

Integrated Clinical Masterbook

Complete 311 Conditions Guide
with NICE & BNF Treatment Protocols


Acne Vulgaris

History (Symptoms)	Onset of spots (face, chest, back), age of onset, current skincare, psychological impact.
Examination (Signs)	Non-inflammatory (comedones) & inflammatory lesions (papules, pustules, cysts). Scarring.
Bedside / GP	Clinical diagnosis.
Investigations	None routinely. Hormone profile if hyperandrogenism (PCOS) suspected.
Management (NICE/BNF)	Mild: Topical adapalene/benzoyl peroxide. Mod/Severe: Oral antibiotics (Lymecycline). Severe: Isotretinoin.

BNF/BNFC Dosage Guide:

- Adapalene 0.1% / Benzoyl peroxide 2.5% OD
- Lymecycline 408mg OD (Avoid in pregnancy/children <12)

 **Red Flags: Acne fulminans (systemic upset, fever), Endocrinopathy (virilisation).**


 *Patient Explanation: "Blocked oil glands causing inflammation. Takes 8-12 weeks for treatments to clear pores."*


Acute Bronchitis

History (Symptoms)	Cough <3 weeks (clear/green sputum), mild SOB, wheeze, viral malaise.
Examination (Signs)	Wheeze or coarse crackles clearing with cough. NO focal dullness/bronchial breathing.
Bedside / GP	Vital signs (CRB-65) to rule out pneumonia/sepsis.
Investigations	None usually. Point-of-Care CRP if pneumonia suspected.
Management (NICE/BNF)	Self-care (fluids, honey). No routine antibiotics. Amoxicillin only if systemically unwell/high-risk.

BNF/BNFC Dosage Guide:

- Amoxicillin 500mg TDS (Adult) | 250mg TDS (Child 1-5y) PO

 **Red Flags: Pneumonia (focal signs), PE (pleuritic pain/haemoptysis), Lung cancer (cough >3 wks).**

 **Patient Explanation: "Viral inflammation of main airways. Antibiotics won't help. Clears in 3-4 weeks."**


Acute Coronary Syndromes (ACS)

History (Symptoms)	Crushing central chest pain >15 mins at rest. Radiation to left arm/jaw. Nausea, sweating.
Examination (Signs)	Pale, clammy. Abnormal heart rate/BP. Possible heart failure signs (crackles).
Bedside / GP	Immediate 12-lead ECG (ST elevation/depression, T-wave inversion).
Investigations	Serial high-sensitivity Troponin, CXR, U&Es, Lipids.
Management (NICE/BNF)	Call 999. Aspirin 300mg, GTN, Morphine. Hospital: PCI (STEMI) or medical/angiography (NSTEMI).

BNF/BNFC Dosage Guide:

- Aspirin 300mg STAT (Emergency) or 75mg OD (Maintenance)
- Morphine 5-10mg IV titrated (Emergency pain)
- GTN 400mcg (1-2 sprays) Sublingual PRN

 **Red Flags: Aortic dissection (tearing pain to back, unequal pulses), Massive PE.**

 *Patient Explanation: "A blocked heart blood vessel causing muscle damage. Emergency hospital treatment needed."*

Acute Kidney Injury (AKI)

History (Symptoms)	Oliguria, dark urine, thirst, nausea. Recent sepsis, D&V, or new meds (NSAIDs, ACEi).
Examination (Signs)	Dehydration (dry mucosa) OR Fluid overload (oedema). Palpable bladder.
Bedside / GP	Fluid balance. Urine dipstick (blood/protein). Bladder scan.
Investigations	U&Es (rise in creatinine). Renal ultrasound if obstruction suspected.
Management (NICE/BNF)	IV/oral fluids. Stop nephrotoxic drugs (NSAIDs, ACEi, diuretics). Treat cause (e.g., infection).


 **Red Flags: Urinary obstruction, rapidly progressive glomerulonephritis, hyperkalaemia.**

 *Patient Explanation: "Kidneys temporarily struggling to filter blood due to dehydration or meds. Needs fluids and medication review."*

Asthma


History (Symptoms)	Episodic wheeze, chest tightness, cough (worse at night). Triggers: cold, exercise, allergens.
Examination (Signs)	Polyphonic widespread expiratory wheeze. Severe: tachypnoea, silent chest.
Bedside / GP	Peak Expiratory Flow Rate (PEFR). SpO2.
Investigations	Spirometry (obstructive, reversible). FeNO test.
Management (NICE/BNF)	SABA (Salbutamol) PRN + ICS (Preventer). Step up: LABA/LTRA. Acute: O2, Nebulisers, Prednisolone. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Salbutamol 5mg NEB or 100-200mcg Inhaler PRN• Prednisolone 40mg OD PO (Adult Acute Asthma) 1-2mg/kg PO (Child)


 **Red Flags: Life-threatening: Silent chest, cyanosis, exhaustion, SpO2 < 92%.**

 *Patient Explanation: "Sensitive airways that narrow. Preventer inhalers stop inflammation; relievers open airways during attacks."*

Atrial Fibrillation (AF)


History (Symptoms)	Palpitations, SOB, syncope, fatigue. Often asymptomatic.
Examination (Signs)	Irregularly irregular pulse. Variable volume.
Bedside / GP	12-lead ECG (absent P waves, irregular QRS). BP check.
Investigations	Echocardiogram. Bloods (TFTs, U&Es, Coagulation).
Management (NICE/BNF)	Rate control (Beta-blocker/Diltiazem). Anticoagulation (DOAC) based on CHA2DS2-VASc score.

 **Red Flags: Haemodynamic instability (shock), acute heart failure, acute stroke signs.**

 *Patient Explanation: "Irregular heart rhythm. We use meds to slow the rate and blood thinners to prevent strokes."*

Cellulitis


History (Symptoms)	Acute red, hot, swollen skin (often lower leg). Fever, chills. History of minor trauma/bite.
Examination (Signs)	Unilateral erythema, oedema, warmth. Poorly defined borders. Lymphadenopathy.
Bedside / GP	NEWS2 for sepsis. Outline erythema with marker pen.
Investigations	Clinical diagnosis. Wound swab if exudate. Bloods if unwell.
Management (NICE/BNF)	Oral Flucloxacillin. Elevate leg. IV antibiotics if severe/systemic. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Flucloxacillin 500mg QDS PO (Skin infections)


 **Red Flags: Necrotizing fasciitis (pain out of proportion, purple skin), Sepsis.**

 *Patient Explanation: "Deep skin bacterial infection. Requires antibiotics and leg elevation to reduce swelling."*

Chronic Obstructive Pulmonary Disease (COPD)

History (Symptoms)	Progressive exertional SOB, chronic cough, regular sputum. Age >35, smoking history.
Examination (Signs)	Barrel chest, pursed-lip breathing, prolonged expiration, wheeze, cyanosis.
Bedside / GP	SpO2 (chronically 88-92%). BMI.
Investigations	Spirometry (FEV1/FVC < 0.70 post-bronchodilator). CXR.
Management (NICE/BNF)	Stop smoking. Vaccines. Inhalers (SABA/SAMA -> LAMA/LABA -> ICS). Pulmonary rehab.


 **Red Flags: Haemoptysis, weight loss (Lung cancer). Cor pulmonale (right heart failure).**

 *Patient Explanation: "Lung damage from smoking trapping air. Inhalers help open airways but cannot reverse damage."*

Deep Vein Thrombosis (DVT)

History (Symptoms)	Unilateral calf swelling, pain, warmth. Risks: surgery, immobility, cancer, COCP.
Examination (Signs)	Unilateral calf swelling (>3cm difference), pitting oedema, tenderness.
Bedside / GP	Two-Level Wells Score.
Investigations	Wells likely: proximal ultrasound. Wells unlikely: D-dimer (if +ve -> US).
Management (NICE/BNF)	DOAC (Apixaban/Rivaroxaban) for 3-6 months. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Apixaban 5mg BD PO (Stroke prevention in AF)


 **Red Flags: Pulmonary embolism (SOB, pleuritic chest pain, haemoptysis).**

 *Patient Explanation: "Blood clot in deep leg vein. Blood thinners stop it growing and moving to the lungs."*

Type 2 Diabetes Mellitus

History (Symptoms)	Polyuria, polydipsia, weight loss, fatigue, recurrent thrush/infections.
Examination (Signs)	Assess BMI, BP. Diabetic foot check (neuropathy/pulses).
Bedside / GP	Capillary blood glucose, Urine dipstick (glucose).
Investigations	HbA1c (≥ 48 mmol/mol). Fasting glucose ≥ 7.0 . U&Es, Lipids.
Management (NICE/BNF)	Lifestyle. 1st: Metformin. 2nd: SGLT2i, DPP4i, Sulfonylureas. Manage BP/Lipids. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Metformin 500mg OD, titrate to 1g BD PO

 **Red Flags: HHS (severe dehydration, altered consciousness), DKA (vomiting, ketones).**

 *Patient Explanation: "Body cannot properly use insulin, causing high blood sugar. Managed with diet and tablets."*

Acoustic Neuroma

History (Symptoms)	Gradual unilateral hearing loss, tinnitus, vertigo/unsteadiness. Rare: facial numbness.
Examination (Signs)	Sensorineural hearing loss. Trigeminal/Facial nerve palsies in large tumours.
Bedside / GP	Cranial nerve examination, Otoscopy (usually normal).
Investigations	Pure tone audiometry. MRI Head is gold standard.
Management (NICE/BNF)	Conservative (watch & wait), Stereotactic radiosurgery, or Surgical removal.


 **Red Flags: Signs of raised intracranial pressure (severe headache, morning vomiting).**

 *Patient Explanation: "A slow-growing, non-cancerous nerve tumour affecting hearing and balance."*

Acute Cholangitis

History (Symptoms)	RUQ pain, high fever/rigors, and jaundice (Charcot's Triad). Dark urine.
Examination (Signs)	Fever, scleral icterus, RUQ tenderness. Confusion/hypotension if severe.
Bedside / GP	Vital signs (sepsis check). Urine dipstick.
Investigations	LFTs (obstructive), FBC, CRP. Ultrasound abdomen. ERCP.
Management (NICE/BNF)	Emergency: IV fluids, broad-spectrum IV antibiotics, urgent biliary drainage (ERCP).


 **Red Flags: Septic shock (hypotension, tachycardia, altered mental state).**

 *Patient Explanation: "Serious bile duct infection, usually from a trapped gallstone. Urgent hospital treatment."*

Acute Angle-Closure Glaucoma

History (Symptoms)	Sudden onset severe deep eye pain. Decreased vision, seeing 'halos' around lights. Nausea.
Examination (Signs)	Acutely red eye. Hazy cornea. Fixed, semi-dilated pupil. Eye feels hard.
Bedside / GP	Visual acuity testing (reduced). Urgent ophthalmic assessment.
Investigations	Tonometry (IOP >30 mmHg). Slit-lamp examination.
Management (NICE/BNF)	Same-day emergency. Eye drops (Pilocarpine), IV Acetazolamide. Laser iridotomy.


 **Red Flags: Delay in treatment leads to rapid, irreversible vision loss.**

 **Patient Explanation:** "Dangerous fluid pressure buildup in the eye. Emergency treatment needed to save vision."

Acute Pancreatitis

History (Symptoms)	Sudden severe epigastric pain radiating to the back. Vomiting. Gallstones/ alcohol history.
Examination (Signs)	Epigastric tenderness. Tachycardia. Rare: Bruising around umbilicus.
Bedside / GP	Vital signs (assess for shock).
Investigations	Serum Amylase/Lipase (>3x normal). Ultrasound (gallstones). CT Abdomen.
Management (NICE/BNF)	Hospital admission. Nil by mouth, IV fluids, strong analgesia.


 **Red Flags: Hypovolaemic shock, ARDS (severe shortness of breath).**

 **Patient Explanation:** "Severe pancreas inflammation. Needs hospital admission for fluids and pain relief."

Addison's Disease

History (Symptoms)	Chronic fatigue, weakness, weight loss, salt craving, dizziness on standing.
Examination (Signs)	Postural hypotension. Hyperpigmentation (palmar creases, buccal mucosa).
Bedside / GP	Lying and standing blood pressure.
Investigations	U&Es (hyponatraemia, hyperkalaemia). 9am Serum Cortisol (low). Short Synacthen test.
Management (NICE/BNF)	Lifelong Hydrocortisone & Fludrocortisone. 'Sick day rules' (double steroid dose). BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Hydrocortisone 100mg IV QDS (Severe Asthma/Emergency)

 **Red Flags: Addisonian Crisis (sudden severe weakness, vomiting, shock). Emergency!**

 *Patient Explanation: "Adrenal glands stop making stress hormones. Treatable with lifelong daily hormone tablets."*

Anaemia (Iron Deficiency)


History (Symptoms)	Lethargy, SOB on exertion, palpitations. Hx of heavy periods or GI bleeding.
Examination (Signs)	Conjunctival pallor, tachycardia. Koilonychia (spoon-shaped nails).
Bedside / GP	Urine dipstick (haematuria check). Rectal exam (if GI bleed suspected).
Investigations	FBC (microcytic, hypochromic). Low Ferritin. Endoscopy/Colonoscopy.
Management (NICE/BNF)	Oral iron replacement (Ferrous Sulfate) for 3 months. Find and treat cause.

 **Red Flags: Unexplained weight loss, change in bowel habit, melaena (GI tract cancer).**

 *Patient Explanation: "Lack of iron means poor red blood cell production. We treat with iron and find the cause."*

Anaphylaxis

History (Symptoms)	Sudden symptoms after allergen exposure. Itching, difficulty breathing, feeling faint.
Examination (Signs)	Stridor, wheeze, urticaria, angioedema. Hypotension, tachycardia.
Bedside / GP	ABCDE assessment. Monitor SpO ₂ , BP, HR.
Investigations	Mast cell tryptase blood test. Later: Allergy testing.
Management (NICE/BNF)	Emergency: IM Adrenaline (1:1000). High-flow oxygen, IV fluids, Antihistamines. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Adrenaline 1:1000 0.5mg (0.5mL) IM (Adult Anaphylaxis) 0.15-0.3mg IM (Child)


 **Red Flags: Airway compromise (stridor), severe hypotension. Biphasic reaction.**

 *Patient Explanation: "Severe allergic reaction affecting breathing and blood pressure. Requires immediate adrenaline."*

Anal Fissure


History (Symptoms)	Intense 'tearing' pain during defecation, lasting hours. Bright red blood on toilet paper.
Examination (Signs)	Visible linear tear in anal canal skin. Spasm of the anal sphincter.
Bedside / GP	Visual inspection of the anus.
Investigations	None required unless underlying Crohn's or malignancy suspected.
Management (NICE/BNF)	High fibre diet, laxatives. Topical GTN or Diltiazem cream to relax sphincter. BNF/BNFC Dosage Guide: • GTN 400mcg (1-2 sprays) Sublingual PRN


 **Red Flags: Multiple fissures, chronic diarrhoea (think Crohn's disease or anal cancer).**

 *Patient Explanation: "Small tear in the back passage skin. Painful but treatable with creams to relax the muscle."*

Anorexia Nervosa


History (Symptoms)	Significant weight loss, intense fear of weight gain, distorted body image, amenorrhoea.
Examination (Signs)	Low BMI (<18.5), bradycardia, hypotension, hypothermia, lanugo hair, muscle wasting.
Bedside / GP	ECG (prolonged QTc, bradycardia), strict weight and BMI monitoring.
Investigations	Bloods: U&Es (hypokalaemia if purging), FBC, TFTs, LFTs.
Management (NICE/BNF)	Referral to specialist eating disorder services. CBT-ED, MANTRA. Careful nutritional rehabilitation.


 **Red Flags: BMI <13, HR <40, high risk of refeeding syndrome (requires inpatient medical admission).**

 *Patient Explanation: "A serious mental health condition where a person keeps their body weight as low as possible through restricting food."*

Appendicitis


History (Symptoms)	Periumbilical abdominal pain migrating to the right iliac fossa (RIF). Anorexia, nausea, low-grade fever.
Examination (Signs)	RIF tenderness (McBurney's point), guarding, rebound tenderness. Rovsing's sign positive.
Bedside / GP	Urine dipstick (rule out UTI/pregnancy), Vital signs.
Investigations	Bloods: FBC (neutrophilia), CRP. Ultrasound or CT Abdomen if diagnosis is unclear.
Management (NICE/BNF)	NBM (nil by mouth), IV fluids, IV antibiotics. Surgical appendicectomy.


 **Red Flags: Rigid board-like abdomen, severe generalized pain (suggests appendix rupture and peritonitis).**

 *Patient Explanation: "Inflammation of a small pouch attached to the large intestine. It causes severe tummy pain and usually needs surgical removal."*

Bipolar Disorder


History (Symptoms)	Episodes of mania (elevated mood, decreased need for sleep, grandiosity) alternating with severe depression.
Examination (Signs)	During mania: pressured speech, flight of ideas, extreme distractibility, poor insight.
Bedside / GP	Psychiatric risk assessment (risk to self and others).
Investigations	Bloods to rule out organic causes of mania (TFTs, calcium). Urine drug screen.
Management (NICE/BNF)	Mood stabilizers (Lithium, Valproate), atypical antipsychotics for acute mania. Psychological therapies.


 **Red Flags: Active suicidal ideation, psychotic symptoms (delusions/hallucinations), reckless behavior risking harm.**

 *Patient Explanation: "A mental health condition that affects moods, causing extreme highs (mania) and profound lows (depression)."*

Breast Cancer


History (Symptoms)	Painless breast lump, changes in breast shape, nipple discharge (blood-stained), nipple retraction.
Examination (Signs)	Hard, irregular, fixed palpable mass. Skin dimpling (peau d'orange). Axillary lymphadenopathy.
Bedside / GP	Clinical breast examination.
Investigations	Triple Assessment: 1. Clinical Exam 2. Imaging (Mammogram/Ultrasound) 3. Pathology (Core biopsy).
Management (NICE/BNF)	Surgery (lumpectomy or mastectomy). Adjuvant treatments: Radiotherapy, Chemotherapy, Endocrine therapy (Tamoxifen).


 **Red Flags: Rapidly growing lump, inflammatory breast cancer (red, hot, swollen breast without infection).**

 *Patient Explanation: "Cancer that starts in the breast tissue. We use a combination of scans, biopsies, and surgery to treat it."*

Bronchiectasis


History (Symptoms)	Chronic daily cough with large amounts of thick, purulent sputum. Recurrent chest infections. Occasional haemoptysis.
Examination (Signs)	Coarse inspiratory crackles (often bibasal). Finger clubbing in severe/chronic cases.
Bedside / GP	Sputum culture and sensitivities (often colonised with Pseudomonas or Haemophilus).
Investigations	High-Resolution CT (HRCT) of the chest shows widened airways ('signet ring' sign).
Management (NICE/BNF)	Daily chest physiotherapy (airway clearance). Prompt antibiotics for exacerbations. Bronchodilators.


 **Red Flags: Massive haemoptysis (coughing up large amounts of blood) requires emergency embolization.**

 **Patient Explanation:** "Long-term lung condition where the airways are abnormally widened, leading to a build-up of excess mucus and frequent infections."

Chronic Kidney Disease (CKD)


History (Symptoms)	Often asymptomatic until advanced. Fatigue, oedema (swollen ankles), nausea, pruritus (itchy skin), nocturia.
Examination (Signs)	Hypertension, fluid overload (oedema, raised JVP), pallor (due to anaemia of chronic disease).
Bedside / GP	Blood pressure monitoring, Urine dipstick (looking for proteinuria/haematuria).
Investigations	eGFR <60 ml/min for >3 months. Urine ACR (Albumin:Creatinine Ratio). Renal ultrasound.
Management (NICE/BNF)	Strict BP control (ACE inhibitors or ARBs), Statins for CV risk. Manage complications (Iron/EPO for anaemia).


