

How to do an Osteopathic Examination of the Hospitalized Patient

In hospital patients you will need to adapt your examination approach to whatever positional or motion limitations are imposed on the patient by his/her condition or treatment protocol. In cases where the patient cannot stand, or cannot sit, obviously you will have to limit your inspection/testing to that which is possible. I suggest that you do your osteopathic structural exam per region as you do your physical exam (integrated with the PE), you can do a separate MSK exam, but it is not time efficient.

To assess a patient in the supine position for motion restriction and tissue texture abnormalities along the spine:

Place your hands palm up with fingertips lateral to the spinous processes, under the transverse processes, and flex your DIP joints, pushing anteriorly to induce rotational motion testing at several joints simultaneously in the thoracic and lumbar spine. The soft tissues can easily be assessed simultaneously in this manner for texture and tension abnormalities as well. Consider viscerosomatic reflex activity as you palpate the soft tissues at the various segments. You can conclude where there is somatic dysfunction quite efficiently by comparing the resistance you feel in your fingers at different segmental levels.

Motion asymmetry may be noted both passively and actively. Usually, you will place more reliance on passive testing, because you are palpating the body's response to a motion demand that you are inducing in a controlled manner. A couple of exceptions are the assessment of the costal cage, in which you ask the patient to inhale and exhale while you monitor for asymmetric "pump, bucket, and caliper type motion," and the extremities.

How to Document your Findings for an H&P

The osteopathic structural exam (AKA MSK exam) is reported in the medical record as a narrative. You will note your findings of tissue texture abnormalities, asymmetries of structure, restriction of motion and tenderness (TART). You should include specific segmental dysfunction in your note when there is one.

Example of a note with NO positive findings:

Osteopathic Structural Exam: The patient was examined in the sitting and supine positions. There were no tissue texture abnormalities, asymmetries of structure, restrictions of motion or areas of tenderness in the cranial, cervical, thoracic, lumbar, pelvic regions or in the upper or lower extremities.

Example of POSITIVE findings (patient admitted for COPD exacerbation, shortness of breath and upper GI bleed):

Osteopathic Structural Exam: The patient was examined in the supine position only, as he could not sit or stand due to severe shortness of breath and orthostatic hypotension. Significant positive findings are as follows: The craniocervical junction has restriction of motion at the right OA, which resists translation to the left, worse in flexion (EslRr). The cervicothoracic junction has a tight band of paraspinal soft tissue and restriction of motion in a group at T1-3, FRISr, with depressed left supraclavicular fossa and elevated first right rib, held in inhalation. There is a firm, fibrotic, resistant soft tissue tone in the paraspinal area at T5-T7 on the left, which is tender to palpation. The thoracolumbar junction has paraspinal muscle spasm on the left and T11-L2 resists rotation left. The diaphragm is held in inhalation on the left. The lumbosacral junction has resistance to motion in extension, left rotation and left sidebending at L5 (FRrSr). There is crepitus and decreased range of motion at the right shoulder, wrist, knee and ankle in all directions of motion.

How to Make a Diagnosis of Somatic Dysfunction

Structural asymmetry or tenderness alone does **not** support the diagnosis of somatic dysfunction. In fact, just one of the TART components alone does not signify somatic dysfunction. Positive findings of motion restriction coupled with one other component (tissue texture changes, Asymmetry of Structure, or Tenderness) supports a diagnosis of somatic dysfunction. So, when doing the regional exam for TART changes, remember that motion restriction is more important than static asymmetry. Your palpatory exam will be the primary modality used in order to evaluate sympathetic nervous system activity (visero-somatic reflexes) in the tissues of the paraspinal and rib angle areas associated with a cervical, thoracic or lumbar segment (i.e., bogginess, dryness, resilience, firmness).

How to Chart the Diagnosis of Somatic Dysfunction

You must specify the body region(s) (i.e., cranial, cervical, thoracic, lumbar, sacral, pelvic, costal cage, upper or lower extremity) of somatic dysfunction in the assessment section of the H&P.

EXAMPLE: A patient entering the hospital with cholecystitis and cholelithiasis will likely have a viscerosomatic reflex inducing somatic dysfunction in the thoracic region, usually b/w T6-9. Your osteopathic MSK screening exam should reveal that information to you. Your diagnosis, entered in the chart might be:

1. Acute cholecystitis with cholelithiasis
2. Thoracic somatic dysfunction secondary to #1.

Designing a Management Plan

A management plan needs to be constructed for all positive findings in your exam, especially those that are active or current. An active problem is differentiated from an inactive problem by its effect on the patient's current health problems. The management plan for somatic dysfunction is Osteopathic Manipulative Treatment.

1. Types of treatment (ME, S/CS, MFR, FPR)
2. Dose (Daily, BID, TID)
3. Duration of treatment (until dysfunction resolves, until d/c, for 2 days then reassess, as an outpatient)
4. **Obtain and document informed consent for treatment (Patient/Guardian/Person with power of attorney, has been explained the risks and benefits of OMT and has consented to treatment)**
5. Review your treatment plan with your intern or fellow before initiating treatment.