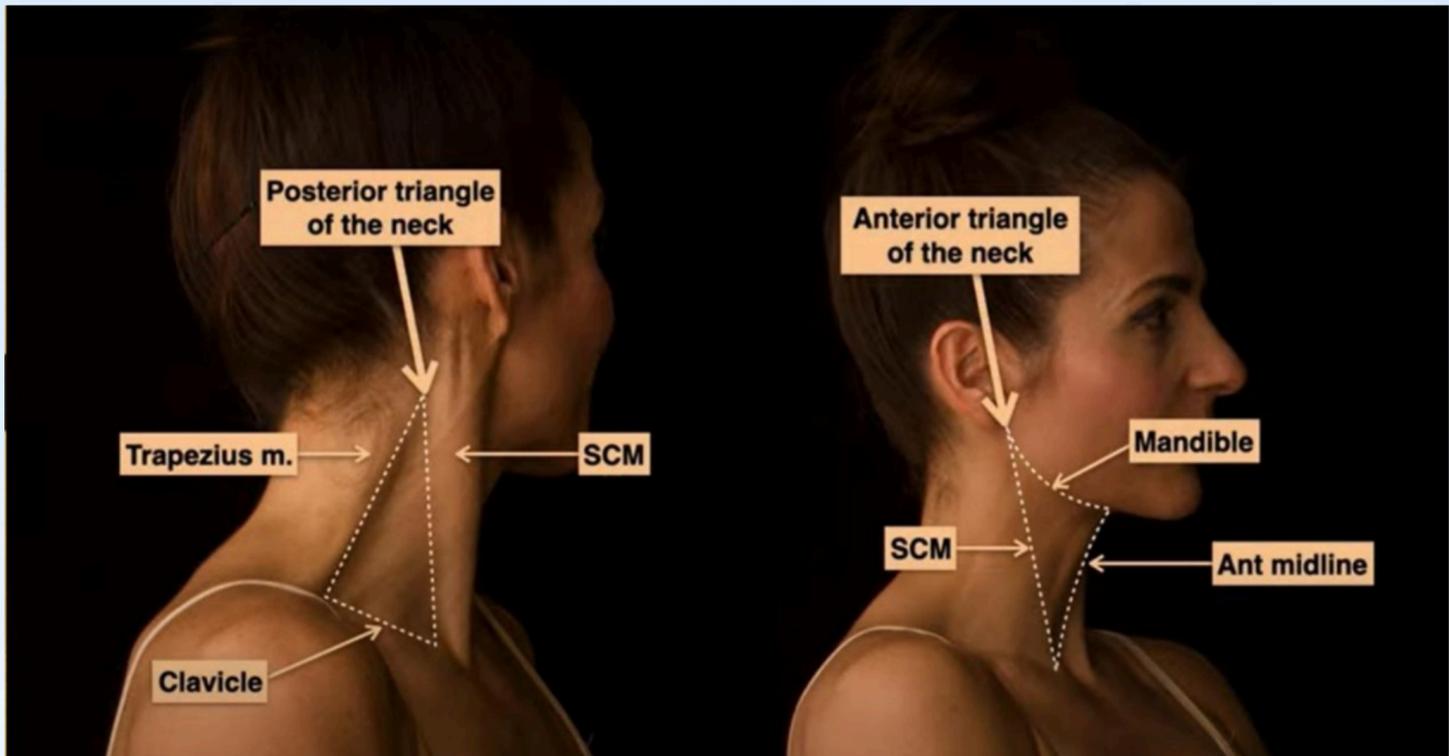


# MINI-OSCE MACLEOD

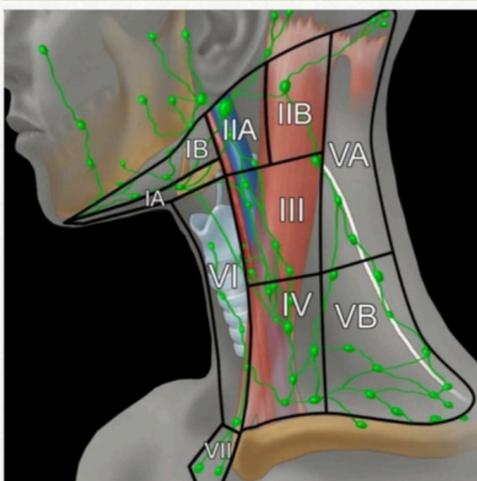
## Neck exam



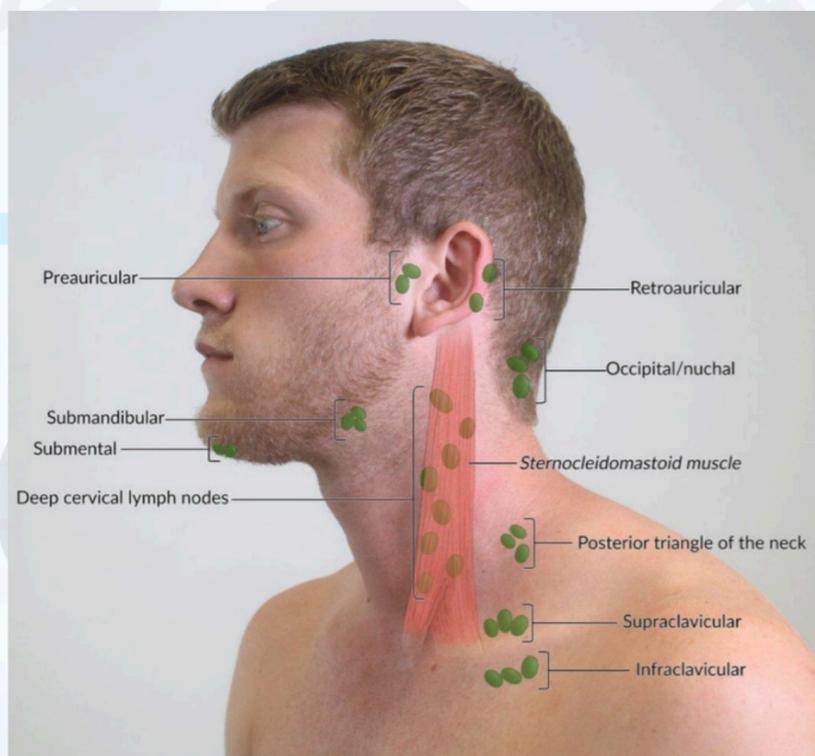