 **Red Flags: Rapidly declining eGFR, severe hyperkalaemia, symptoms of uraemia (encephalopathy, pericarditis).**

 *Patient Explanation: "A long-term condition where the kidneys don't work as well as they should. We manage it by controlling blood pressure to prevent further damage."*

Coeliac Disease


History (Symptoms)	Chronic diarrhoea, bloating, abdominal pain, unexplained weight loss, extreme fatigue. In children: faltering growth.
Examination (Signs)	Often normal. May have pallor (anaemia), mouth ulcers, or a blistering itchy skin rash (dermatitis herpetiformis).
Bedside / GP	Weight and BMI assessment.
Investigations	Blood: IgA tTG antibodies (patient MUST be eating a gluten-containing diet). Gold standard: Duodenal biopsy via endoscopy showing villous atrophy.
Management (NICE/BNF)	Strict, lifelong gluten-free diet. Dietician referral. Monitor for osteoporosis (DEXA scan).


 **Red Flags: Unexplained significant weight loss with iron deficiency anaemia (requires urgent cancer pathway referral).**

 *Patient Explanation: "An autoimmune condition where your immune system reacts to gluten (a protein found in wheat), damaging the lining of your gut."*

Colorectal Cancer


History (Symptoms)	Persistent change in bowel habit (looser stools/increased frequency), rectal bleeding, tenesmus (feeling of incomplete emptying), weight loss.
Examination (Signs)	Palpable abdominal mass or palpable rectal mass on DRE. Signs of anaemia (pallor).
Bedside / GP	Digital Rectal Examination (DRE), FIT (Faecal Immunochemical Test) for occult blood.
Investigations	Urgent colonoscopy with biopsy. CT Chest/Abdomen/Pelvis for staging.
Management (NICE/BNF)	Surgical resection. Adjuvant chemotherapy depending on staging. Palliative care if advanced.


 **Red Flags: Large bowel obstruction (abdominal distension, absolute constipation, vomiting), bowel perforation.**

 *Patient Explanation: "Cancer of the large bowel or rectum. We use a camera test (colonoscopy) to find it and usually treat it with surgery."*

Congestive Heart Failure

History (Symptoms)	Breathlessness on exertion, orthopnoea (breathless lying flat), paroxysmal nocturnal dyspnoea (waking up gasping), ankle swelling, fatigue.
Examination (Signs)	Raised JVP, displaced apex beat, bibasal fine crackles, pitting peripheral oedema.
Bedside / GP	12-lead ECG, Daily weight monitoring, Urine output.
Investigations	Bloods: NT-proBNP (elevated). Echocardiogram confirms diagnosis and assesses Ejection Fraction.
Management (NICE/BNF)	Symptomatic: Loop diuretics (Furosemide). Prognostic: ACE inhibitors, Beta-blockers, Spironolactone, SGLT2 inhibitors. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Furosemide 40mg OD PO (Titrate to symptoms)


 **Red Flags: Acute pulmonary oedema (severe sudden breathlessness, pink frothy sputum) is a medical emergency.**

 *Patient Explanation: "The heart has become too weak or stiff to pump blood around the body efficiently, leading to fluid building up in the lungs and legs."*

Crohn's Disease


History (Symptoms)	Chronic diarrhoea (often non-bloody), right lower quadrant abdominal pain, weight loss, extreme fatigue, recurrent mouth ulcers.
Examination (Signs)	Abdominal tenderness, perianal skin tags or fistulas, clubbing. Extra-intestinal: uveitis, erythema nodosum.
Bedside / GP	Stool sample for Faecal Calprotectin (raised indicates bowel inflammation).
Investigations	Colonoscopy with biopsies (shows 'skip lesions' and cobblestone appearance affecting any part of the GI tract from mouth to anus).
Management (NICE/BNF)	Induce remission: Oral/IV Corticosteroids. Maintenance: Immunosuppressants (Azathioprine) or Biologics (Infliximab).


 **Red Flags: Toxic megacolon, bowel obstruction, severe malnutrition.**

 *Patient Explanation: "A lifelong condition that causes patches of inflammation anywhere along the digestive system. We use strong medications to calm the immune system down."*

Dementia (Alzheimer's)


History (Symptoms)	Gradual, progressive short-term memory loss, difficulty finding words, getting lost in familiar places, changes in mood/personality.
Examination (Signs)	Usually physically normal in early stages. Positive findings on cognitive assessments (e.g., 10-CS, ACE-III, MoCA).
Bedside / GP	Formal cognitive assessment. Collateral history from family/carers is crucial.
Investigations	Dementia screen bloods (B12, Folate, TFTs, Syphilis) to rule out reversible causes. CT/MRI Head shows medial temporal lobe atrophy.
Management (NICE/BNF)	Acetylcholinesterase inhibitors (Donepezil, Rivastigmine). Advance care planning, social care support.


 **Red Flags: Sudden/rapid onset of confusion and hallucinations (this strongly points to Delirium due to infection/illness, not Dementia).**

 *Patient Explanation: "A progressive physical disease of the brain that causes memory loss and confusion. Medications can temporarily help symptoms but cannot cure the disease."*

Dehydration

History (Symptoms)	Thirst, dry mouth, dark urine, lethargy, dizziness, confusion. Hx of D&V, poor intake.
Examination (Signs)	Dry mucous membranes, reduced skin turgor, sunken eyes, tachycardia, hypotension, prolonged capillary refill.
Bedside / GP	Vital signs (HR, BP). Urine dipstick (high specific gravity, ketones).
Investigations	U&Es (Hypernatraemia or hyponatraemia, elevated urea/creatinine indicating AKI).
Management (NICE/BNF)	Oral rehydration salts. If severe/unable to tolerate oral: IV fluids (0.9% Saline).


 **Red Flags: Hypovolaemic shock (severe hypotension, altered mental status, anuria).**

 *Patient Explanation: "Your body has lost more fluid than you've taken in. We need to replace the water and salts, either by drinking or through a drip."*

Delirium

History (Symptoms)	Acute, fluctuating change in cognition, inattention, altered consciousness, hallucinations, agitation or extreme lethargy.
Examination (Signs)	Disorientation, fluctuating GCS, hyperactive (agitated) or hypoactive (sleepy). Search for underlying cause (infection, retention).
Bedside / GP	4AT Score (Alertness, AMT4, Attention, Acute change). Urine dipstick, vital signs, bladder scan.
Investigations	Bloods (FBC, U&Es, CRP, Calcium, TFTs, LFTs) to find cause. CXR, blood cultures if infection suspected.
Management (NICE/BNF)	Treat underlying cause (PINCH ME: Pain, Infection, Nutrition, Constipation, Hydration, Meds, Environment). Reorientation, avoid sedatives if possible.

 **Red Flags: Sudden headache or focal neurological signs (rule out stroke/intracranial bleed).**

 *Patient Explanation: "An acute state of confusion often caused by a physical illness like an infection or dehydration. It usually improves when the physical illness is treated."*

Diabetes in Pregnancy (Gestational)

History (Symptoms)	Often asymptomatic. Macrosomic baby on previous scans, polyhydramnios, family hx of diabetes, high BMI.
Examination (Signs)	Symphysis fundal height larger than expected for gestational age.
Bedside / GP	Urine dipstick (glycosuria). Capillary blood glucose.
Investigations	Oral Glucose Tolerance Test (OGTT) at 24-28 weeks (Fasting >5.6, or 2-hour >7.8 mmol/L).
Management (NICE/BNF)	Diet and lifestyle. If targets not met: Metformin. If still high or severe macrosomia: Insulin. BNF/BNFC Dosage Guide: • Metformin 500mg OD, titrate to 1g BD PO




Red Flags: Hypoglycaemia (if on insulin), pre-eclampsia (often co-exists with GDM).




Patient Explanation: "High blood sugar that develops during pregnancy because your body can't produce enough extra insulin. Treated with diet and sometimes medication to protect the baby."

Diabetes Insipidus


History (Symptoms)	Extreme polyuria (large volumes of pale urine), intense polydipsia (craving ice water), nocturia.
Examination (Signs)	Signs of dehydration if water access is restricted. Usually normal examination.
Bedside / GP	Fluid balance chart, Urine dipstick (very pale, low specific gravity).
Investigations	Serum osmolality (high) and urine osmolality (inappropriately low). Water deprivation test.
Management (NICE/BNF)	Cranial DI: Desmopressin (synthetic ADH). Nephrogenic DI: Treat underlying cause, Thiazide diuretics, low salt diet.


 **Red Flags: Severe hypernatraemia leading to seizures, coma, or death if unable to drink water.**

 *Patient Explanation: "A condition where the kidneys can't retain water, causing you to pee large amounts and feel extremely thirsty. It's an issue with a brain hormone, not sugar."*

Diabetic Ketoacidosis (DKA)


History (Symptoms)	Polyuria, polydipsia, weight loss, nausea, vomiting, severe abdominal pain, breathlessness, confusion. Usually Type 1 Diabetes.
Examination (Signs)	Kussmaul breathing (deep, sighing respirations), 'pear drop' (ketone) breath smell, tachycardia, dehydration, altered GCS.
Bedside / GP	Capillary blood glucose (>11 mmol/L or known DM), Capillary/Urine ketones (High >3.0).
Investigations	Venous blood gas (VBG) shows metabolic acidosis (pH < 7.3, Bicarbonate < 15). U&Es (monitor potassium).
Management (NICE/BNF)	Medical Emergency (FIG-PICK): Fluids (IV 0.9% Saline), Insulin (Fixed Rate IV Infusion), Glucose (add when BM <14), Potassium replacement. Treat infection.


 **Red Flags: Cerebral oedema (headache, falling GCS, bradycardia), severe hypokalaemia causing arrhythmias.**

 *Patient Explanation: "A dangerous complication of diabetes where lack of insulin causes the body to break down fat, producing acidic ketones. Requires urgent hospital drip treatment."*

Diabetic Nephropathy


History (Symptoms)	Often asymptomatic until late stages (CKD). Foamy urine, ankle swelling, fatigue, known long-standing diabetes.
Examination (Signs)	Hypertension, peripheral oedema, signs of other diabetic complications (retinopathy, neuropathy).
Bedside / GP	Blood pressure check, Urine dipstick (proteinuria).
Investigations	Urine Albumin:Creatinine Ratio (ACR > 3mg/mmol). eGFR and U&Es.
Management (NICE/BNF)	Strict blood glucose and blood pressure control. ACE inhibitor or ARB (first line for renoprotection). SGLT-2 inhibitors.


 **Red Flags: Rapid decline in eGFR or sudden heavy proteinuria (consider other forms of glomerulonephritis).**

 *Patient Explanation: "Long-term high blood sugar has damaged the small filters in your kidneys, causing protein to leak into your urine. Blood pressure medication protects them."*

Diabetic Neuropathy

History (Symptoms)	Numbness, tingling, or burning pain in the feet/hands (glove and stocking distribution), worse at night. Erectile dysfunction, gastroparesis.
Examination (Signs)	Reduced sensation to 10g monofilament. Loss of vibration sense (tuning fork) and proprioception. Absent ankle reflexes. Foot ulcers.
Bedside / GP	Diabetic foot check.
Investigations	Clinical diagnosis. HbA1c to check diabetes control. Nerve conduction studies if atypical.
Management (NICE/BNF)	Optimize blood glucose. Neuropathic pain relief: Duloxetine, Amitriptyline, Pregabalin, or Gabapentin. Podiatry referral for ulcers.

 **Red Flags: Charcot foot (red, hot, swollen, deformed painless foot), painless infected foot ulcer leading to sepsis/amputation.**

 *Patient Explanation: "High blood sugar has damaged the nerves in your extremities, causing numbness or pain. Good sugar control and special painkillers can help, plus daily foot checks."*

Diverticular Disease

History (Symptoms) Diverticulosis: asymptomatic. Diverticular disease: intermittent lower left-sided abdominal pain, bloating, constipation/diarrhoea. Diverticulitis: constant severe LIF pain, fever.

Examination (Signs) Left Iliac Fossa (LIF) tenderness. Guarding/rigidity if perforated.

Bedside / GP Vital signs (fever, tachycardia in diverticulitis). Urine dipstick to rule out UTI.


Investigations Bloods (raised CRP/WBC in diverticulitis). CT Abdomen (diagnostic for diverticulitis). Colonoscopy (later, to rule out cancer).

Management (NICE/BNF) Disease: High fibre diet. Uncomplicated Diverticulitis: Oral Co-amoxiclav, liquid diet. Complicated/Severe: IV antibiotics, surgery (Hartmann's).

BNF/BNFC Dosage Guide:


- Co-amoxiclav 625mg TDS PO or 1.2g IV TDS


 **Red Flags: Perforation (rigid abdomen, peritonitis), large lower GI bleed, abscess formation.**

 *Patient Explanation: "Small pouches form in the wall of your large bowel. If they get inflamed or infected (diverticulitis), it causes severe pain and needs antibiotics or a special diet."*

Down's Syndrome (Trisomy 21)


History (Symptoms)	Prenatal screening. Delayed motor and speech milestones, learning disability. Frequent respiratory or ear infections.
Examination (Signs)	Upward slanting palpebral fissures, epicanthic folds, single palmar crease, hypotonia, flat facial profile, large protruding tongue.
Bedside / GP	Assess developmental milestones, hearing, and vision.
Investigations	Prenatal: Combined test, NIPT, Amniocentesis. Postnatal: Karyotyping. Echocardiogram (high risk of congenital heart defects like AVSD).
Management (NICE/BNF)	MDT approach. Physiotherapy, SALT, special educational support. Treat complications (cardiac surgery, thyroid replacement).


 **Red Flags: Atlantoaxial instability (neck pain, weakness in limbs), early-onset Alzheimer's disease, acute leukaemia.**

 *Patient Explanation: "A genetic condition caused by an extra copy of chromosome 21, resulting in some level of learning disability and specific physical characteristics."*

Ectopic Pregnancy


History (Symptoms)	Missed period (amenorrhoea) + lower abdominal/pelvic pain + vaginal bleeding. Shoulder tip pain (if ruptured). History of PID, IVF, or previous ectopic.
Examination (Signs)	Lower abdominal tenderness, cervical motion tenderness on bimanual exam. Signs of shock (tachycardia, hypotension) if ruptured.
Bedside / GP	Urinary pregnancy test (UPT) is MUST DO for any female of childbearing age with abdo pain. Vital signs.
Investigations	Transvaginal Ultrasound (empty uterus, adnexal mass). Serum bHCG (suboptimal rise).
Management (NICE/BNF)	Expectant (if small, low HCG), Medical (Methotrexate injection), or Surgical (Laparoscopic salpingectomy).


 **Red Flags: Ruptured ectopic: severe acute abdominal pain, hypovolaemic shock, syncope. A surgical emergency.**

 *Patient Explanation: "A pregnancy that is growing outside the womb, usually in a fallopian tube. It cannot survive and can cause dangerous internal bleeding if not treated."*

Encephalitis


History (Symptoms)	Fever, headache, altered mental status, confusion, strange behaviour, seizures. History of recent viral illness, cold sores (HSV), or travel.
Examination (Signs)	Fever, altered GCS, focal neurological deficits (e.g., aphasia, weakness), psychiatric features. Less prominent meningism than meningitis.
Bedside / GP	Neurological exam, Vital signs (fever).
Investigations	Lumbar Puncture (CSF for viral PCR, particularly HSV). MRI Brain (temporal lobe swelling in HSV). EEG.
Management (NICE/BNF)	Immediate IV Acyclovir (do not wait for LP results if suspected). Supportive care (ICU if required).


 **Red Flags: Status epilepticus, raised intracranial pressure (reduced GCS, bradycardia, hypertension).**

 *Patient Explanation: "A severe viral infection causing inflammation of the brain tissue itself. It causes confusion and seizures and requires immediate hospital treatment with antiviral drips."*

Endometrial Cancer

History (Symptoms)	Post-menopausal bleeding (PMB) is the hallmark. Intermenstrual bleeding or heavy periods in younger women. Obesity, PCOS, Tamoxifen use.
Examination (Signs)	Abdominal palpation often normal. Speculum exam to view cervix/vagina. Bimanual exam (enlarged uterus).
Bedside / GP	Pregnancy test in premenopausal women.
Investigations	Transvaginal Ultrasound (TVUS) -> Endometrial thickness >4mm is abnormal. Pipelle endometrial biopsy or Hysteroscopy with biopsy.
Management (NICE/BNF)	Total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAH & BSO). +/- Radiotherapy.

 **Red Flags: Any post-menopausal bleeding must be referred on a 2-week wait suspected cancer pathway.**

 *Patient Explanation: "Cancer of the lining of the womb. The most common symptom is bleeding after the menopause. We investigate it with an ultrasound and a small biopsy."*

Endometriosis

History (Symptoms)	Cyclical pelvic pain, severe dysmenorrhoea (painful periods), dyspareunia (painful sex), dyschezia (painful bowel movements), subfertility.
Examination (Signs)	Often normal. May have fixed, retroverted uterus or tender nodularity in the posterior fornix on bimanual exam.
Bedside / GP	Urine dip/pregnancy test, STI screen/swabs to rule out PID.
Investigations	Pelvic Ultrasound (may show 'chocolate cysts' / endometriomas). Gold standard: Laparoscopy for direct visualization.
Management (NICE/BNF)	Pain relief (NSAIDs/Paracetamol). Hormonal: COCP (back-to-back), Progesterone, Mirena IUS. Surgical: Excision/ablation of lesions.

BNF/BNFC Dosage Guide:

- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)




Red Flags: Bowel/ureter obstruction in severe deep infiltrating endometriosis.




Patient Explanation: "Tissue similar to the womb lining grows outside the womb, like on the ovaries. It bleeds during your period, causing inflammation and severe pain."

Epididymitis / Epididymo-orchitis


History (Symptoms)	Unilateral scrotal pain and swelling developing over days. Fever, dysuria, urethral discharge. Age <35 (STI usually), Age >35 (UTI usually).
Examination (Signs)	Unilateral tender, swollen epididymis/testis. Erythematous, warm scrotum. Prehn's sign (elevation of testis relieves pain - though unreliable). Intact cremasteric reflex.
Bedside / GP	Urine dipstick (leukocytes/nitrites). First-catch urine for Chlamydia/ Gonorrhoea NAAT.
Investigations	Scrotal Ultrasound ONLY if testicular torsion or tumour cannot be completely ruled out clinically.
Management (NICE/BNF)	STI cause (Ceftriaxone IM + Doxycycline). Enteric/UTI cause (Ofloxacin or Ciprofloxacin for 14 days). Scrotal support, analgesia. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Ceftriaxone 2g IV BD (Adult Meningitis) 80mg/kg IV OD (Child)• Doxycycline 100mg OD/BD PO (Avoid in pregnancy/children)


 **Red Flags: Testicular Torsion (sudden onset severe pain, high-riding testis, absent cremasteric reflex) is a surgical emergency.**

 **Patient Explanation:** "An infection of the coiled tube at the back of the testicle, usually caused by a sexually transmitted infection or a urine infection. Treated with a course of antibiotics."

Epilepsy


History (Symptoms)	Recurrent unprovoked seizures. Type varies: tonic-clonic (stiffening, jerking, tongue biting, incontinence), absence (staring spells), focal (twitching/strange sensations). Aura, post-ictal confusion.
Examination (Signs)	Usually normal between episodes. Check for signs of underlying cause (e.g., neurocutaneous syndromes, focal weakness).
Bedside / GP	Collateral history is vital (video of event if possible). 12-lead ECG (to rule out cardiac syncope/Long QT).
Investigations	EEG (electroencephalogram). MRI Brain (to rule out structural lesions/tumours).
Management (NICE/BNF)	Antiepileptic drugs (AEDs) depending on seizure type: Sodium Valproate (NOT in women of childbearing age), Levetiracetam, Lamotrigine, Carbamazepine. Driving advice.


 **Red Flags: Status Epilepticus (seizure >5 mins or incomplete recovery between seizures). A medical emergency requiring PR Diazepam/IV Lorazepam.**

 **Patient Explanation:** "A condition affecting the brain's electrical signals, causing repeated seizures or 'fits'. Daily medication can help stabilize the signals and prevent them."

Epistaxis (Nosebleed)


History (Symptoms)	Bleeding from one or both nostrils. Hx of nose-picking, trauma, nasal sprays, hypertension, or anticoagulants (Warfarin/DOACs).
Examination (Signs)	Active bleeding or clots in the nasal cavity. Anterior bleed (Kiesselbach's plexus/Little's area). Posterior bleed (profuse, down back of throat).
Bedside / GP	Vital signs (HR, BP to check for hypovolaemia). Inspect nasal cavity with a speculum/headlight.
Investigations	FBC and Coagulation screen ONLY if bleeding is heavy, prolonged, or patient is on blood thinners.
Management (NICE/BNF)	First aid: Trotter's method (pinch soft fleshy part of nose for 10-15 mins, lean forward). Cautery (Silver Nitrate). Anterior nasal packing. Admit if uncontrolled.


 **Red Flags: Recurrent unilateral epistaxis with nasal obstruction/discharge (rule out nasopharyngeal cancer). Haemodynamic instability.**

 *Patient Explanation: "A nosebleed, usually from a fragile blood vessel just inside the nose. Pinching the soft part of the nose and leaning forward usually stops it."*

Essential Tremor


History (Symptoms)	Postural and action tremor (worse when holding arms out or using hands, e.g., holding a cup). Improves with alcohol. Family history common.
Examination (Signs)	Bilateral, symmetrical upper limb tremor. Absent at rest. No rigidity, bradykinesia, or gait abnormalities (unlike Parkinson's).
Bedside / GP	Ask patient to draw a spiral or pour water (demonstrates action tremor).
Investigations	Clinical diagnosis. TFTs to rule out hyperthyroidism.
Management (NICE/BNF)	Propranolol (Beta-blocker) or Primidone if symptoms are disabling.


 **Red Flags: Unilateral tremor at rest (Parkinson's), intention tremor with past-pointing (Cerebellar disease/MS).**

 *Patient Explanation: "A common nervous system condition causing your hands to shake when you try to use them. It's not Parkinson's, and medication can dampen the shaking if it bothers you."*

Fibroids (Uterine Leiomyomas)


History (Symptoms)	Often asymptomatic. Heavy menstrual bleeding (menorrhagia), pelvic pressure, urinary frequency, dyspareunia, subfertility.
Examination (Signs)	Firm, enlarged, irregularly shaped, non-tender uterus on bimanual pelvic examination.
Bedside / GP	Urine dipstick/pregnancy test. Check for signs of anaemia (pallor).
Investigations	FBC (iron deficiency anaemia). Transvaginal or Pelvic Ultrasound confirms diagnosis.
Management (NICE/BNF)	Watch & wait if asymptomatic. Medical: Mirena IUS, Tranexamic acid, COCP. Surgical: Uterine artery embolisation, myomectomy, or hysterectomy.


 **Red Flags: Rapid growth of fibroid (rule out leiomyosarcoma - very rare). Severe anaemia causing heart failure.**

 *Patient Explanation: "Non-cancerous growths of muscle in the womb. They are very common and can cause heavy periods, but only need treatment if they cause symptoms."*

Fibromyalgia


History (Symptoms)	Chronic, widespread pain lasting >3 months, extreme fatigue, unrefreshing sleep, 'brain fog' (cognitive dysfunction), headaches.
Examination (Signs)	Multiple tender points across the body. Normal joints (no swelling/erythema). Normal neurological exam.
Bedside / GP	Use diagnostic questionnaires (Widespread Pain Index).
Investigations	Diagnosis of exclusion. Normal bloods (ESR, CRP, TFTs, Rheumatoid Factor, FBC).
Management (NICE/BNF)	Explanation & validation. Graded exercise, CBT. Meds: Amitriptyline, Duloxetine, Pregabalin. (Avoid opioids!).


 **Red Flags: Joint swelling, raised inflammatory markers (ESR/CRP), weight loss (Points to inflammatory arthritis or cancer).**

 *Patient Explanation: "A chronic condition causing widespread pain and profound tiredness. Your brain's pain signals are turned up too high. Exercise and specific nerve painkillers help manage it."*

Gallstones and Biliary Colic


History (Symptoms)	Episodic severe Right Upper Quadrant (RUQ) or epigastric pain, often triggered by heavy/fatty meals. Pain may radiate to right shoulder/back. Nausea and vomiting.
Examination (Signs)	RUQ tenderness. In simple biliary colic, there is NO fever and Murphy's sign is negative. Patient is typically restless.
Bedside / GP	Vital signs (to rule out fever/cholecystitis). Urine dipstick (rule out renal colic).
Investigations	Bloods: LFTs (usually normal in simple colic), CRP/FBC. Abdominal Ultrasound (first-line, highly sensitive for gallstones).
Management (NICE/BNF)	Analgesia (NSAIDs like Diclofenac or opioids). Lifestyle advice (low-fat diet). Elective laparoscopic cholecystectomy to prevent recurrence.


 **Red Flags: Constant RUQ pain + fever + positive Murphy's sign = Acute Cholecystitis.**
Jaundice = Choledocholithiasis. Jaundice + fever + RUQ pain = Acute Cholangitis (Emergency!).

 *Patient Explanation: "Hard stones form in your gallbladder. When the gallbladder squeezes to release bile after a meal, a stone gets temporarily stuck in the duct, causing severe cramping pain."*

Gastric Cancer


History (Symptoms)	Persistent dyspepsia (indigestion), unexplained weight loss, early satiety (feeling full quickly), dysphagia, upper abdominal pain, nausea/vomiting.
Examination (Signs)	Often normal early on. Late signs: Epigastric mass, left supraclavicular lymphadenopathy (Virchow's node / Troisier's sign), signs of anaemia (pallor).
Bedside / GP	Check for clinical signs of anaemia. Abdominal palpation.
Investigations	FBC (iron deficiency anaemia). Urgent upper GI endoscopy (OGD) with biopsy (gold standard). CT chest/abdomen/pelvis for staging.
Management (NICE/BNF)	MDT approach. Surgical resection (partial or total gastrectomy) +/- neoadjuvant or adjuvant chemotherapy.


 **Red Flags: Any patient >55 with new-onset, unexplained dyspepsia requires an urgent 2-week-wait endoscopy referral.**

 *Patient Explanation: "Cancer in the stomach lining. It can mimic simple indigestion but causes weight loss and feeling full quickly. A camera test is needed to check the stomach."*

Gastro-oesophageal Reflux Disease (GORD)

History (Symptoms)	Heartburn (retrosternal burning pain), acid regurgitation, waterbrash, chronic cough (worse at night), hoarseness. Worse after large meals or lying down.
Examination (Signs)	Usually normal physical examination.
Bedside / GP	Calculate BMI (obesity is a major risk factor).
Investigations	Often a clinical diagnosis treated empirically. Endoscopy only if red flags are present or if treatment fails.
Management (NICE/BNF)	Lifestyle: weight loss, small meals, elevate head of bed, avoid triggers (coffee, alcohol). Meds: Full-dose PPI (Omeprazole/Lansoprazole) for 4-8 weeks. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Omeprazole 20-40mg OD PO• Lansoprazole 15-30mg OD PO

 **Red Flags: ALARM symptoms: Anaemia, Loss of weight, Anorexia, Recent onset/Progressive symptoms, Melaena/haematemesis, Swallowing difficulty (Dysphagia).**

 *Patient Explanation: "Stomach acid leaks up into the food pipe because the valve between them is weak. It causes a burning sensation. Acid-lowering tablets and diet changes help."*

Gonorrhoea

History (Symptoms) Men: Purulent urethral discharge, dysuria. Women: Often asymptomatic, or altered vaginal discharge, pelvic pain, intermenstrual bleeding. Rectal/pharyngeal infections.

Examination (Signs) Mucopurulent discharge from urethra or cervix. Cervical excitation on bimanual exam (if PID).


Bedside / GP Sexual health history. Offer full STI screen.


Investigations NAAT (Nucleic Acid Amplification Test) via first-catch urine in men, vulvovaginal swab in women. Endocervical/urethral swabs for culture & sensitivities.

Management (NICE/BNF) First-line: Single dose Ceftriaxone IM (intramuscular injection). Partner notification and contact tracing. Abstain from sex until treated.

BNF/BNFC Dosage Guide:


- Ceftriaxone 2g IV BD (Adult Meningitis) | 80mg/kg IV OD (Child)


 **Red Flags: Pelvic Inflammatory Disease (PID) in women, which can lead to ectopic pregnancy and infertility. Disseminated gonococcal infection (fever, arthritis, rash).**

 **Patient Explanation:** "A sexually transmitted bacterial infection. It can cause discharge and pain, but sometimes has no symptoms. It is treated with an antibiotic injection."

Haemochromatosis


History (Symptoms)	Early: chronic fatigue, joint pain (especially 2nd/3rd knuckles). Late: bronze skin pigmentation, erectile dysfunction, amenorrhoea, symptoms of heart failure or diabetes.
Examination (Signs)	Hepatomegaly, bronze/slate-grey skin discolouration, signs of chronic liver disease, joint swelling.
Bedside / GP	Blood pressure, BMI, joint examination.
Investigations	Bloods: Raised Transferrin Saturation (>45% is the best initial test) and high Ferritin. Genetic testing for HFE gene mutation. LFTs, HbA1c.
Management (NICE/BNF)	Regular therapeutic venesection (blood letting) to reduce iron stores. Monitor for complications (cirrhosis, diabetes, heart failure).


 **Red Flags: Hepatocellular carcinoma (HCC) risk is significantly increased if cirrhosis has developed. Requires ultrasound screening.**

 *Patient Explanation: "A genetic condition where the body absorbs too much iron from the diet. The iron builds up in organs like the liver and heart. We treat it by regularly removing some blood."*

Haemorrhoids (Piles)

History (Symptoms)	Painless, bright red rectal bleeding (on toilet paper or splashing in the pan). Perianal itching, feeling of a lump or incomplete emptying.
Examination (Signs)	Visible prolapsed vascular cushions on inspection or when asking patient to bear down. Usually not palpable on simple DRE unless thrombosed.
Bedside / GP	External inspection of the anus. Digital Rectal Examination (DRE) to rule out lower rectal masses.
Investigations	Proctoscopy (to visualize internal haemorrhoids). Flexi-sigmoidoscopy or colonoscopy if red flags are present to rule out bowel cancer.
Management (NICE/BNF)	Lifestyle: high fluid and fibre diet, avoid straining. Topical treatments (steroid/ local anaesthetic creams). Outpatient: Rubber band ligation. Surgical: Haemorrhoidectomy.

 **Red Flags: Change in bowel habit, weight loss, dark blood mixed with stool, or age >40-50 with unexplained rectal bleeding (Cancer pathways). Thrombosed haemorrhoid (extreme severe pain).**


 *Patient Explanation: "Swollen blood vessels just inside or outside the back passage. They cause bright red bleeding and itching. Drinking more water and eating fibre usually helps."*


Henoch-Schonlein Purpura (IgA Vasculitis)

History (Symptoms)	Child (typically 3-15 years). Recent upper respiratory tract infection. Presents with a rash, colicky abdominal pain, and joint pain (arthralgia).
Examination (Signs)	Non-blanching, symmetrical, palpable purpuric rash (small bruises/red spots), predominantly on the buttocks and extensor surfaces of the legs. Joint swelling (knees/ankles).
Bedside / GP	Urine dipstick is MANDATORY to check for haematuria and proteinuria (renal involvement). Blood pressure.
Investigations	Usually a clinical diagnosis. U&Es, FBC, CRP if diagnosis unclear or severe.
Management (NICE/BNF)	Mostly supportive: Analgesia (Paracetamol/NSAIDs), rest. Very close follow-up of blood pressure and urine dipstick for at least 6 months to monitor for kidney disease.

BNF/BNFC Dosage Guide:


- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)


 **Red Flags: Significant renal involvement (nephritis/nephrotic syndrome), severe GI bleeding, or intussusception (severe abdo pain/redcurrant jelly stool).**

 *Patient Explanation: "A self-limiting condition where tiny blood vessels become inflamed, causing a spotty rash on the legs and bottom, plus joint and tummy pain. We must monitor their urine to ensure the kidneys are safe."*

Hernias (Inguinal/Femoral)


History (Symptoms)	Lump in the groin. Aching, dragging sensation, or pain, especially on straining, lifting, or coughing. May disappear when lying down.
Examination (Signs)	Palpable lump. Cough impulse present. Inguinal: Above and medial to pubic tubercle. Femoral: Below and lateral to pubic tubercle. Check if reducible.
Bedside / GP	Examine while standing and lying flat. Examine the scrotum in men.
Investigations	Usually a clinical diagnosis. Ultrasound scan if the diagnosis is ambiguous.
Management (NICE/BNF)	Conservative (watch and wait if asymptomatic/reducible). Surgical repair (mesh repair) for symptomatic or high-risk hernias.


 **Red Flags: Incarceration (irreducible/stuck) or Strangulation (extreme pain, tender, red, irreducible + signs of bowel obstruction like vomiting) = Surgical Emergency.**

 *Patient Explanation: "A weakness in the abdominal muscle wall allowing a part of the bowel or fat to push through, causing a lump. It can be repaired with a simple operation."*

Herpes Simplex Virus (Genital)


History (Symptoms)	Painful genital ulceration, dysuria (pain passing urine), vaginal/urethral discharge. First episode often includes systemic flu-like symptoms (fever, myalgia).
Examination (Signs)	Multiple small, painful vesicles (blisters) or shallow ulcers on the genitals. Tender inguinal lymphadenopathy.
Bedside / GP	Sexual health history. STI screen.
Investigations	Viral swab from the base of the ulcer for HSV PCR (differentiates between HSV-1 and HSV-2).
Management (NICE/BNF)	Oral antiviral (e.g., Aciclovir 400mg TDS for 5 days) for the primary episode. Topical lidocaine for pain. Saline bathing. Avoid sex until healed.


 **Red Flags: Urinary retention (due to extreme pain or autonomic neuropathy). Neonatal transmission risk if active lesions present at term in pregnancy.**

 *Patient Explanation: "A viral infection causing painful blisters on the genitals. Once caught, the virus stays in the body and can cause mild recurrences. Antiviral tablets help clear the outbreak faster."*

Human Immunodeficiency Virus (HIV)


History (Symptoms)	Primary infection: 'seroconversion illness' (fever, sore throat, rash, swollen glands 2-6 weeks post-exposure). Asymptomatic phase for years. Late: severe weight loss, rare infections.
Examination (Signs)	Generalised lymphadenopathy, oral thrush, oral hairy leukoplakia, unusual skin rashes, signs of specific opportunistic infections.
Bedside / GP	Sexual health and drug use history. Calculate risk for PEP (Post-Exposure Prophylaxis) if exposure was <72 hours ago.
Investigations	HIV testing: 4th generation laboratory test (HIV antigen/antibody). Point-of-care rapid tests. Viral load (HIV RNA) and CD4 cell count.
Management (NICE/BNF)	cART (Combination Antiretroviral Therapy) started immediately. Aims for an undetectable viral load (U=U: Undetectable = Untransmittable).


 **Red Flags: Late-stage presentation / AIDS: CD4 < 200, leading to opportunistic infections (Pneumocystis pneumonia, Kaposi's sarcoma, cerebral toxoplasmosis).**

 *Patient Explanation: "A virus that attacks the immune system. Modern treatments are highly effective daily tablets that keep the virus completely suppressed so patients live long, healthy lives and cannot pass it on."*

Hyperosmolar Hyperglycaemic State (HHS)


History (Symptoms)	Patient with Type 2 Diabetes. Gradual onset (days to weeks) of severe polyuria, polydipsia, profound weakness, confusion, and lethargy. Often triggered by an infection.
Examination (Signs)	Profound dehydration (sunken eyes, dry mouth, poor skin turgor, tachycardia, hypotension). Altered mental state or focal neurological signs.
Bedside / GP	Capillary blood glucose (usually very high, e.g., >30 mmol/L). Blood ketones (usually low/negative).
Investigations	Serum osmolality (>320 mOsm/kg). U&Es (hypernatraemia, very high urea/creatinine indicating AKI). ABG/VBG (NO significant acidosis).
Management (NICE/BNF)	Medical Emergency. Very cautious, slow IV fluid replacement (0.9% Saline) to slowly lower osmolality. Slow IV insulin ONLY if ketones present or glucose not falling with fluids.


 **Red Flags: Rapid fluid shifts during treatment can cause cerebral oedema or central pontine myelinolysis. Very high mortality rate. High risk of VTE (give prophylactic heparin).**

 **Patient Explanation:** "A severe complication of Type 2 Diabetes where extremely high blood sugar causes you to lose dangerous amounts of water through your urine. It requires urgent, very careful fluid drips in hospital."

Hyperlipidaemia / Dyslipidaemia


History (Symptoms)	Usually entirely asymptomatic. Discovered via routine blood tests or health checks. Check family history of premature heart disease.
Examination (Signs)	Often normal. May have corneal arcus (white ring in eye), xanthelasma (yellow patches around eyelids), or tendon xanthomata (lumps on Achilles/knuckles in Familial Hypercholesterolaemia).
Bedside / GP	Calculate QRISK3 score (10-year risk of cardiovascular disease). Measure BMI and BP.
Investigations	Full lipid profile (Total cholesterol, LDL, HDL, Triglycerides). Non-fasting is usually sufficient now. HbA1c, TFTs, U&Es.
Management (NICE/BNF)	Lifestyle: Mediterranean diet, exercise, smoking cessation. Primary prevention (QRISK3 >10%): Atorvastatin 20mg. Secondary prevention: Atorvastatin 80mg. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Atorvastatin 20mg OD (Primary) or 80mg OD (Secondary prevention)


 **Red Flags: Extremely high total cholesterol (>7.5) or strong family history suggests Familial Hypercholesterolaemia (needs specialist referral).**

 *Patient Explanation: "High levels of fat/cholesterol in the blood. It doesn't cause symptoms but silently blocks your arteries over time, increasing heart attack and stroke risk. Treated with diet and statins."*

Hypoglycaemia

History (Symptoms)	Autonomic: sweating, shaking, palpitations, hunger. Neuroglycopenic: confusion, drowsiness, odd behaviour, speech difficulty. Usually seen in diabetic patients on insulin/sulfonylureas.
Examination (Signs)	Tachycardia, pallor, sweating, altered consciousness, seizures, or coma.
Bedside / GP	Capillary blood glucose (CBG < 4.0 mmol/L is the diagnostic threshold).
Investigations	In non-diabetics: 'Hypoglycaemia screen' during the attack (Insulin, C-peptide, Cortisol) to find the cause.
Management (NICE/BNF)	Conscious/able to swallow: Fast-acting oral carbohydrate (e.g., pure fruit juice, Glucogel, sweets). Unconscious: IM Glucagon or IV Dextrose (10% or 20%). Follow with complex carbs.

 **Red Flags: Coma or seizures resulting from prolonged profound hypoglycaemia. Never give oral fluids/food to an unconscious or drowsy patient (choking risk).**


 **Patient Explanation:** "Your blood sugar has dropped too low, causing your brain and body to panic. You need fast-acting sugar immediately. If unconscious, an ambulance is needed for a glucose drip."