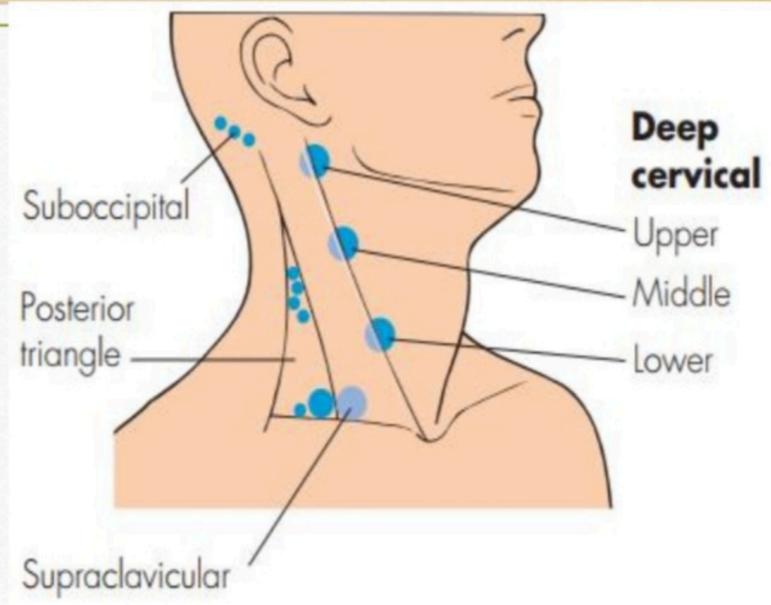
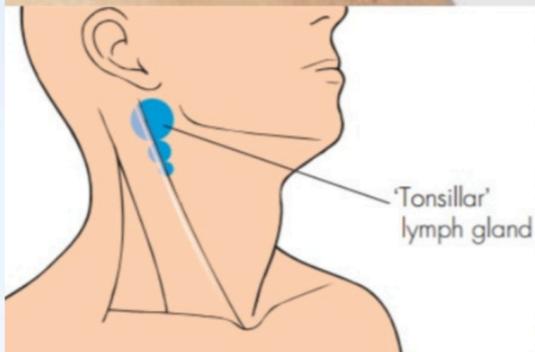
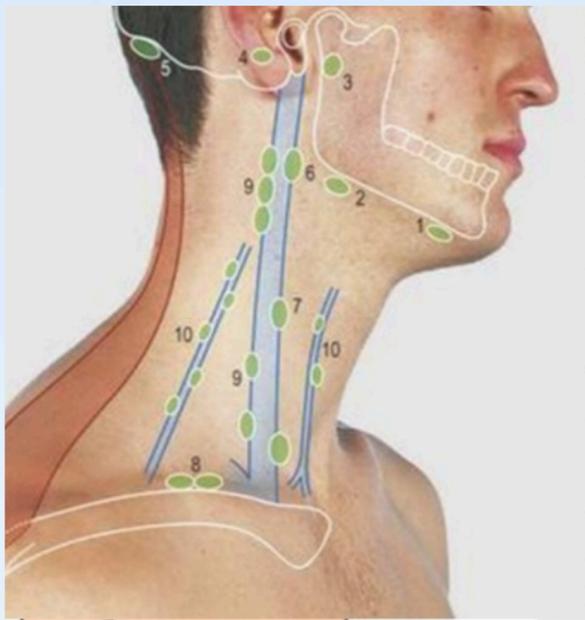
الفريق الأكاديمي  
لجنة الطب والجراحة