Hypothyroidism

History (Symptoms)	Fatigue, weight gain, cold intolerance, constipation, heavy periods (menorrhagia), depressed mood, poor memory, dry skin/hair loss.
Examination (Signs)	Bradycardia, non-pitting oedema (myxoedema), dry skin, brittle hair, loss of outer third of eyebrows, slow-relaxing reflexes.
Bedside / GP	Weight measurement, heart rate check.
Investigations	Thyroid Function Tests (TFTs): High TSH, Low Free T4. Check TPO antibodies (Anti-thyroid peroxidase) for Hashimoto's thyroiditis.
Management (NICE/BNF)	Oral Levothyroxine (synthetic T4). Titrate dose based on TSH levels (rechecked every 6-8 weeks until stable).

BNF/BNFC Dosage Guide:

- Levothyroxine 50-100mcg OD PO (Adjust to TSH)

 **Red Flags: Myxoedema coma: severe, life-threatening hypothyroidism presenting with hypothermia, bradycardia, heart failure, and coma. Medical emergency.**

 *Patient Explanation: "Your thyroid gland isn't producing enough metabolism-controlling hormones, making everything in your body slow down. Treated with a daily replacement hormone tablet."*

Impetigo

History (Symptoms) Rapidly spreading rash, usually on the face (around the mouth and nose) or limbs. Itchy. More common in children.

Examination (Signs) Non-bullous (common): Vesicles that rupture, leaving characteristic 'honey-coloured' or golden crusts. Bullous: large fluid-filled blisters (less common).


Bedside / GP Clinical inspection.


Investigations Usually a clinical diagnosis. Skin swab for microscopy and culture only if recurrent or not responding to treatment.

Management (NICE/BNF) Localised: Hydrogen peroxide 1% cream or topical antibiotic (Fusidic acid/Mupirocin). Widespread/Systemic: Oral Flucloxacillin (or Clarithromycin).

BNF/BNFC Dosage Guide:


- Flucloxacillin 500mg QDS PO (Skin infections)
- Clarithromycin 500mg BD PO


 **Red Flags: Highly contagious. Patient must stay off school/work until crusts dry out or 48 hours after starting antibiotics. Watch for post-streptococcal glomerulonephritis.**

 *Patient Explanation: "A very contagious bacterial skin infection common in children. It causes golden, crusty sores around the mouth. Treated with antibiotic creams or tablets."*

Macular Degeneration (Age-Related / AMD)


History (Symptoms)	Gradual (dry) or sudden (wet) loss of central vision, distortion of straight lines (metamorphopsia), difficulty reading or recognising faces. Generally older patients.
Examination (Signs)	Reduced visual acuity. Fundoscopy: yellow deposits (drusen) in the macula. Neovascularisation or subretinal haemorrhage in wet AMD.
Bedside / GP	Amsler grid test (lines appear wavy). Visual acuity check.
Investigations	Optical Coherence Tomography (OCT) scan and Fluorescein Angiography to confirm wet AMD.
Management (NICE/BNF)	Dry: No medical cure, lifestyle advice (smoking cessation), vitamin supplements (AREDS2). Wet: Urgent intra-vitreous Anti-VEGF injections.


 **Red Flags: Sudden onset of profound visual loss or sudden severe metamorphopsia requires urgent referral to eye casualty (Wet AMD).**

 *Patient Explanation: "A condition that affects the middle part of your vision. 'Dry' happens slowly as you age, while 'wet' happens quickly due to leaky blood vessels and needs eye injections to stop it worsening."*

Malaria

History (Symptoms)	Fever (often cyclical/spiking), severe rigors, sweats, headache, myalgia, fatigue. Crucial: Recent travel to a malaria-endemic area (usually tropics/sub-tropics).
Examination (Signs)	Fever, tachycardia. May have hepatosplenomegaly or jaundice in severe cases. Look for signs of severe anaemia.
Bedside / GP	Urgent vital signs (risk of septic shock-like presentation). Rapid diagnostic tests (RDTs) if available.
Investigations	Gold standard: Thick and thin blood films (sent urgently, repeated over 3 days if initially negative). FBC, U&Es, LFTs.
Management (NICE/BNF)	Uncomplicated: Oral Artemisinin-based Combination Therapy (ACT). Severe/ Falciparum: IV Artesunate. Discuss with infectious diseases team.

 **Red Flags: Cerebral malaria (seizures, coma), severe anaemia, acute kidney injury, ARDS (respiratory distress). High mortality if missed.**

 *Patient Explanation: "A serious tropical disease spread by mosquitoes. A parasite infects your red blood cells, causing high fevers and chills. It requires urgent targeted antibiotics (antimalarials)."*

Meningitis (Bacterial)

History (Symptoms) Acute onset of severe headache, fever, neck stiffness, photophobia (dislike of bright lights), vomiting, altered mental state. In infants: poor feeding, bulging fontanelle.

Examination (Signs) Fever, neck stiffness. Positive Kernig's sign, positive Brudzinski's sign. Non-blanching purpuric rash (Meningococcal septicaemia).


Bedside / GP Tumbler test (glass test) for non-blanching rash. Immediate ABCDE assessment.


Investigations Lumbar Puncture (CSF shows high neutrophils, low glucose, high protein) UNLESS signs of raised ICP. Blood cultures, PCR.

Management (NICE/BNF) Pre-hospital/GP: IM/IV Benzylpenicillin immediately if rash present. Hospital: IV Ceftriaxone. Dexamethasone to prevent hearing loss.

BNF/BNFC Dosage Guide:


- Dexamethasone 0.15mg/kg PO STAT (Croup)
- Ceftriaxone 2g IV BD (Adult Meningitis) | 80mg/kg IV OD (Child)


 **Red Flags: Signs of raised intracranial pressure (reduced GCS, focal neurology, bradycardia). DO NOT perform an LP if these are present (risk of brain herniation).**

 *Patient Explanation: "A life-threatening bacterial infection of the lining of the brain and spinal cord. It causes a stiff neck, fever, and sometimes a rash that doesn't fade under a glass. Needs urgent hospital drips."*

Menopause

History (Symptoms)	Cessation of periods for >12 months. Vasomotor symptoms (hot flushes, night sweats), vaginal dryness/atrophy, mood changes, joint aches, poor sleep.
Examination (Signs)	Often normal. May have atrophic vaginitis on speculum exam (pale, dry, thinned vaginal mucosa).
Bedside / GP	Weight, blood pressure, breast check if appropriate.
Investigations	Clinical diagnosis for women >45. FSH blood test ONLY needed if <45 or atypical presentation.
Management (NICE/BNF)	Lifestyle advice. Hormone Replacement Therapy (HRT): Oestrogen (+ Progesterone if uterus intact to prevent endometrial cancer). Vaginal oestrogen for dryness.

 **Red Flags: Post-menopausal bleeding (PMB) is endometrial cancer until proven otherwise (requires 2-week-wait urgent ultrasound).**

 *Patient Explanation: "The natural time when your ovaries stop producing eggs and your hormone levels drop, stopping your periods. We can use hormone tablets or patches to relieve the uncomfortable symptoms."*

Migraine

History (Symptoms) Recurrent, severe, unilateral, throbbing headaches lasting 4-72 hours. Associated with nausea, vomiting, photophobia, and phonophobia. May have an 'aura' (e.g., visual zig-zags) before onset.

Examination (Signs) Normal neurological examination between attacks. Patient prefers a dark, quiet room during an attack.


Bedside / GP Fundoscopy and neuro exam to rule out secondary headache causes.


Investigations Clinical diagnosis. Brain imaging (MRI/CT) only if red flags are present.

Management (NICE/BNF) Acute: Oral Triptan (e.g., Sumatriptan) + NSAID/Paracetamol. Antiemetics. Prophylaxis (if >4 days/month): Propranolol, Topiramate, or Amitriptyline.

BNF/BNFC Dosage Guide:


- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)


 **Red Flags: Sudden 'thunderclap' headache (SAH), new headache in patient >50 (Temporal Arteritis), headache waking patient from sleep, associated focal weakness/seizures.**

 *Patient Explanation: "A complex neurological condition causing severe, throbbing headaches often with sickness and light sensitivity. Painkillers and specific 'triptan' tablets help abort attacks."*

Multiple Myeloma


History (Symptoms)	Older patient. CRAB symptoms: Calcium (stones/confusion), Renal (thirst), Anaemia (fatigue), Bone pain (especially back pain). Recurrent infections.
Examination (Signs)	Pallor, bony tenderness (spine/ribs). Signs of renal failure or hypercalcaemia (confusion).
Bedside / GP	Urine dipstick (protein, though Bence Jones might not show on standard dip).
Investigations	Serum Free Light Chains, Serum/Urine Electrophoresis (monoclonal paraprotein band). Bone marrow biopsy. Whole body MRI or low-dose CT for lytic bone lesions ('pepper pot skull').
Management (NICE/BNF)	Chemotherapy (e.g., Bortezomib, Thalidomide, Dexamethasone). Autologous stem cell transplant. Bisphosphonates for bone disease. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Dexamethasone 0.15mg/kg PO STAT (Croup)


 **Red Flags: Spinal Cord Compression (medical emergency: severe back pain, leg weakness, sensory loss, bowel/bladder incontinence).**

 **Patient Explanation:** "A cancer of the plasma cells in the bone marrow. It crowds out healthy blood cells, damages bones (causing pain and fractures), and strains the kidneys."

Multiple Sclerosis (MS)

History (Symptoms)	Young adult (20-40, female > male). Relapsing-remitting neurological symptoms: optic neuritis (painful loss of vision), limb numbness/tingling, weakness, unsteadiness, urinary incontinence.
Examination (Signs)	Depends on lesion location. Hyperreflexia, upgoing plantars, intention tremor, nystagmus, relative afferent pupillary defect (RAPD). 'Lesions disseminated in time and space'.
Bedside / GP	Full neurological, cranial nerve, and ophthalmology examination.
Investigations	MRI Brain and Cervical Spine (shows demyelinating plaques). Lumbar Puncture (oligoclonal bands in CSF not found in serum).
Management (NICE/BNF)	Acute relapses: High-dose oral or IV Methylprednisolone. Disease-modifying therapies (DMTs) like Ocrelizumab or Natalizumab. Symptom management. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Prednisolone 40mg OD PO (Adult Acute Asthma) 1-2mg/kg PO (Child)

 **Red Flags: Rapidly progressive neurological decline. Beware of 'pseudo-relapses' caused by an underlying infection (e.g., UTI).**

 **Patient Explanation:** "An autoimmune disease where the immune system mistakenly attacks the protective coating (myelin) around nerves in the brain and spine, disrupting signals and causing various symptoms."

Osteoarthritis

History (Symptoms) Joint pain that is worse with activity/weight-bearing and better with rest. Short-lived morning stiffness (<30 minutes). Commonly affects knees, hips, and small joints of the hands.

Examination (Signs) Crepitus (crunching sensation), restricted range of movement, bony swelling. Hand: Heberden's nodes (DIP joints) and Bouchard's nodes (PIP joints). No warmth or severe erythema.


Bedside / GP BMI (obesity is a major risk factor).


Investigations Clinical diagnosis if >45 with typical symptoms. X-ray (LOSS: Loss of joint space, Osteophytes, Subchondral sclerosis, Subchondral cysts).

Management (NICE/BNF) Core: Weight loss, strengthening exercises, physio. Analgesia: Topical NSAIDs, Oral Paracetamol/NSAIDs. Intra-articular steroid injections. Final: Joint replacement surgery.

BNF/BNFC Dosage Guide:

- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)


 **Red Flags: Hot, red, swollen joint (Septic Arthritis or Gout). Morning stiffness > 1 hour (Rheumatoid Arthritis).**

 *Patient Explanation: "The smooth cartilage protecting your joints has worn away over time, causing the bones to rub together. This leads to pain and stiffness. Exercise and weight loss are the best initial treatments."*

Osteoporosis

History (Symptoms)	Often a 'silent' disease until a fracture occurs. Fragility fractures (fracture from a fall from standing height or less) typical in the wrist, hip, or vertebrae. Loss of height, kyphosis.
Examination (Signs)	May have dorsal kyphosis (Dowager's hump) from vertebral wedge fractures. Otherwise normal.
Bedside / GP	Calculate FRAX score or QFracture score to assess 10-year fracture risk.
Investigations	DEXA Scan (T-score less than or equal to -2.5 defines osteoporosis. T-score -1.0 to -2.5 is osteopenia). Bloods to rule out secondary causes (Calcium, Vitamin D, TFTs, Myeloma screen).
Management (NICE/BNF)	Lifestyle (weight-bearing exercise, calcium-rich diet). Vitamin D/Calcium supplements. First-line medical: Oral Bisphosphonates (e.g., Alendronic acid).


 **Red Flags: Pathological fractures (e.g., breaking a bone by just rolling over in bed) must raise suspicion for bone metastases or multiple myeloma.**

 *Patient Explanation: "Your bones have lost their density and become more fragile and porous, meaning they break easily from minor bumps or falls. We use special tablets to strengthen the bone structure."*

Ovarian Cancer


History (Symptoms)	Often vague and present late. 'IBS-like' symptoms in a woman >50: persistent abdominal bloating, early satiety (feeling full quickly), pelvic/abdo pain, increased urinary urgency/frequency.
Examination (Signs)	Abdominal distension, palpable pelvic or abdominal mass, ascites (fluid in the abdomen).
Bedside / GP	Abdominal and bimanual pelvic examination.
Investigations	CA125 blood test (tumour marker). If elevated -> Urgent Pelvic/Transvaginal Ultrasound. CT chest/abdomen/pelvis for staging.
Management (NICE/BNF)	MDT approach. Surgical resection (Total Abdominal Hysterectomy, Bilateral Salpingo-Oophorectomy, and omentectomy) + Platinum-based Chemotherapy.


 **Red Flags: Any woman >50 with new onset 'IBS' symptoms must be investigated for ovarian cancer. Massive ascites.**

 *Patient Explanation: "Cancer of the ovaries. Because the ovaries are deep inside the pelvis, it often grows quietly, causing vague symptoms like bloating and feeling full, which is why it is caught late."*

Pancreatic Cancer


History (Symptoms)	Painless obstructive jaundice (yellow skin, dark urine, pale stools). Unexplained profound weight loss, upper abdominal pain radiating to the back, new-onset diabetes in an older, thin patient.
Examination (Signs)	Jaundice, scratch marks (pruritus). Courvoisier's law: A palpable, non-tender gallbladder in a jaundiced patient is unlikely to be gallstones (strongly suggests pancreatic/biliary cancer).
Bedside / GP	Urine dipstick (bilirubin).
Investigations	High-resolution CT Abdomen/Pancreas (first-line imaging). Tumour marker CA19-9. Endoscopic ultrasound (EUS) with biopsy.
Management (NICE/BNF)	Surgical resection (Whipple's procedure / pancreaticoduodenectomy) if resectable. Palliative stenting for jaundice. Palliative chemotherapy.


 **Red Flags: Painless jaundice is a red-flag symptom for malignancy until proven otherwise.**

 *Patient Explanation: "A very aggressive cancer in the pancreas. It often blocks the bile ducts, causing you to turn yellow (jaundice) without any pain. It requires urgent specialist scans."*

Parkinson's Disease

History (Symptoms)	Unilateral onset. Resting 'pill-rolling' tremor, slowness of movement (bradykinesia), stiffness, shuffling steps, small handwriting (micrographia), loss of smell (anosmia), REM sleep behaviour disorder.
Examination (Signs)	Resting tremor (3-5 Hz) that improves with movement. 'Lead-pipe' or 'Cogwheel' rigidity. Bradykinesia (slow finger tapping). Mask-like face (hypomimia). Festinating gait.
Bedside / GP	Assess gait, handwriting, and perform full neurological examination.
Investigations	A clinical diagnosis made by a specialist. A trial of Levodopa (symptoms should improve). SPECT scan (DaTscan) if diagnosis is in doubt.
Management (NICE/BNF)	Dopamine replacement therapy: Levodopa (co-careldopa), Dopamine agonists (Ropinirole), MAO-B inhibitors (Rasagiline). Physiotherapy. Meds must be given exactly on time in hospital.

 **Red Flags: Early frequent falls, early dementia, rapid progression, downward gaze palsy (Suggests 'Parkinson-Plus' syndromes like PSP or MSA).**

 **Patient Explanation:** "A progressive brain disorder where the brain slowly stops producing dopamine. This causes tremors, stiffness, and slow movement. Tablets replace the dopamine to improve symptoms."

Pelvic Inflammatory Disease (PID)

History (Symptoms) Bilateral lower abdominal pain, deep dyspareunia (pain during sex), abnormal vaginal discharge, fever, irregular vaginal bleeding. Often follows an STI (Chlamydia/Gonorrhoea).

Examination (Signs) Fever. Bimanual exam: Cervical excitation (severe pain on moving the cervix), adnexal tenderness.


Bedside / GP Pregnancy test (to rule out ectopic). Vital signs.


Investigations Endocervical and High Vaginal Swabs (for NAAT Chlamydia/Gonorrhoea and culture). Pelvic ultrasound (to check for tubo-ovarian abscess).

Management (NICE/BNF) Empiric antibiotics IMMEDIATELY (do not wait for swab results): IM Ceftriaxone + Oral Doxycycline (14 days) + Oral Metronidazole (14 days). Treat partners.

BNF/BNFC Dosage Guide:


- Ceftriaxone 2g IV BD (Adult Meningitis) | 80mg/kg IV OD (Child)
- Doxycycline 100mg OD/BD PO (Avoid in pregnancy/children)


 **Red Flags: Ectopic pregnancy (always rule out). Tubo-ovarian abscess rupture (severe sudden pain, peritonitis, shock). Future risks include infertility.**

 *Patient Explanation: "A severe infection of the womb and fallopian tubes, usually travelling up from the vagina. Requires a strong course of multiple antibiotics to prevent permanent damage or infertility."*

Pneumothorax


History (Symptoms)	Sudden onset of unilateral, sharp, pleuritic chest pain and breathlessness. Spontaneous: tall, thin, young men. Secondary: patients with underlying lung disease (COPD/Asthma).
Examination (Signs)	Reduced chest expansion on affected side. Hyper-resonant percussion note. Reduced or absent breath sounds on the affected side.
Bedside / GP	SpO ₂ , Respiratory Rate, Blood Pressure.
Investigations	Erect Chest X-ray (shows absent lung markings and a visible pleural edge). Ultrasound (if trained/in A&E).
Management (NICE/BNF)	Primary <2cm and no SOB: Discharge & review. Primary >2cm or SOB: Needle aspiration. Secondary or failed aspiration: Chest drain insertion. High-flow oxygen.


 **Red Flags: Tension Pneumothorax: Severe respiratory distress, tracheal deviation AWAY from the affected side, hypotension. EMERGENCY: requires immediate needle decompression before CXR.**

 *Patient Explanation: "A 'collapsed lung'. Air escapes from the lung and gets trapped in the chest cavity, squashing the lung. Small ones heal themselves; larger ones need a needle or tube to suck the air out."*

Polycystic Ovary Syndrome (PCOS)


History (Symptoms)	Oligomenorrhoea or amenorrhoea (irregular or no periods), subfertility, hirsutism (excess body/facial hair), acne, weight gain/obesity.
Examination (Signs)	Acanthosis nigricans (dark, velvety skin folds due to insulin resistance), signs of hyperandrogenism (hirsutism, acne), high BMI.
Bedside / GP	Weight, BMI, Blood pressure.
Investigations	Rotterdam Criteria (needs 2 of 3): 1. Irregular periods 2. Clinical/biochemical hyperandrogenism 3. Polycystic ovaries on ultrasound. Bloods: High LH, normal FSH, high testosterone.
Management (NICE/BNF)	Weight loss. COCP (to regulate periods and improve acne/hair). Metformin (for insulin resistance). Fertility: Clomifene or letrozole.
	BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Metformin 500mg OD, titrate to 1g BD PO


 **Red Flags: Endometrial hyperplasia/cancer risk is increased due to unopposed oestrogen if woman has <4 periods a year (need to induce withdrawal bleeds).**

 **Patient Explanation:** "A hormonal imbalance affecting the ovaries, causing irregular periods, excess hair growth, and difficulty getting pregnant. Losing weight and using the contraceptive pill are common treatments."