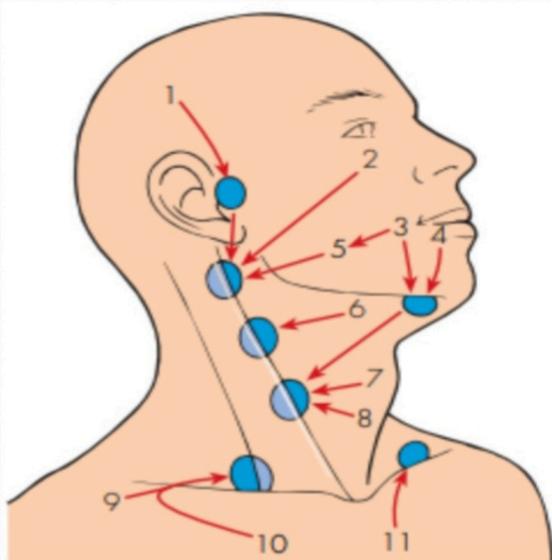
## Neck Levels and Groups



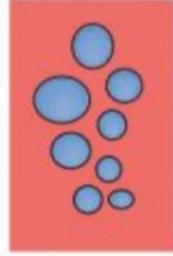
- IA, IB: Submental, Submandibular
- II: Upper Jugular Group
- III: Middle Jugular Group
- IV: Lower Jugular Group
- V: Posterior Triangle Group
- VI: Anterior Compartment Group (Pretracheal)
- VII: Prevertebral Compartment Group (Retropharyngeal and retrostyloid)



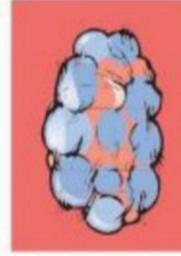
**Sites of primary neoplasms that metastasize to the cervical lymph glands**



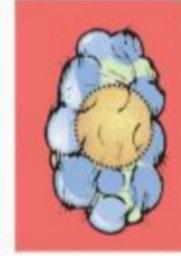
1. Scalp (sometimes via the preauricular node)  
Parotid gland  
Upper face  
Ear
2. Maxillary antrum and other air sinuses  
Nasal cavity and nasopharynx
3. Tongue  
Buccal mucosa  
Floor of mouth  
Mandible
4. Lips
5. Tonsil  
Base of tongue  
Oropharynx
6. Submandibular gland  
Skin of neck
7. Larynx and laryngopharynx
8. Thyroid  
Upper oesophagus
9. Upper limb and both sides of the chest wall
10. Breast
11. Lungs, stomach and all the viscera