Prostate Cancer


History (Symptoms)	Often asymptomatic. LUTS: hesitancy, poor stream, terminal dribbling, frequency, nocturia. Back pain, bone pain, or weight loss indicates advanced/metastatic disease.
Examination (Signs)	Digital Rectal Examination (DRE): The prostate feels hard, nodular, asymmetrical, and fixed. Loss of the central sulcus.
Bedside / GP	DRE. Urine dipstick to rule out UTI.
Investigations	Prostate Specific Antigen (PSA) blood test (counsel patient first). Multiparametric MRI of the prostate. Transrectal/Transperineal ultrasound-guided biopsy.
Management (NICE/BNF)	Localised: Active surveillance, Radical prostatectomy, or Radiotherapy. Metastatic: Hormonal therapy (Androgen Deprivation Therapy like Goserelin), Chemotherapy.


 **Red Flags: Spinal Cord Compression (back pain, leg weakness, urinary retention) in a man with known or suspected prostate cancer is an emergency.**

 *Patient Explanation: "Cancer of the prostate gland in men. It grows slowly. We test for it with a blood test (PSA), an examination of the back passage, and special scans. Not all cases need immediate treatment."*

Psoriasis

History (Symptoms)	Chronic, itchy, or sore red, scaly rash. Often cyclical (flares and remissions). Associated joint pain (psoriatic arthritis). Triggers: stress, strep throat, certain drugs (beta-blockers).
Examination (Signs)	Well-demarcated, erythematous plaques with thick, silvery scales. Extensor surfaces (knees, elbows), scalp, natal cleft. Auspitz sign (pinpoint bleeding when scale is picked). Nail pitting, onycholysis.
Bedside / GP	Assess joints for signs of Psoriatic Arthritis.
Investigations	Clinical diagnosis. Rheumatology referral if joint symptoms are present.
Management (NICE/BNF)	Topical: Emollients, potent Corticosteroids + Vitamin D analogues (Calcipotriol). Systemic/Severe: Phototherapy (UVB), Methotrexate, Biologics (Adalimumab).

 **Red Flags: Psoriatic erythroderma (widespread redness covering >90% of body) or Generalised Pustular Psoriasis (systemically unwell/fever) require urgent dermatology admission.**

 *Patient Explanation: "An immune condition causing skin cells to replace themselves too quickly, leading to thick, red, scaly patches on elbows and knees. Creams and light therapy help slow this down."*

Pulmonary Embolism (PE)

History (Symptoms) Sudden onset of dyspnoea (shortness of breath), pleuritic chest pain, cough, haemoptysis (coughing up blood). Risk factors: recent surgery, immobility, cancer, COCP, pregnancy.

Examination (Signs) Tachypnoea, tachycardia, hypoxia. May have signs of a DVT (unilateral swollen/tender calf). Right heart strain (raised JVP).


Bedside / GP Calculate Two-Level PE Wells Score. Vital signs (SpO₂, HR). 12-lead ECG (often sinus tachycardia; classic S1Q3T3 is rare).


Investigations Wells likely (>4): Urgent CTPA (CT Pulmonary Angiogram). Wells unlikely: D-dimer (if positive, then CTPA).

Management (NICE/BNF) Immediate DOAC (Apixaban or Rivaroxaban) whilst awaiting scans. If massive PE with hypotension (shock): Thrombolysis (Alteplase).

BNF/BNFC Dosage Guide:


- Apixaban 5mg BD PO (Stroke prevention in AF)


 **Red Flags: Massive PE causing right ventricular failure and cardiogenic shock. Requires emergency thrombolysis or surgical embolectomy.**

 *Patient Explanation: "A blood clot has travelled to the blood vessels in your lungs, blocking the flow and causing sudden chest pain and shortness of breath. You need immediate blood-thinning medication."*

Reactive Arthritis


History (Symptoms)	Asymmetrical oligoarthritis (usually lower limbs) developing 1-4 weeks after a GI infection (e.g., Campylobacter/Salmonella) or STI (e.g., Chlamydia). 'Can't see, can't pee, can't climb a tree'.
Examination (Signs)	Hot, swollen, tender joint (often knee or ankle). Conjunctivitis/anterior uveitis (red eye). Urethritis (dysuria/discharge). Dactylitis (sausage-like toe).
Bedside / GP	Urine dipstick, STI screen (first-catch urine for Chlamydia NAAT), Stool culture if recent diarrhoea.
Investigations	Joint aspiration to RULE OUT Septic Arthritis (fluid is sterile in reactive arthritis but shows high white cells). Bloods: raised CRP/ESR. HLA-B27 testing.
Management (NICE/BNF)	NSAIDs for joint pain. Intra-articular steroid injections. Treat the underlying trigger infection (e.g., Doxycycline for Chlamydia). Usually self-resolves in 6 months. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Doxycycline 100mg OD/BD PO (Avoid in pregnancy/children)


 **Red Flags: Always treat an acute, hot, swollen joint as Septic Arthritis until proven otherwise by joint aspiration.**

 *Patient Explanation: "Your immune system has overreacted to a recent tummy bug or sexually transmitted infection, causing your joints, eyes, and water pipe to become inflamed. It usually gets better on its own."*

Respiratory Failure


History (Symptoms)	Profound breathlessness, agitation, confusion, morning headaches (in Type 2), bounding pulse, cyanosis. Hx of COPD, asthma, or opioid overdose.
Examination (Signs)	Type 1 (Hypoxia only): Tachypnoea, cyanosis. Type 2 (Hypoxia + Hypercapnia): CO ₂ retention flap (asterixis), bounding pulse, warm peripheries, drowsiness.
Bedside / GP	Vital signs (SpO ₂ , Respiratory Rate, Heart Rate). Immediate ABCDE.
Investigations	Arterial Blood Gas (ABG) is diagnostic. Type 1: PaO ₂ <8.0 kPa, PaCO ₂ normal/low. Type 2: PaO ₂ <8.0 kPa, PaCO ₂ >6.0 kPa. Chest X-ray to find cause.
Management (NICE/BNF)	Type 1: High-flow Oxygen (target SpO ₂ 94-98%). Type 2: Controlled Oxygen (target 88-92% until ABG known), Non-Invasive Ventilation (BiPAP), or intubation. Treat cause.


 **Red Flags: Falling respiratory rate and dropping GCS in an asthma or COPD patient signals imminent respiratory arrest.**

 *Patient Explanation: "Your lungs are failing to get enough oxygen into your blood, and sometimes failing to clear the waste gas (carbon dioxide) out. This is an emergency needing oxygen and sometimes a breathing machine."*

Retinal Detachment


History (Symptoms)	Painless, sudden onset of 'flashes of light' (photopsia), new 'floaters' (spots/cobwebs in vision), followed by a dark shadow or 'curtain' falling over the vision.
Examination (Signs)	Visual field defect corresponding to the detachment. Relative Afferent Pupillary Defect (RAPD) if large. Retinal tear/detachment visible on fundoscopy/slit-lamp.
Bedside / GP	Visual acuity test, Visual fields by confrontation.
Investigations	Urgent specialist ophthalmology assessment with dilated fundoscopy and slit-lamp examination. Optical Coherence Tomography (OCT).
Management (NICE/BNF)	Surgical emergency. Laser photocoagulation or cryotherapy to seal the tear. Vitrectomy or scleral buckle surgery.


 **Red Flags: Macula-on detachment (central vision still intact) requires absolute immediate surgery to save the central vision. If macula is 'off', vision loss may be permanent.**

 *Patient Explanation: "The light-sensitive lining at the back of your eye has started to peel away, like wallpaper coming off a wall. It causes a curtain-like shadow over your sight and needs urgent surgery to fix."*

Rheumatoid Arthritis


History (Symptoms)	Symmetrical polyarthritis (affecting small joints of hands/feet). Prominent morning stiffness lasting > 1 hour. Fatigue, weight loss, systemic malaise.
Examination (Signs)	Symmetrical swelling/tenderness of MCP, PIP, and wrist joints (DIP joints spared). 'Boggy' joints. Late signs: Ulnar deviation, swan-neck, and boutonniere deformities. Rheumatoid nodules.
Bedside / GP	Examine hands, wrists, and feet for active synovitis. Check cardiovascular risk.
Investigations	Bloods: Rheumatoid Factor (RF) and Anti-CCP antibodies (highly specific). Raised CRP/ESR. X-rays of hands/feet (periarticular osteopenia, joint space narrowing, erosions).
Management (NICE/BNF)	Urgent Rheumatology referral. DMARDs (Methotrexate, Sulfasalazine). Bridging oral/IM corticosteroids during flare-ups. Biologics (TNF-inhibitors) if severe.


 **Red Flags: Atlanto-axial subluxation (neck pain radiating to occiput, limb weakness). High risk of accelerated cardiovascular disease (heart attacks/strokes).**

 **Patient Explanation:** "An autoimmune disease where your body attacks the lining of your joints, causing pain, swelling, and stiffness, especially in the morning. Strong medications help stop the damage."

Schizophrenia


History (Symptoms)	Positive symptoms: Auditory hallucinations (hearing voices), delusions (paranoid, grandiose), thought insertion/broadcasting. Negative symptoms: Apathy, anhedonia, poverty of speech, social withdrawal.
Examination (Signs)	Lack of insight. Blunted affect, thought blocking, auditory hallucinations evident during consultation (e.g., looking around the room at empty space).
Bedside / GP	Full psychiatric history and risk assessment (suicide, neglect, risk to others). Collateral history.
Investigations	Urine drug screen to rule out substance-induced psychosis. Bloods/CT head to rule out organic brain disease.
Management (NICE/BNF)	Antipsychotic medications (e.g., Olanzapine, Risperidone). Clozapine for treatment-resistant cases. CBT for psychosis, family intervention, social support.


 **Red Flags: Command hallucinations (voices telling the patient to harm themselves or others). Neuroleptic Malignant Syndrome (fever, rigidity, confusion) from medication.**

 *Patient Explanation: "A severe mental health condition causing a disconnect from reality. You might hear voices or hold unusual beliefs. It is treated with a combination of medication and talking therapies."*

Sepsis


History (Symptoms)	Fever, chills, extreme shivering, muscle pain, confusion, severe breathlessness, feeling like 'I'm going to die', not passing urine all day. History of recent infection.
Examination (Signs)	Tachycardia (HR >90), Tachypnoea (RR >20), Hypotension (Systolic BP <100), altered mental state, mottled/ashen/cyanotic skin, prolonged capillary refill.
Bedside / GP	Calculate NEWS2 Score. Check ABCDE. Look for the source (chest, urine, skin, abdomen).
Investigations	Sepsis Six (Take 3, Give 3): Take blood cultures, lactate, and urine output. Give high-flow oxygen, IV antibiotics, and IV fluids.
Management (NICE/BNF)	Immediate hospital admission. Broad-spectrum IV antibiotics within 1 hour. Aggressive IV fluid resuscitation (crystalloids). ICU support for vasopressors if shock persists.


 **Red Flags: Septic Shock: Profound hypotension not responding to IV fluids, requiring ICU admission and medication to squeeze the blood vessels.**

 *Patient Explanation: "A life-threatening reaction to an infection. Instead of just fighting the bug, your immune system starts damaging your own organs. Requires emergency drips and antibiotics."*

Sickle Cell Disease / Crisis


History (Symptoms)	Patient of African/Caribbean descent. Vaso-occlusive crisis: Sudden, severe bone pain (back, limbs, ribs). Chest syndrome: chest pain, SOB, fever.
Examination (Signs)	Signs of anaemia (pallor, tachycardia). Jaundice (haemolysis). Swollen, painful joints/bones. Dactylitis in children (swollen hands/feet).
Bedside / GP	SpO2 (hypoxia triggers sickling). Urinalysis.
Investigations	FBC (low Hb, high reticulocytes). Blood film (sickle-shaped cells). Haemoglobin electrophoresis confirms diagnosis.
Management (NICE/BNF)	Crisis: Strong analgesia (Opiates), aggressive IV hydration, Oxygen if hypoxic. Preventative: Hydroxycarbamide (increases HbF), Penicillin V prophylaxis, vaccinations.


 **Red Flags: Acute Chest Syndrome (fever, chest pain, lung infiltrates) is a major cause of death. Splenic sequestration crisis in children (sudden severe anaemia and shock).**

 **Patient Explanation:** "A genetic condition where red blood cells are shaped like sickles instead of donuts. They get stuck in blood vessels, causing extreme pain. We treat this with strong painkillers, fluids, and sometimes oxygen."

Skin Cancer (Melanoma, SCC, BCC)

History (Symptoms)	BCC: Slow-growing 'pearly' nodule. SCC: Rapidly growing, scaly/crusted ulcerated lump. Melanoma: New or changing mole (ABCDE: Asymmetry, Border irregularity, Colour variation, Diameter >6mm, Evolving).
Examination (Signs)	BCC: Pearly edges, telangiectasia (visible blood vessels), central ulcer. SCC: Hyperkeratotic, crusty. Melanoma: Pigmented, irregular, dark lesions.
Bedside / GP	Dermoscopy examination. Examine regional lymph nodes.
Investigations	Urgent 2-week-wait dermatology referral. Excision biopsy is diagnostic (DO NOT do a punch biopsy for suspected melanoma).
Management (NICE/BNF)	Surgical excision with clear margins. For advanced melanoma: Immunotherapy (e.g., Pembrolizumab) or targeted BRAF therapy.

 **Red Flags: Any changing mole, bleeding mole, or mole that looks completely different from the others ('ugly duckling sign') must be referred urgently.**

 **Patient Explanation:** "Cancer of the skin cells, usually caused by sun damage. BCCs and SCCs are usually easily cured with minor surgery. Melanomas are more dangerous as they can spread and require urgent removal."

Stroke (Ischaemic and Haemorrhagic)

History (Symptoms) Sudden onset of focal neurological deficit. FAST symptoms: Facial droop, Arm weakness, Speech slurred/aphasia, Time to call 999. Hemiparesis, hemisensory loss, visual field loss.

Examination (Signs) Assess using NIHSS. Upper motor neuron signs: weakness, hyperreflexia, upgoing plantars. Homonymous hemianopia. Dysphasia/Dysarthria.


Bedside / GP BM/Capillary blood glucose (to rule out hypoglycaemia, a classic stroke mimic). 12-lead ECG (to check for AF).


Investigations Urgent non-contrast CT Head (to rule out haemorrhage before giving blood thinners). CT Angiogram.

Management (NICE/BNF) Ischaemic: Thrombolysis (Alteplase) if within 4.5 hours of onset. Mechanical thrombectomy if large vessel occlusion. Aspirin 300mg (once haemorrhage ruled out). Haemorrhagic: BP control, neurosurgery discussion.

BNF/BNFC Dosage Guide:

- Aspirin 300mg STAT (Emergency) or 75mg OD (Maintenance)

 **Red Flags: Reduced consciousness (GCS <8) or signs of raised ICP (bradycardia/hypertension) suggest massive swelling or brainstem involvement. Emergency intubation may be needed.**

 **Patient Explanation: "A 'brain attack' where blood supply to part of the brain is cut off by a clot or a burst vessel. Immediate emergency hospital treatment is needed to limit brain damage."**

Subarachnoid Haemorrhage (SAH)


History (Symptoms) Sudden, explosive, severe 'thunderclap' headache reaching maximum intensity within minutes. 'The worst headache of my life'. Photophobia, neck stiffness, vomiting, collapse/seizure.


Examination (Signs) Meningism (neck stiffness, positive Kernig's sign). Reduced GCS. Focal neurological signs. Retinal haemorrhages on fundoscopy.

Bedside / GP Immediate ABCDE and GCS assessment.

Investigations Urgent non-contrast CT Head (high sensitivity in first 6 hours). If CT is normal but high suspicion, do Lumbar Puncture at 12 hours (xanthochromia/yellow CSF). CT Angiogram to find aneurysm.


Management (NICE/BNF) Emergency neurosurgery referral. Coiling or clipping of the ruptured aneurysm. Oral Nimodipine (calcium channel blocker) to prevent cerebral vasospasm.


 **Red Flags: High risk of re-bleeding in the first few days (often fatal). Vasospasm causing delayed ischaemic strokes.**

 *Patient Explanation: "A dangerous bleed on the surface of the brain, usually from a burst weakened blood vessel (aneurysm). It causes a sudden, extreme headache and requires urgent specialist brain surgery."*

Systemic Lupus Erythematosus (SLE)


History (Symptoms)	Young female (often Afro-Caribbean/Asian). Extreme fatigue, joint pain, photosensitive skin rash, mouth ulcers, hair loss, Raynaud's phenomenon, pleuritic chest pain.
Examination (Signs)	Malar 'butterfly' rash across cheeks and nose (sparing nasolabial folds). Non-erosive arthritis. Pleural/pericardial rub.
Bedside / GP	Urine dipstick (check for protein/blood indicating Lupus Nephritis). Blood pressure.
Investigations	Bloods: ANA (positive in 99%), Anti-dsDNA (highly specific, correlates with disease activity). Low complement (C3/C4). Raised ESR (but normal CRP unless infected).
Management (NICE/BNF)	Sun protection. First line: Hydroxychloroquine. Flares: NSAIDs, oral Corticosteroids. Severe organ involvement: Immunosuppressants (Azathioprine, Cyclophosphamide).


 **Red Flags: Lupus Nephritis (proteinuria, high BP) can progress to end-stage renal failure. Increased risk of miscarriages/clots due to Antiphospholipid Syndrome.**

 **Patient Explanation:** "A complex autoimmune disease where your immune system attacks various parts of your body, including skin, joints, and kidneys. It causes a characteristic butterfly face rash and severe fatigue."

Testicular Torsion

History (Symptoms)	Adolescent boy. Sudden onset of severe, unilateral testicular pain. Often accompanied by lower abdominal pain, nausea, and vomiting. May wake patient from sleep.
Examination (Signs)	Tender, swollen, retracted (high-riding) testicle. Abnormal transverse lie. Absent cremasteric reflex. Prehn's sign is negative (elevating the testicle does NOT relieve pain).
Bedside / GP	Nil by mouth (prepare for theatre).
Investigations	Clinical diagnosis. DO NOT delay surgery for an ultrasound scan. Time is testicle.
Management (NICE/BNF)	Surgical emergency. Urgent scrotal exploration within 6 hours of pain onset to untwist the cord and fix both testicles to the scrotum (bilateral orchidopexy).

 **Red Flags: Irreversible testicular necrosis/death occurs after 6 hours of ischaemia. Any acute swollen scrotum in a young male is torsion until proven otherwise surgically.**

 *Patient Explanation: "The testicle has twisted on its blood supply cord, cutting off the blood. It causes extreme sudden pain and requires an emergency operation within a few hours to save the testicle."*

Transient Ischaemic Attack (TIA)

History (Symptoms) Sudden onset of focal neurological symptoms (speech loss, limb weakness, facial droop, visual loss/amaurosis fugax) that completely resolve within 24 hours.

Examination (Signs) Neurological examination is often completely NORMAL by the time they are seen (as symptoms have resolved). Check BP, listen for carotid bruits.


Bedside / GP BM/Capillary glucose to rule out 'hypo'. 12-lead ECG to rule out Atrial Fibrillation.


Investigations MRI Brain (NOT CT) to look for small areas of ischaemia. Carotid Doppler ultrasound. 24h ECG/Holter monitor.

Management (NICE/BNF) Immediate Aspirin 300mg daily. Specialist TIA clinic review within 24 hours. Secondary prevention: Clopidogrel 75mg, high-dose Statin, BP control. Carotid endarterectomy if severe stenosis.

BNF/BNFC Dosage Guide:


- Aspirin 300mg STAT (Emergency) or 75mg OD (Maintenance)
- Clopidogrel 300mg STAT, then 75mg OD


 **Red Flags: A TIA is a major warning sign for a full stroke in the coming days/weeks. Driving restrictions apply (must not drive for 1 month).**

 *Patient Explanation: "A 'mini-stroke' where the blood supply to the brain is temporarily blocked, causing stroke symptoms that get better quickly. It is a major warning sign that a full stroke could happen soon."*

Tuberculosis (TB)


History (Symptoms)	Chronic cough (>3 weeks), haemoptysis (coughing blood), severe night sweats (drenching the bed), unexplained weight loss, lethargy. Hx of travel/ birth in endemic area or immunosuppression.
Examination (Signs)	Often normal. May have crackles/bronchial breathing at lung apices. Cervical lymphadenopathy. Clubbing (late).
Bedside / GP	Isolate the patient (negative pressure room) if infectious TB suspected.
Investigations	Chest X-ray (upper lobe cavitation/consolidation). Sputum for Acid Fast Bacilli (AFB) smear and culture x 3 (including early morning sample). IGRA / Mantoux test for latent TB.
Management (NICE/BNF)	Notification to Public Health. 6 months combination antibiotics (Rifampicin, Isoniazid, Pyrazinamide, Ethambutol for 2 months, then R+I for 4 months). Direct Observation Therapy (DOTs).


 **Red Flags: Rifampicin causes orange tears/urine. Isoniazid causes peripheral neuropathy (give Pyridoxine/Vit B6). Miliary TB (widespread dissemination in blood) is life-threatening.**

 **Patient Explanation:** "A bacterial infection that usually affects the lungs, causing a long-term bloody cough, weight loss, and extreme night sweats. Needs 6 months of strong combination antibiotics to cure completely."

Ulcerative Colitis (UC)

History (Symptoms)	Gradual onset of frequent, small volume bloody diarrhoea with mucus. Left lower quadrant abdominal pain, tenesmus (feeling of incomplete bowel emptying), urgency.
Examination (Signs)	May have abdominal tenderness. Systemic signs if severe: fever, tachycardia. Extraintestinal: primary sclerosing cholangitis (jaundice), erythema nodosum, episcleritis.
Bedside / GP	Faecal Calprotectin (raised). Stool culture (to rule out infectious gastroenteritis).
Investigations	Bloods: FBC (anaemia), CRP/ESR. Colonoscopy with biopsies (continuous mucosal inflammation, limited to the colon, starting at the rectum).
Management (NICE/BNF)	Inducing remission: Oral/topical Mesalazine (5-ASA) or Corticosteroids. Maintenance: Mesalazine, Azathioprine, Biologics. Curative surgery: Panproctocolectomy.

 **Red Flags: Toxic Megacolon: Severe acute flare causing massive colon dilation, fever, and shock. High risk of perforation. High long-term risk of colorectal cancer.**


 **Patient Explanation:** "A lifelong autoimmune disease causing ulcers and inflammation in the lining of the large bowel and rectum. It causes bloody diarrhoea and needs medication to keep the gut lining calm."


Urinary Tract Infection (Upper / Pyelonephritis)

History (Symptoms)	Loin/flank pain, high fever, rigors (shivering), nausea, vomiting. May be accompanied by lower UTI symptoms (dysuria, frequency, urgency).
Examination (Signs)	High fever. Renal angle tenderness (costovertebral angle tenderness) on percussion. Suprapubic tenderness.
Bedside / GP	Urine dipstick (Positive for Nitrites and Leukocytes). Vital signs (assess for sepsis).
Investigations	Mid-stream urine (MSU) for microscopy, culture and sensitivities. Bloods: FBC, CRP, U&Es. Renal ultrasound if recurrent or male.
Management (NICE/BNF)	Non-pregnant/Community: Oral Cefalexin or Co-amoxiclav (7-10 days). Severe/Sepsis: Hospital admission, IV Ceftriaxone, IV fluids.

BNF/BNFC Dosage Guide:


- Ceftriaxone 2g IV BD (Adult Meningitis) | 80mg/kg IV OD (Child)
- Co-amoxiclav 625mg TDS PO or 1.2g IV TDS


 **Red Flags: Sepsis. Urinary obstruction with an infected kidney (e.g., a kidney stone blocking an infected kidney) is a urological emergency needing urgent drainage/stent.**

 *Patient Explanation: "A bacterial infection that has travelled up from the bladder into the kidneys themselves, causing high fevers and back pain. Needs a longer course of strong antibiotics."*

Acid-base abnormality


History (Symptoms)	Symptoms of underlying cause (e.g. vomiting for alkalosis, D&V/sepsis for acidosis, COPD for resp acidosis). Confusion, breathlessness.
Examination (Signs)	Kussmaul breathing (metabolic acidosis), hypoventilation (metabolic alkalosis). Check fluid status and GCS.
Bedside / GP	Vital signs, SpO ₂ .
Investigations	Arterial or Venous Blood Gas (ABG/VBG), U&Es (for anion gap), Glucose/Ketones.
Management (NICE/BNF)	Treat underlying cause (e.g. insulin for DKA, IV fluids for dehydration, BiPAP for COPD type 2 resp failure).


 **Red Flags: Severe acidaemia (pH < 7.1) causing cardiac arrhythmias and shock.**

 *Patient Explanation: "The blood's pH balance is off due to another illness like a kidney problem or breathing issue. We find and treat the root cause."*

Adverse drug effects


History (Symptoms)	Recent start/dose change of medication. Rashes, GI upset, bleeding, dizziness, or confusion.
Examination (Signs)	Depends on drug. Look for urticaria, jaundice, signs of bleeding (bruising), or altered mental state.
Bedside / GP	Review medication history (including OTC and herbals).
Investigations	Targeted bloods (e.g., U&Es for ACEi, LFTs for statins, FBC for methotrexate). Drug levels (Digoxin, Lithium, Phenytoin).
Management (NICE/BNF)	Stop or reduce the offending drug. Supportive care. Report severe/novel reactions via the MHRA Yellow Card scheme.


 **Red Flags: Anaphylaxis, Steven-Johnson Syndrome (severe blistering rash), acute liver/kidney failure, agranulocytosis.**

 *Patient Explanation: "An unwanted reaction to a medication. It can range from mild stomach upset to severe allergic reactions. We usually stop the drug and report the reaction."*

Alcoholic hepatitis


History (Symptoms)	Heavy alcohol use. Rapid onset of jaundice, malaise, fever, right upper quadrant pain, anorexia.
Examination (Signs)	Jaundice, tender hepatomegaly (enlarged liver), fever, ascites. Stigmata of chronic liver disease may be present.
Bedside / GP	Assess for alcohol withdrawal risk (CIWA score).
Investigations	LFTs (AST > ALT, usually 2:1 ratio). FBC (macrocytosis, high WBC). Coagulation (prolonged PT). Ultrasound abdomen.
Management (NICE/BNF)	Strict alcohol abstinence. Nutritional support (Thiamine/Pabrinex). Severe cases (high Maddrey's discriminant function): Corticosteroids.


 **Red Flags: Hepatic encephalopathy (confusion), severe bleeding (varices), hepatorenal syndrome.**

 *Patient Explanation: "Severe inflammation of the liver caused by heavy drinking. It causes yellowing of the skin and requires immediate cessation of alcohol and sometimes hospital treatment."*

Allergic disorder


History (Symptoms)	Itchy eyes, sneezing, rhinorrhoea, itchy rash (hives), lip/tongue swelling after exposure to trigger (food, pollen, pet, drug).
Examination (Signs)	Urticarial rash (weals), angioedema, conjunctival injection, wheeze.
Bedside / GP	Assess airway/breathing (ABCDE).
Investigations	Clinical diagnosis. Specific IgE tests (RAST) or skin prick testing later in immunology clinic.
Management (NICE/BNF)	Avoid trigger. Oral non-sedating antihistamines (Cetirizine, Loratadine). Topical nasal steroids for rhinitis. Epipen for severe reactions.


 **Red Flags: Anaphylaxis (stridor, severe wheeze, hypotension, collapse) - requires immediate IM Adrenaline.**

 *Patient Explanation: "An overreaction of the immune system to a harmless substance. We manage it by avoiding the trigger and using antihistamine medicines."*

Ankylosing Spondylitis


History (Symptoms)	Young male (usually <30). Insidious onset of chronic lower back pain. Worse in the morning and with rest, IMPROVES with exercise. Waking up in the second half of the night with pain.
Examination (Signs)	Reduced spinal mobility (Schober's test <5cm), tender sacroiliac joints, loss of lumbar lordosis. Question mark posture in late disease.
Bedside / GP	Examine posture and spinal range of motion.
Investigations	X-ray of sacroiliac joints (sacroiliitis) and spine ('bamboo spine' late stage). MRI is better for early disease. Bloods: HLA-B27 positive, raised CRP/ESR.
Management (NICE/BNF)	First line: NSAIDs and intensive physiotherapy. Second line (if severe): Anti-TNF biologic drugs (e.g., Adalimumab).


 **Red Flags: Acute anterior uveitis (painful red eye), aortic regurgitation, spinal fractures from minor trauma due to rigid spine.**

 *Patient Explanation: "An inflammatory arthritis affecting the spine, making it stiff and painful, especially after resting. Exercise helps. Special medications can slow down the inflammation."*

Anxiety disorder: generalised (GAD)

History (Symptoms)	Excessive, uncontrollable worry about multiple everyday things on most days for >6 months. Restlessness, fatigue, muscle tension, sleep disturbance, poor concentration.
Examination (Signs)	Often normal physically. May appear tense, fidgety, or have a fast heart rate.
Bedside / GP	GAD-7 questionnaire to assess severity.
Investigations	TFTs to rule out hyperthyroidism. Toxicology screen if substance abuse suspected.
Management (NICE/BNF)	Mild: Psychoeducation, self-help. Moderate/Severe: Cognitive Behavioural Therapy (CBT) and/or SSRIs (e.g., Sertraline).

 **Red Flags: High suicide risk, co-morbid severe depression, self-medication with large amounts of alcohol/drugs.**

 *Patient Explanation: "A persistent, long-term condition where you feel highly anxious and worried about various things most days, making it hard to function. Talking therapies and medications can help."*

Anxiety disorder: post-traumatic stress disorder (PTSD)

History (Symptoms)	History of exposure to a traumatic event. Re-experiencing (flashbacks, nightmares), avoidance of triggers, hyperarousal (startle response, insomnia), negative changes in mood/cognition.
Examination (Signs)	Distressed when recalling trauma, hypervigilance.
Bedside / GP	Screen for co-morbidities like depression and substance abuse.
Investigations	Clinical diagnosis based on specific psychiatric criteria.
Management (NICE/BNF)	Trauma-focused CBT or Eye Movement Desensitisation and Reprocessing (EMDR). SSRIs/SNRIs (Venlafaxine/Sertraline) if therapy is ineffective or patient prefers meds.




Red Flags: Risk of suicide or severe self-neglect. Dangerous impulsive behaviour.




Patient Explanation: "A psychological reaction to a deeply distressing or frightening event. It causes flashbacks, nightmares, and high stress levels. Specific therapies like EMDR and CBT are very effective."

Aortic Aneurysm (Abdominal - AAA)


History (Symptoms)	Often asymptomatic until rupture. Discovered incidentally on scans. If symptomatic: pulsatile feeling in abdomen, unexplained back or abdominal pain.
Examination (Signs)	Expansile, pulsatile mass in the central/upper abdomen (above umbilicus).
Bedside / GP	Abdominal palpation. Check blood pressure.
Investigations	Abdominal Ultrasound (diagnostic). CT Angiogram to plan surgery if size >5.5cm.
Management (NICE/BNF)	Screening for men at 65. If <5.5cm: monitor with regular ultrasound. If >5.5cm, rapidly expanding, or symptomatic: Elective EVAR (Endovascular Aneurysm Repair) or open repair.


 **Red Flags: Ruptured AAA: Sudden severe tearing back/abdominal pain, pulsatile mass, and profound hypotension/shock. Surgical emergency (Call 999).**

 *Patient Explanation: "A bulging or swelling in the main blood vessel running down your tummy. If it gets too large, it risks bursting, so we monitor it with scans and repair it if necessary."*

Aortic Dissection


History (Symptoms)	Sudden onset, severe 'tearing' or 'ripping' chest pain radiating straight to the back (between shoulder blades). History of uncontrolled hypertension or Marfan's syndrome.
Examination (Signs)	Unequal blood pressures in the arms (>20mmHg difference). Radio-radial or radio-femoral pulse delay. Aortic regurgitation murmur. Signs of shock.
Bedside / GP	Measure BP in both arms. Immediate 12-lead ECG.
Investigations	Urgent CT Angiogram of chest/abdomen/pelvis (shows false lumen). Chest X-ray (widened mediastinum).
Management (NICE/BNF)	Type A (ascending aorta): Emergency open cardiac surgery. Type B (descending aorta): Strict medical management (IV beta-blockers like Labetalol to lower BP), sometimes endovascular stenting.


 **Red Flags: Cardiac tamponade (muffled heart sounds, raised JVP, hypotension), stroke, or limb ischaemia resulting from the dissection blocking branching arteries.**

 *Patient Explanation: "A tear in the inner layer of the main artery from the heart. Blood rushes between the layers, causing extreme pain. This is a life-threatening emergency requiring urgent hospital care."*

Aortic Valve Disease (Stenosis/Regurgitation)


History (Symptoms)	Stenosis (SAD): Syncope (fainting on exertion), Angina, Dyspnoea. Regurgitation: Exertional breathlessness, palpitations.
Examination (Signs)	Stenosis: Ejection systolic murmur radiating to carotids, slow-rising pulse, narrow pulse pressure. Regurgitation: Early diastolic murmur, collapsing pulse, wide pulse pressure.
Bedside / GP	12-lead ECG (LVH signs), Blood pressure.
Investigations	Echocardiogram (gold standard to assess valve area/gradient and ventricular function).
Management (NICE/BNF)	Symptomatic severe stenosis: Surgical Aortic Valve Replacement (SAVR) or Transcatheter Aortic Valve Implantation (TAVI). Treat heart failure symptoms.


 **Red Flags: Onset of syncope or angina in aortic stenosis indicates very poor prognosis without urgent valve replacement.**

 **Patient Explanation:** "The main valve out of your heart is either too tight (stenosis) or leaky (regurgitation). When it causes symptoms like fainting or breathlessness, it usually needs replacing."

Arterial Ulcers


History (Symptoms)	Painful ulcer on the lower leg/foot, often on toes or lateral malleolus. Pain is worse when leg is elevated, better when hanging over bed. History of smoking, diabetes, peripheral arterial disease.
Examination (Signs)	Punched-out appearance, deep, pale/necrotic base. Surrounding skin is cold, hairless, pale, and shiny. Weak or absent foot pulses.
Bedside / GP	Examine pulses. Ankle-Brachial Pressure Index (ABPI) <0.8 indicates arterial disease.
Investigations	Doppler ultrasound. CT or MR Angiography of lower limbs to assess extent of disease.
Management (NICE/BNF)	<p>DO NOT USE COMPRESSION BANDAGING. Refer to vascular surgery. Risk factor modification (stop smoking, Statins, Aspirin). Revascularisation (angioplasty/bypass).</p> <p>BNF/BNFC Dosage Guide:</p> <ul style="list-style-type: none">• Aspirin 300mg STAT (Emergency) or 75mg OD (Maintenance)


 **Red Flags: Critical limb ischaemia (rest pain, gangrene, ABPI <0.5). High risk of amputation without urgent surgical intervention.**

 *Patient Explanation: "A wound caused by poor blood supply carrying oxygen to the leg. They are very painful. We cannot use tight bandages; instead, we need to try and improve the blood flow, often with surgery."*

Asbestos-related lung disease


History (Symptoms)	Occupational history of asbestos exposure (builders, plumbers, shipyard workers 20-40 years ago). Progressive breathlessness, dry cough. May be asymptomatic if just pleural plaques.
Examination (Signs)	Fine end-inspiratory crackles, finger clubbing (in asbestosis). Signs of pleural effusion (dull percussion, reduced breath sounds).
Bedside / GP	Detailed occupational history is crucial. Pulse oximetry.
Investigations	Chest X-ray (pleural plaques, lower zone fibrosis). High Resolution CT (HRCT). Spirometry (restrictive pattern).
Management (NICE/BNF)	No curative treatment. Symptomatic relief, smoking cessation (smoking + asbestos massively increases lung cancer risk). Industrial injuries compensation claims.


 **Red Flags: Mesothelioma (pleural cancer): unilateral chest pain, massive recurrent pleural effusion, weight loss.**

 *Patient Explanation: "Lung scarring caused by breathing in asbestos dust many years ago. It makes lungs stiff and causes breathlessness. There is no cure, but we monitor for complications like lung cancer."*

Atopic Dermatitis (Eczema)


History (Symptoms)	Intense itching, dry skin, recurrent red/flaky patches. Often starts in childhood. Personal or family history of atopy (asthma, hayfever, eczema).
Examination (Signs)	Erythematous, scaling, excoriated (scratched) plaques. Distribution: flexor surfaces (creases of elbows, backs of knees) in adults/older children; face and extensors in infants.
Bedside / GP	Identify triggers (soaps, stress, weather, pets).
Investigations	Clinical diagnosis. Swab if bacterial or viral infection suspected.
Management (NICE/BNF)	Copious emollients (moisturisers) multiple times a day. Topical corticosteroids for flares (mild on face, stronger on body). Avoid soap (use soap substitutes).


 **Red Flags: Eczema herpeticum: rapid worsening with painful, punched-out blisters (HSV infection) - requires urgent oral/IV Aciclovir. Secondary bacterial infection.**

 *Patient Explanation: "A common condition where the skin barrier is dry and easily irritated, causing intensely itchy red patches. Copious moisturiser and steroid creams during flare-ups help control it."*

Atrophic Vaginitis


History (Symptoms)	Post-menopausal woman. Vaginal dryness, burning, itching, dyspareunia (painful sex), occasional light spotting, recurrent UTIs or urinary frequency.
Examination (Signs)	Pale, thin, dry, and smooth vaginal mucosa on speculum examination. Loss of vaginal rugae.
Bedside / GP	Urine dipstick (if urinary symptoms to rule out UTI).
Investigations	Clinical diagnosis based on symptoms and low oestrogen state. Swabs if infection suspected.
Management (NICE/BNF)	First line: Non-hormonal vaginal moisturisers and lubricants. Second line: Topical vaginal oestrogen (creams, pessaries, or rings) unless contraindicated.


 **Red Flags: Any significant post-menopausal bleeding must still be investigated with a 2-week wait referral for an ultrasound to rule out endometrial cancer.**

 *Patient Explanation: "Thinning and drying of the vaginal walls due to a drop in oestrogen after the menopause. It can be uncomfortable, but vaginal moisturisers and local oestrogen creams work very well."*

Attention Deficit Hyperactivity Disorder (ADHD)


History (Symptoms)	Symptoms present before age 12, in >1 setting (home and school/work). Inattention (easily distracted, forgets things), Hyperactivity (fidgeting, can't sit still), Impulsivity (interrupts, acts without thinking).
Examination (Signs)	Observation of behaviour during consultation (though may mask symptoms).
Bedside / GP	Conners' rating scales or similar questionnaires completed by parents/teachers/patient.
Investigations	Specialist psychiatric/paediatric assessment.
Management (NICE/BNF)	Children: Parent-training/education first. Meds if severe. Adults/Severe: Stimulants (Methylphenidate, Lisdexamfetamine) or non-stimulants (Atomoxetine).