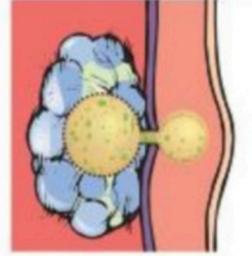
Enlarged discrete glands



'Matted' glands



Abscess forms in the centre of the glands

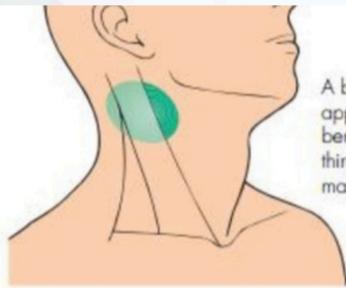


Abscess bursts through the deep fascia and becomes 'collar-stud' in shape

The development of a 'collar-stud' abscess.

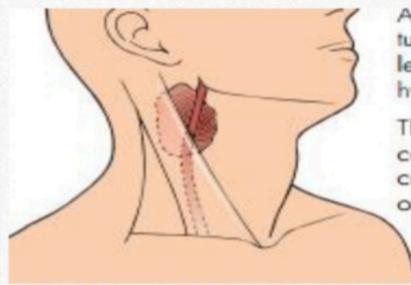


A large tuberculous 'collar-stud' abscess.



A branchial cyst appears from beneath the upper third of the sternomastoid muscle

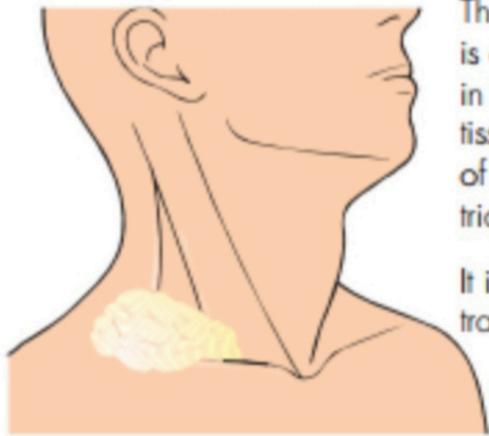
FIG 11.12 The site of a branchial cyst.



A carotid body tumour should be level with the hyoid cartilage  
The external carotid artery may cross the surface of the tumour

FIG 11.15 The site of a carotid body tumour.





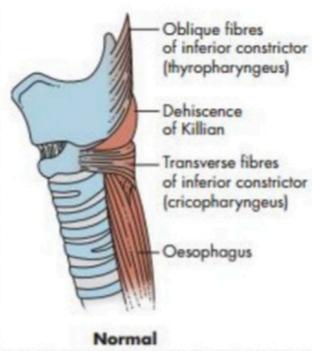
The cystic hygroma is commonly found in the subcutaneous tissues at the base of the posterior triangle

It is brilliantly translucent

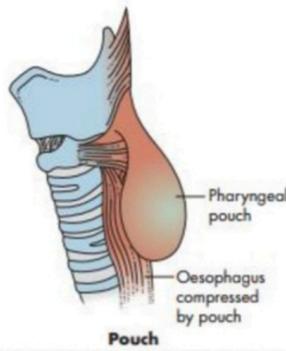
**FIG 11.18** The site of a cystic hygroma.



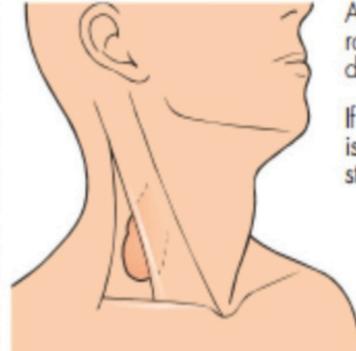
**FIG 11.19** TWO EXAMPLES OF CYSTIC HYGROMA. In a very young child – the common age of presentation, and in a young adult.