 **Red Flags: Cardiovascular risks with stimulant medications (must check baseline BP, HR, and ECG if family hx of sudden cardiac death). Increased risk of substance abuse.**

 *Patient Explanation: "A neurodevelopmental condition that affects focus, self-control, and physical restlessness. It's managed with specific behavioural strategies and often medication that helps the brain concentrate."*

Autism Spectrum Disorder


History (Symptoms)	Deficits in social communication/interaction (poor eye contact, lack of back-and-forth conversation). Restricted, repetitive patterns of behaviour, interests, or activities (stimming, strict routines, sensory sensitivities).
Examination (Signs)	Observation of play (in children), interaction style, literal interpretation of language.
Bedside / GP	Developmental milestones history.
Investigations	Multidisciplinary specialist assessment (Paediatrician, Speech and Language, Psychology). Questionnaires like the M-CHAT or ADOS.
Management (NICE/BNF)	No medical 'cure'. Supportive therapies (Speech and Language Therapy, Occupational Therapy). Educational support (EHCP in schools). Routine and structured environment.


 **Red Flags: Regression of previously acquired language or social skills requires urgent neurological investigation.**

 *Patient Explanation: "A lifelong developmental condition affecting how people communicate and interact with the world. People with autism may have intense special interests and prefer strict routines."*

Bacterial Vaginosis


History (Symptoms)	Thin, watery, grey/white vaginal discharge with a characteristic 'fishy' odour, especially noticeable after sex. NO soreness or severe itching.
Examination (Signs)	Thin, homogenous discharge coating the vaginal walls. No signs of inflammation (vulva/vagina are not red or sore).
Bedside / GP	Vaginal pH > 4.5. 'Whiff test' (adding potassium hydroxide to sample produces fishy smell).
Investigations	High vaginal swab for microscopy (shows 'clue cells' and reduced lactobacilli).
Management (NICE/BNF)	Oral Metronidazole for 5-7 days, OR topical Metronidazole/Clindamycin gel. Advise avoiding vaginal douching and perfumed soaps.


 **Red Flags: Increased risk of pre-term labour if pregnant and symptomatic. Increased risk of acquiring other STIs.**

 **Patient Explanation:** "An imbalance of the natural bacteria in the vagina, causing a watery discharge with a fishy smell. It is not a sexually transmitted infection. Antibiotics and avoiding scented soaps help clear it."

Basal Cell Carcinoma (BCC)

History (Symptoms)	Slow-growing, painless skin lesion on sun-exposed areas (face, neck, ears). Non-healing 'scab' that occasionally bleeds.
Examination (Signs)	Nodular BCC: 'Pearly' nodule with a rolled edge, central ulceration, and visible tiny blood vessels (telangiectasia). Superficial BCC: red, scaly patch.
Bedside / GP	Dermoscopy reveals arborising vessels.
Investigations	Excision biopsy or punch biopsy for histology.
Management (NICE/BNF)	Surgical excision with standard margins. Alternatives for low-risk/superficial lesions: Topical Imiquimod, Cryotherapy, or Photodynamic Therapy (PDT). Mohs micrographic surgery for high-risk facial sites.

 **Red Flags: Lesions near the eyes/nose can cause significant local tissue destruction if left untreated, though BCCs practically never spread to other organs (no metastasis).**

 *Patient Explanation: "The most common and least dangerous type of skin cancer. It grows very slowly and almost never spreads, but it needs removing to stop it damaging the surrounding skin."*

Bell's Palsy

History (Symptoms) Acute onset (over hours to a few days) of unilateral facial weakness. May have altered taste, hyperacusis (sounds seem too loud), or pain behind the ear. No other neurological symptoms.

Examination (Signs) Lower Motor Neuron (LMN) facial nerve (CN VII) palsy: Affects the ENTIRE half of the face, including the forehead (patient cannot wrinkle forehead or close eye properly on affected side).


Bedside / GP Full cranial nerve examination to rule out other deficits. Check ears (for vesicles - Ramsay Hunt syndrome).


Investigations Clinical diagnosis. Exclude stroke, Lyme disease, and middle ear infection.

Management (NICE/BNF) Oral Prednisolone (steroids) started within 72 hours of onset. Eye care is critical: lubricating drops and taping eye closed at night to prevent corneal ulcers.

BNF/BNFC Dosage Guide:


- Prednisolone 40mg OD PO (Adult Acute Asthma) | 1-2mg/kg PO (Child)


 **Red Flags: Forehead sparing (patient CAN wrinkle forehead) indicates an Upper Motor Neuron lesion (i.e., a Stroke), NOT Bell's palsy.**

 *Patient Explanation: "A temporary weakness of the nerve controlling your facial muscles, usually caused by a viral inflammation. Steroids speed up recovery, and it's vital to keep your eye protected if it won't close."*

Benign Paroxysmal Positional Vertigo (BPPV)


History (Symptoms)	Short episodes of intense room-spinning vertigo lasting seconds to a minute, triggered by specific head movements (e.g., rolling over in bed, looking up).
Examination (Signs)	Normal hearing. Positive Dix-Hallpike manoeuvre (triggers vertigo and horizontal/torsional nystagmus).
Bedside / GP	Dix-Hallpike manoeuvre (diagnostic).
Investigations	Usually none required if classic history and positive Dix-Hallpike.
Management (NICE/BNF)	Epley manoeuvre (repositioning particle movement) performed in clinic. Patient can do Brandt-Daroff exercises at home.


 **Red Flags: Vertigo associated with headache, focal neurological signs, or hearing loss/tinnitus (points to stroke, acoustic neuroma, or Meniere's disease).**

 *Patient Explanation: "Tiny calcium crystals in your inner ear have broken loose and are confusing your balance sensors. Moving your head in a specific sequence (Epley manoeuvre) tips the crystals back where they belong."*

Benign Prostatic Hyperplasia (BPH)


History (Symptoms)	Older man. Lower Urinary Tract Symptoms (LUTS): Voiding (hesitancy, weak stream, straining, incomplete emptying) and Storage (frequency, urgency, nocturia).
Examination (Signs)	Palpable bladder if retaining urine. Digital Rectal Examination (DRE): enlarged, smooth, firm, symmetrical prostate with a central sulcus.
Bedside / GP	International Prostate Symptom Score (IPSS). Urine dipstick (rule out UTI/ blood). Bladder scan for post-void residual.
Investigations	Bloods: U&Es (check renal function), PSA (to counsel and rule out cancer).
Management (NICE/BNF)	Lifestyle: reduce caffeine/fluids before bed. Medical: Alpha-blockers (Tamsulosin) relax muscle, 5-alpha reductase inhibitors (Finasteride) shrink prostate. Surgical: TURP.


 **Red Flags: Acute urinary retention (painful inability to pee), recurrent UTIs, renal failure (post-renal AKI), or a hard, nodular prostate on DRE (Cancer).**

 *Patient Explanation: "The prostate gland naturally enlarges as men age, squeezing the tube that carries urine. Medication can relax the muscle or shrink the gland to make it easier to pee."*

Bladder Cancer

History (Symptoms)	Painless, visible haematuria (blood in the urine) is the most common presentation. May have recurrent UTIs or irritative voiding symptoms (dysuria, urgency). High risk: smoking, dye industry workers.
Examination (Signs)	Often normal physically. Late signs: pelvic mass, weight loss.
Bedside / GP	Urine dipstick (confirms haematuria).
Investigations	Urgent (2-week wait) referral. Flexible cystoscopy (direct visualization) is gold standard. CT Urogram for upper tract/staging. Urine cytology.
Management (NICE/BNF)	Non-muscle invasive: Transurethral resection of bladder tumour (TURBT) +/- intravesical BCG/chemotherapy. Muscle-invasive: Radical cystectomy or Radiotherapy.

 **Red Flags: Unexplained visible haematuria in ANY patient >45 years old requires a 2-week wait cancer referral.**

 *Patient Explanation: "A cancer lining the inside of the bladder, strongly linked to smoking. It usually causes painless bleeding in the urine. We investigate it with a camera test into the bladder."*

Blepharitis

History (Symptoms) Bilateral gritty, itchy, red, burning eyes. Eyelids stuck together in the morning. Chronic relapsing condition. Often associated with Rosacea or Seborrhoeic dermatitis.

Examination (Signs) Inflamed, red lid margins. Crusts or 'scurf' at the base of the eyelashes. Meibomian gland dysfunction.

Bedside / GP External eye examination. Visual acuity (should be normal).

Investigations Clinical diagnosis. Swabs only if severe purulent discharge.

Management (NICE/BNF) Eyelid hygiene is key: warm compresses, lid massage, and cleaning with diluted baby shampoo/bicarbonate. Artificial tears for dry eyes. Severe: oral tetracyclines (Lymecycline).

BNF/BNFC Dosage Guide:

- Lymecycline 408mg OD (Avoid in pregnancy/children <12)



Red Flags: Unilateral symptoms, vision loss, severe pain, or ulceration of the cornea.



Patient Explanation: "Chronic inflammation of the edges of the eyelids, often due to blocked oil glands. Regular cleaning with warm flannels and lid massage keeps it under control."

Cardiac Arrest

History (Symptoms) Sudden collapse, unresponsive, not breathing or gasping (agonal breathing). Often caused by Myocardial Infarction, arrhythmias, hypoxia, or severe trauma.

Examination (Signs) Unresponsive. Absent central pulse (carotid). No signs of life.


Bedside / GP IMMEDIATE assessment (Danger, Response, Airway, Breathing).


Investigations Attach defibrillator pads immediately to check rhythm: Shockable (Ventricular Fibrillation, Pulseless Ventricular Tachycardia) vs Non-shockable (Asystole, PEA).

Management (NICE/BNF) Immediate high-quality CPR (30 compressions: 2 breaths). Early defibrillation if shockable. IV Adrenaline & Amiodarone per ALS algorithm. Identify and treat reversible causes (4Hs and 4Ts).

BNF/BNFC Dosage Guide:


- Adrenaline 1:1000 0.5mg (0.5mL) IM (Adult Anaphylaxis) | 0.15-0.3mg IM (Child)


 **Red Flags: Failure to recognise agonal breathing as cardiac arrest. Delays to starting CPR and defibrillation dramatically reduce survival.**

 *Patient Explanation: "The heart has completely stopped pumping blood. Immediate chest compressions and an automated defibrillator (shock box) are needed to try and restart it."*

Carpal Tunnel Syndrome


History (Symptoms)	Pain, tingling, and numbness in the thumb, index, and middle fingers (median nerve distribution). Worse at night, often wakes patient. Shaking the hand relieves symptoms.
Examination (Signs)	Wasting of the thenar eminence (thumb muscle). Positive Tinel's sign (tapping wrist causes tingling). Positive Phalen's test (wrist flexion causes symptoms).
Bedside / GP	Check for underlying causes (pregnancy, hypothyroidism, diabetes).
Investigations	Often a clinical diagnosis. Nerve conduction studies (NCS) if diagnosis is in doubt or prior to surgery.
Management (NICE/BNF)	First line: Nocturnal wrist splint. Second line: Local corticosteroid injection. Definitive: Carpal tunnel release surgery.


 **Red Flags: Severe motor weakness or profound muscle wasting requires urgent surgical decompression to prevent permanent nerve damage.**

 *Patient Explanation: "The main nerve to your hand is being squished as it passes through a narrow tunnel in your wrist. A splint worn at night keeps the wrist straight and gives the nerve room."*

Cataracts


History (Symptoms)	Gradual, painless blurring of vision. Glare from bright lights (especially headlights when driving at night). 'Washed out' colours. Increasing age is the main risk factor.
Examination (Signs)	Reduced visual acuity. Loss of the red reflex on fundoscopy (appears as a dark shadow or opacity against the red background). A white pupil (leukocoria) in advanced cases.
Bedside / GP	Visual acuity test (Snellen chart). Ophthalmoscopy (check red reflex).
Investigations	Specialist assessment by an optometrist or ophthalmologist using a slit lamp.
Management (NICE/BNF)	Conservative: update glasses prescription. Surgical: Phacoemulsification (removal of the cloudy lens and replacement with an artificial intraocular lens) when it affects daily life.


 **Red Flags: Leukocoria (white pupil) in a child must be urgently investigated to rule out Retinoblastoma (eye cancer).**

 *Patient Explanation: "The natural lens inside your eye has become cloudy with age, making your vision blurry and sensitive to glare. A very common and quick operation can replace it with a clear artificial lens."*

Cervical Cancer

History (Symptoms)	Post-coital bleeding (bleeding after sex), intermenstrual bleeding, abnormal vaginal discharge, pelvic pain. Often asymptomatic and picked up on screening.
Examination (Signs)	Speculum examination: visible abnormal, bleeding, or ulcerated mass on the cervix. Hard/fixed cervix on bimanual examination.
Bedside / GP	Smear test (if due for screening). Full STI screen.
Investigations	Urgent 2-week-wait colposcopy. Cervical biopsy. CT/MRI pelvis for staging.
Management (NICE/BNF)	Early: LLETZ (Large Loop Excision of the Transformation Zone) or Radical Hysterectomy. Advanced: Chemoradiotherapy.

 **Red Flags: Any unexplained visible mass on the cervix or persistent post-coital bleeding needs an urgent 2-week-wait referral.**

 *Patient Explanation: "Cancer of the neck of the womb, usually caused by the HPV virus. We catch early changes through the cervical smear program to prevent it developing into cancer."*

Cholecystitis (Acute)

History (Symptoms) Continuous, severe Right Upper Quadrant (RUQ) or epigastric pain lasting >6 hours. Associated with fever, nausea, vomiting. History of gallstones.

Examination (Signs) Fever, tachycardia. RUQ tenderness. Positive Murphy's sign (patient catches breath when you press RUQ and they breathe in).


Bedside / GP Vital signs (fever). Urine dipstick.


Investigations Bloods: Raised WBC and CRP. LFTs usually normal (or mildly deranged).
First-line imaging: Abdominal Ultrasound (thickened gallbladder wall, gallstones, pericholecystic fluid).

Management (NICE/BNF) Hospital admission. NBM, IV fluids, IV antibiotics (e.g., Co-amoxiclav). Early laparoscopic cholecystectomy (usually within 72 hours).

BNF/BNFC Dosage Guide:


- Co-amoxiclav 625mg TDS PO or 1.2g IV TDS


 **Red Flags: Jaundice indicates a stone has slipped into the common bile duct (Cholelithiasis). Sepsis/Septic shock.**

 *Patient Explanation: "A gallstone has become stuck in the neck of your gallbladder, causing it to become severely inflamed and infected. You need hospital antibiotics and an operation to remove it."*

Cluster Headache


History (Symptoms)	Strictly unilateral, excruciating pain around the eye. Lasts 15-180 minutes. Occurs in 'clusters' (e.g., 1-2 times a day for weeks, then disappears for months). Common in male smokers.
Examination (Signs)	During attack: Agitated/restless pacing. Ipsilateral autonomic signs: watery eye, nasal congestion, eyelid drooping (Horner's syndrome), facial sweating.
Bedside / GP	Assess cranial nerves to rule out structural pathology.
Investigations	Clinical diagnosis. MRI brain if atypical or first presentation to rule out secondary causes.
Management (NICE/BNF)	Acute: 100% High-flow Oxygen (12L/min via non-rebreathe mask) AND Subcutaneous Triptan (e.g., Sumatriptan). Prophylaxis: Verapamil.


 **Red Flags: New onset cluster-like headache in >50s, signs of raised ICP. Must rule out glaucoma and carotid artery dissection.**

 *Patient Explanation: "One of the most painful headache conditions known, sometimes called 'suicide headaches'. It causes severe pain behind one eye with a runny nose. Standard painkillers don't work; we use pure oxygen and injections."*

Compartment Syndrome


History (Symptoms)	Severe pain that is out of proportion to the injury (often a tibia/forearm fracture). Pain is unremitting and not relieved by strong opioids.
Examination (Signs)	Pain on PASSIVE stretch of the muscles in that compartment is the most reliable early sign. The limb feels tense/wood-like. Late signs: Pulseless, pallor, paralysis, paraesthesia.
Bedside / GP	Palpate limb tension, passive stretch test.
Investigations	Diagnosis is mostly clinical. Direct intra-compartmental pressure monitoring (>30 mmHg confirms diagnosis).
Management (NICE/BNF)	Surgical emergency. Immediate removal of all restrictive casts/bandages. Urgent Fasciotomy (surgical release of the fascia) to relieve pressure.


 **Red Flags: Waiting for the '5 Ps' (Pulseless, Pallor, etc.) is dangerous—these are late signs of irreversible muscle and nerve death.**

 *Patient Explanation: "Extreme swelling inside a muscle compartment after a break or crush injury. The pressure cuts off the blood supply. It requires an emergency operation to slice open the tough skin covering the muscle and relieve the pressure."*

Conjunctivitis

History (Symptoms)	Bacterial: Purulent (sticky/yellow) discharge, eyes stuck shut in morning. Viral: Watery discharge, recent cold. Allergic: Intensely itchy, watery, bilateral.
Examination (Signs)	Diffuse redness (conjunctival injection). Normal visual acuity, normal pupil reactivity, no photophobia. Cornea is clear.
Bedside / GP	Visual acuity test (must be normal). Check for pre-auricular lymph nodes (common in viral).
Investigations	Clinical diagnosis. Eye swab only if severe, non-resolving, or in neonates (Chlamydia/Gonorrhoea risk).
Management (NICE/BNF)	Bacterial: Often self-limiting, Chloramphenicol drops if severe. Viral: Supportive (cold compresses), contagious. Allergic: Topical antihistamines.

 **Red Flags: Reduced vision, severe pain, photophobia, fixed/irregular pupil, cloudy cornea (All point to dangerous red eye causes like Uveitis, Glaucoma, or Keratitis).**

 *Patient Explanation: "An inflammation of the clear membrane over the white part of your eye. It makes the eye red and crusty or watery. Most cases get better on their own with cleaning, but some need antibiotic drops."*

Croup (Laryngotracheobronchitis)

History (Symptoms) Child (typically 6 months - 3 years). Coryzal symptoms (runny nose) followed by a characteristic harsh 'barking' seal-like cough, hoarse voice, and stridor. Worse at night.

Examination (Signs) Inspiratory stridor (high-pitched noise breathing in), barking cough. Assess for respiratory distress (chest recession, tracheal tug, tachypnoea).


Bedside / GP Calculate Westley Croup Score. Check SpO₂.


Investigations Clinical diagnosis. NO Throat Swabs/blood tests (distressing a child with severe croup can cause complete airway obstruction).

Management (NICE/BNF) Mild/Mod/Severe: Single dose of oral Dexamethasone (0.15mg/kg). Severe/Life-threatening: Oxygen, Nebulised Adrenaline, PICU admission.

BNF/BNFC Dosage Guide:


- Adrenaline 1:1000 0.5mg (0.5mL) IM (Adult Anaphylaxis) | 0.15-0.3mg IM (Child)
- Dexamethasone 0.15mg/kg PO STAT (Croup)


 **Red Flags: Drooling, toxic appearance, no cough, high fever (Points to Epiglottitis - DO NOT examine throat, call an anaesthetist!).**

 **Patient Explanation:** "A common childhood viral infection of the voice box and windpipe. It causes a distinct 'barking' cough. A single dose of steroid medicine helps reduce the swelling in their throat."