**Normal**



**Pouch**

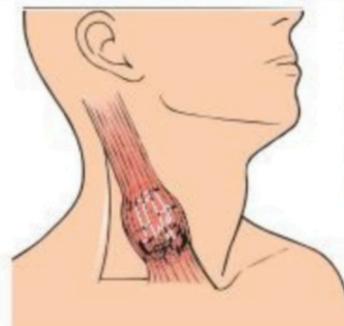


A pharyngeal pouch rarely causes a detectable swelling

If it does, the swelling is behind the sternomastoid muscle



**FIG 11.26** An adult form of torticollis caused by muscular spasm.



A 'sternomastoid tumour' is an area of oedema and necrosis in the lower third of the sternomastoid muscle



**FIG 11.25** An infantile torticollis caused by ischaemia of the sternomastoid muscle.

## Pemberton's sign

- Tests the presence of latent pressure in the thoracic inlet
- Positive Pemberton's sign :facial congestion and cyanosis, as well as respiratory distress after 1 min.
- Indicative of superior vena cava syndrome (SVC), commonly the result of a mediastinumal mass. Although the sign is most commonly described in patients with substernal goiters



### ● Thyroid Percussion:

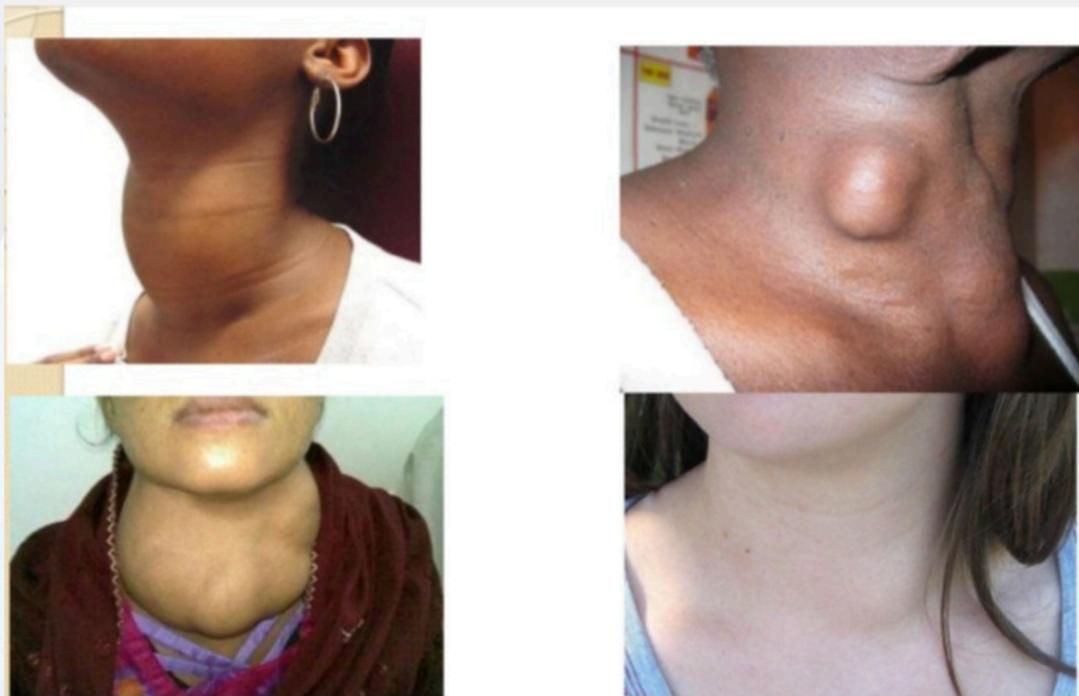
- check for any thyroid gland enlargement
  - sternoclavicular edge to retrosternal area

### ● Thyroid Auscultation:

- listen for carotid bruits bilaterally

### ● Extra considerations

- check reflexes
- Proximal muscle weakness
- consider checking for cardiomegaly
- consider checking for pleural effusion and ascites
- check for pretibial swelling



## Pretibial Myxedema in Graves disease