Cushing's Syndrome


History (Symptoms)	Weight gain (central), easy bruising, proximal muscle weakness (can't stand from chair), depression, irregular periods, hirsutism. Usually caused by long-term steroid medication.
Examination (Signs)	Moon face, buffalo hump (fat pad on back of neck), central obesity, purple abdominal striae (stretch marks), thin skin, hypertension.
Bedside / GP	Check blood pressure, BMI. Check medication history for exogenous steroids.
Investigations	Overnight Dexamethasone Suppression Test (cortisol will not suppress). 24h urinary free cortisol. ACTH levels to determine source (Pituitary vs Adrenal).
Management (NICE/BNF)	Exogenous: Gradually taper down steroid meds (DO NOT stop abruptly). Endogenous: Surgical removal of the responsible tumour (Pituitary or Adrenal).


 **Red Flags: Sudden withdrawal of long-term steroids can trigger a life-threatening Addisonian/Adrenal crisis.**

 *Patient Explanation: "Your body has too much of the stress hormone 'cortisol', usually from taking steroid tablets for a long time. It causes weight gain around the middle and a puffy face. We must reduce the tablets very slowly."*

Cystic Fibrosis


History (Symptoms)	Usually diagnosed at birth via heel prick. Recurrent severe chest infections, chronic productive cough, faltering growth (failure to thrive), loose/oily stools (steatorrhoea).
Examination (Signs)	Finger clubbing, hyperinflated chest, coarse crepitations/wheeze. Signs of malnutrition.
Bedside / GP	Newborn blood spot screening (immunoreactive trypsinogen).
Investigations	Sweat Test (gold standard: high sweat chloride >60mmol/L). Genetic testing for CFTR mutations (most common is delta-F508).
Management (NICE/BNF)	MDT care. Chest physiotherapy, prophylactic antibiotics, bronchodilators, Creon (pancreatic enzyme replacement) with meals. CFTR modulators (e.g., Kaftrio).


 **Red Flags: Massive haemoptysis, pneumothorax, severe exacerbations requiring IV antibiotics (Pseudomonas infections).**

 *Patient Explanation: "A genetic condition that makes the body's mucus extremely thick and sticky. This blocks the lungs (causing infections) and the pancreas (causing digestive problems). It requires daily intensive therapies."*

Acute Limb Ischaemia


History (Symptoms)	Sudden onset of severe, unremitting leg pain. Associated with numbness and inability to move the foot/leg. Often a history of Atrial Fibrillation (embolus) or peripheral arterial disease (thrombosis).
Examination (Signs)	The '6 Ps': Pain, Pallor, Pulselessness, Paraesthesia (numbness), Paralysis (weakness), Perishingly cold.
Bedside / GP	Immediate ABPI (usually unrecordable). Check for pulses using a handheld Doppler. 12-lead ECG to look for AF.
Investigations	Urgent CT Angiogram or formal lower limb angiography. Bloods (Group and Save, Coagulation, U&Es).
Management (NICE/BNF)	Surgical Emergency. Immediate IV Heparin. Urgent vascular surgery referral for Embolectomy, Thrombolysis, or Bypass.


 **Red Flags: Paralysis or paraesthesia indicates severe, late-stage ischaemia with imminent muscle/nerve death. Requires intervention within 4-6 hours to save the limb.**

 *Patient Explanation: "A sudden blockage of the blood supply to your leg, usually by a blood clot. The leg becomes cold, pale, and intensely painful. It is an emergency needing an operation to clear the clot and save the leg."*

Biliary Atresia

History (Symptoms)	Neonate presenting with prolonged jaundice (>14 days in term, >21 days in preterm babies). Passing pale (chalky) stools and dark urine.
Examination (Signs)	Jaundice. Hepatomegaly (enlarged liver). Faltering growth.
Bedside / GP	Inspect nappy for pale stools and dark urine.
Investigations	Split bilirubin blood test (shows high CONJUGATED bilirubin). Liver ultrasound (absent/abnormal gallbladder). Cholangiogram (definitive).
Management (NICE/BNF)	Urgent Kasai procedure (hepatportoenterostomy) to restore bile flow, ideally before 8 weeks of life. Ultimately, most will need a liver transplant.

 **Red Flags: Unconjugated jaundice is common and usually harmless (breast milk jaundice), but prolonged CONJUGATED jaundice with pale stools is an absolute red flag for liver/biliary disease.**

 *Patient Explanation: "A rare but serious disease in babies where the tubes carrying bile from the liver to the gut are blocked or absent. This damages the liver and needs a major operation very early in life."*

Brain Abscess

History (Symptoms) Headache (often dull and constant), fever, focal neurological deficits (e.g., limb weakness, speech difficulty), seizures, confusion. History of ear/sinus infection, head trauma, or endocarditis.

Examination (Signs) Fever, altered GCS, focal weakness/sensory loss, papilloedema (signs of raised intracranial pressure).


Bedside / GP Full neurological examination including fundoscopy.


Investigations Urgent CT Head with contrast (shows a classic 'ring-enhancing lesion'). MRI Head is gold standard. Blood cultures.

Management (NICE/BNF) Urgent neurosurgical referral for burr hole aspiration/drainage. Prolonged course (6-8 weeks) of IV antibiotics (e.g., Ceftriaxone + Metronidazole).

BNF/BNFC Dosage Guide:

- Ceftriaxone 2g IV BD (Adult Meningitis) | 80mg/kg IV OD (Child)

 **Red Flags: Signs of raised intracranial pressure (reduced consciousness, bradycardia, hypertension). DO NOT perform a lumbar puncture (risk of fatal brain herniation).**

 **Patient Explanation:** "A collection of pus inside the brain, usually spreading from another infection like a severe earache. It causes headaches and weakness, requiring a hospital stay for strong antibiotics and sometimes surgery to drain it."

Brain Metastases

History (Symptoms) Gradual onset, progressively worsening headache (worse in the morning or when coughing/straining), nausea, vomiting, new-onset seizures, personality changes. Known history of cancer (especially lung, breast, or melanoma).

Examination (Signs) Focal neurological deficits depending on location (e.g., hemiparesis, visual field loss). Papilloedema on fundoscopy.


Bedside / GP Full neurological exam.


Investigations MRI Head with contrast is the gold standard (often shows multiple lesions). CT Head with contrast if MRI contraindicated.

Management (NICE/BNF) High-dose oral Dexamethasone to reduce surrounding brain swelling (oedema). Anti-epileptics if seizing. Palliative radiotherapy or occasionally surgical resection.

BNF/BNFC Dosage Guide:

- Dexamethasone 0.15mg/kg PO STAT (Croup)

 **Red Flags: Status epilepticus. Rapid neurological deterioration due to raised ICP.**

 *Patient Explanation: "Cancer that has spread from another part of the body (like the lungs or breast) into the brain. It causes pressure inside the skull. We use steroids to reduce the swelling and ease the headaches."*

Bursitis

History (Symptoms) Localised pain, swelling, and tenderness over a joint (commonly the knee 'housemaid's knee' or elbow 'student's elbow'). Pain is worse with movement or pressure on the area.

Examination (Signs) Fluctuant, well-circumscribed swelling over a bursa. May be red and warm. Joint range of motion is usually preserved (unlike septic arthritis).

Bedside / GP Examine joint range of movement.

Investigations Clinical diagnosis. Ultrasound if diagnosis unclear. Aspiration of fluid if septic bursitis is suspected (to check for bacteria).

Management (NICE/BNF) Rest, ice, NSAIDs, avoidance of pressure (use padding/cushions). If septic: Flucloxacillin. Intra-bursal steroid injections if chronic and non-infected.

BNF/BNFC Dosage Guide:

- Flucloxacillin 500mg QDS PO (Skin infections)




Red Flags: Septic bursitis (severe pain, spreading redness, fever) requires antibiotics to prevent spread to the joint.




Patient Explanation: "Inflammation of a small fluid-filled sac (bursa) that usually cushions your joints. It causes a painful, squishy lump, often on the elbow or kneecap. Rest and painkillers usually resolve it."

Candidiasis (Oral and Vaginal Thrush)


History (Symptoms)	Oral: white patches in mouth, soreness, altered taste. Vaginal: thick, white 'cottage-cheese' discharge, severe vulval itching, superficial dyspareunia. Triggers: recent antibiotics, steroid inhalers, diabetes.
Examination (Signs)	Oral: white plaques that leave a red, bleeding base when scraped off. Vaginal: vulval erythema, thick white discharge.
Bedside / GP	Check capillary blood glucose (uncontrolled diabetes is a major trigger). Check inhaler technique (advise rinsing mouth after steroid inhalers).
Investigations	Usually clinical. Swab for culture if recurrent or resistant to standard treatment.
Management (NICE/BNF)	Oral: Nystatin drops or Miconazole oral gel. Vaginal: Topical Clotrimazole (cream/pessary) or Oral Fluconazole.


 **Red Flags: Oral thrush in a young, healthy adult with no obvious triggers should raise suspicion for HIV/immunosuppression.**

 *Patient Explanation: "A common fungal (yeast) infection. In the mouth it causes sore white patches; down below it causes itching and a thick discharge. Easily treated with anti-fungal creams or tablets."*

Central Retinal Artery Occlusion


History (Symptoms)	Sudden, painless, profound loss of vision in one eye. Often described as a 'curtain coming down'. History of cardiovascular risk factors or atrial fibrillation.
Examination (Signs)	Profoundly reduced visual acuity. Relative Afferent Pupillary Defect (RAPD). Fundoscopy: pale, opaque retina with a classic 'cherry-red spot' at the macula.
Bedside / GP	Visual acuity. Test pupillary reflexes. Assess for cardiovascular risk.
Investigations	Urgent ophthalmology referral. Bloods (ESR/CRP to rule out Temporal Arteritis). Carotid dopplers and ECG/Echo to find the source of the embolus.
Management (NICE/BNF)	Ocular emergency, though outcomes are poor. Ocular massage to dislodge the clot. Medical lowering of intraocular pressure. Secondary prevention (Statins, antiplatelets).


 **Red Flags: Rule out Giant Cell Arteritis (jaw claudication, scalp tenderness, headache) which requires immediate high-dose steroids to save the other eye.**

 *Patient Explanation: "A 'stroke of the eye' where the main blood vessel supplying the retina is blocked by a clot. It causes sudden, painless blindness in that eye. Immediate specialist assessment is needed, but sight is often hard to restore."*

Cerebral Palsy


History (Symptoms)	Delayed motor milestones (not sitting/walking on time), abnormal muscle tone ('floppy' or 'stiff' baby), feeding difficulties. History of premature birth or difficult delivery (hypoxic-ischaemic encephalopathy).
Examination (Signs)	Spasticity (increased tone, brisk reflexes), ataxia, or dyskinesia (involuntary movements). Persistent primitive reflexes (e.g., Moro reflex beyond 6 months).
Bedside / GP	Developmental assessment (check gross/fine motor skills, speech, and social milestones).
Investigations	MRI brain (to identify the structural brain lesion, e.g., periventricular leukomalacia).
Management (NICE/BNF)	MDT approach. Physiotherapy, Occupational therapy, SALT. Medical: Baclofen or Diazepam for severe muscle spasticity. Botulinum toxin injections.


 **Red Flags: Loss of previously acquired milestones indicates a progressive neurological disorder (like a metabolic/genetic disease), NOT cerebral palsy (which is a static, non-progressive injury).**

 *Patient Explanation: "A group of lifelong conditions affecting movement and coordination, caused by damage to the brain before, during, or shortly after birth. While the brain damage doesn't get worse, the physical symptoms require ongoing physiotherapy."*

Chlamydia

History (Symptoms)	Often asymptomatic (especially in women). Men: clear/white urethral discharge, dysuria. Women: post-coital bleeding, intermenstrual bleeding, purulent vaginal discharge, lower abdominal pain.
Examination (Signs)	May be normal. Women: Cervicitis, contact bleeding, cervical excitation (if PID is developing).
Bedside / GP	Full sexual health history and STI screen.
Investigations	Nucleic Acid Amplification Test (NAAT). First-catch urine for men; vulvovaginal swab for women.
Management (NICE/BNF)	First line: Doxycycline 100mg BD for 7 days (Azithromycin is now second line). Treat all partners. Abstain from sex for 7 days after treatment. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Doxycycline 100mg OD/BD PO (Avoid in pregnancy/children)


 **Red Flags: Pelvic Inflammatory Disease (PID) causing scarring of fallopian tubes, leading to chronic pelvic pain, ectopic pregnancies, and infertility.**

 *Patient Explanation: "The most common sexually transmitted bacterial infection. It often has no symptoms but can cause discharge and pain. It is easily cured with a week of antibiotics, but partners must also be treated."*

Constipation (Paediatric and Adult)

History (Symptoms)	Infrequent bowel movements (<3 per week), hard/lumpy stools, straining, feeling of incomplete emptying. In children: soiling/overflow incontinence, withholding behaviours (dancing, crossing legs).
Examination (Signs)	Palpable faecal mass in the abdomen (often left iliac fossa). Anal fissure may be visible. DRE in adults if suspecting impaction or cancer.
Bedside / GP	Review diet (fibre/fluid intake) and medications (opioids, anticholinergics).
Investigations	Clinical diagnosis. TFTs/Calcium in adults if refractory. Coeliac screen/TFTs in children if faltering growth.
Management (NICE/BNF)	Adults: Lifestyle -> Bulk-forming (Ispaghula) -> Osmotic (Macrogol) -> Stimulant (Senna). Children: Macrogol (Movicol) first line as a disimpaction regimen, then maintenance.

 **Red Flags: Adults: Change in bowel habit >60 years old, weight loss, PR bleeding (requires 2-week-wait for Colorectal Cancer). Children: delayed passage of meconium (>48h) suggests Hirschsprung's disease.**

 **Patient Explanation:** "Difficulty passing stool, usually due to a lack of fibre or water, or certain medications. In kids, it often starts after a painful poop, causing them to hold it in. Laxatives help soften the stool to break the cycle."

Contact Dermatitis

History (Symptoms) Itchy, red, blistering or scaly rash that appears directly in the area exposed to a specific substance (e.g., nickel jewellery, new cosmetics, cleaning chemicals, latex).

Examination (Signs) Erythema, vesicles, or scaling restricted closely to the area of contact with the offending agent.

Bedside / GP Detailed history of occupational and personal exposures.

Investigations Clinical diagnosis. Patch testing (performed by dermatology) can identify specific allergens if allergic contact dermatitis is suspected.

Management (NICE/BNF) Identify and avoid the trigger. Emollients. Topical corticosteroids (e.g., Hydrocortisone or Betamethasone) for active flares.

BNF/BNFC Dosage Guide:

- Hydrocortisone 100mg IV QDS (Severe Asthma/Emergency)




Red Flags: Occupational dermatitis causing significant time off work may require industrial injuries assessment.




Patient Explanation: "An itchy red rash that breaks out because your skin has reacted to something it touched, like cheap jewellery or strong soaps. Avoiding the trigger and using a steroid cream helps it heal."

Cord Prolapse


History (Symptoms)	Obstetric emergency. Usually occurs after the membranes rupture ('waters break'). The mother may feel something in her vagina.
Examination (Signs)	The umbilical cord is palpable or visible in the vagina past the presenting part of the fetus. Fetal heart rate drops significantly (profound bradycardia) due to cord compression.
Bedside / GP	Vaginal examination to feel the cord. CTG monitoring of fetal heart.
Investigations	Clinical diagnosis. No further investigations needed before action.
Management (NICE/BNF)	EMERGENCY. Call for help (Crash Caesarean). Examiner keeps their hand in the vagina to push the baby's head UP and OFF the cord. Place mother in knee-chest position. Immediate delivery.


 **Red Flags: If the cord is compressed between the baby's head and the pelvis, the baby will suffer profound hypoxia and die within minutes. Do NOT attempt to push the cord back inside.**

 *Patient Explanation: "A severe birth emergency where the baby's umbilical cord drops down into the birth canal ahead of the baby. The baby's head squashes the cord, cutting off its oxygen, requiring an immediate emergency caesarean."*

COVID-19


History (Symptoms)	Fever, new continuous cough, loss of/change in sense of smell or taste (anosmia). Shortness of breath, fatigue, myalgia. Can progress to severe respiratory failure.
Examination (Signs)	Fever, tachypnoea, hypoxia. Bilateral widespread crackles.
Bedside / GP	Pulse oximetry (monitor for 'silent hypoxia' where patient feels okay despite very low SpO ₂).
Investigations	PCR swab or rapid antigen test. CXR: bilateral ground-glass opacities. Bloods: lymphopenia, high CRP, high D-dimer.
Management (NICE/BNF)	Mild: Supportive. Severe/Hospitalised: Oxygen (target 94-98%), Dexamethasone (reduces mortality), Antivirals (e.g., Paxlovid) or monoclonal antibodies for high-risk. Prophylactic LMWH for clots. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Dexamethasone 0.15mg/kg PO STAT (Croup)


 **Red Flags: Significant oxygen desaturation on exertion. Development of pulmonary embolism.**

 *Patient Explanation: "A viral infection causing anything from mild cold symptoms to severe pneumonia. In severe cases, it causes dangerous drops in oxygen requiring hospital oxygen and steroid treatments."*

Crystal Arthropathy (Gout)

History (Symptoms)	Sudden onset of extreme pain, redness, and swelling in a single joint, peaking within 12-24 hours. Most commonly the 1st MTP joint (big toe). Triggered by alcohol, purine-rich foods, or dehydration.
Examination (Signs)	Extremely tender, red, hot, swollen joint. Patient cannot bear a bedsheet touching it. Tophi (white chalky nodules) may be present on ears or joints in chronic cases.
Bedside / GP	Assess joint. Check temperature (can cause mild fever).
Investigations	Joint aspiration (gold standard): shows needle-shaped, negatively birefringent urate crystals. Serum Uric Acid (check 2-4 weeks AFTER the flare, as it may be normal during the acute attack).
Management (NICE/BNF)	Acute: High-dose NSAIDs (Naproxen) OR Colchicine OR oral Corticosteroids. Preventative: Allopurinol (start only after the acute flare has settled).

 **Red Flags: Septic arthritis is the main differential and is a medical emergency. Joint aspiration must be done if there is any doubt.**

 *Patient Explanation: "High levels of uric acid in your blood form sharp crystals inside a joint (usually the big toe), causing a sudden, incredibly painful, red, hot swelling. We treat the pain first, then start tablets later to prevent it returning."*

Disseminated Intravascular Coagulation (DIC)

History (Symptoms)	Critically ill patient (e.g., severe sepsis, major trauma, obstetric emergencies like placental abruption). Spontaneous bleeding from venepuncture sites, nose, gums, or GI tract. Bruising.
Examination (Signs)	Extensive bruising (purpura/ecchymoses), oozing from IV lines, signs of the underlying severe illness/shock.
Bedside / GP	Continuous vital sign monitoring.
Investigations	Bloods: Low platelets, prolonged PT and APTT, very low Fibrinogen, heavily elevated D-dimer. Blood film shows schistocytes (fragmented red cells).
Management (NICE/BNF)	Treat the underlying cause aggressively (e.g., antibiotics for sepsis, deliver baby in abruption). Supportive blood products (Fresh Frozen Plasma, Platelets, Cryoprecipitate) if actively bleeding.



Red Flags: A highly lethal condition if the underlying cause is not rapidly reversed.




Patient Explanation: "A life-threatening complication of severe illness where the body's clotting system goes haywire. It forms tiny clots everywhere, using up all the clotting factors, which paradoxically causes severe, uncontrollable bleeding."


Drug Overdose (Paracetamol)

History (Symptoms)	Intentional or accidental overdose. Often entirely asymptomatic in the first 24 hours. Later: nausea, vomiting, right upper quadrant pain, confusion (encephalopathy).
Examination (Signs)	Early: normal. Late (Days 2-3): jaundice, hepatomegaly, asterixis (flapping tremor), coma.
Bedside / GP	Determine EXACT time of ingestion and total dose taken.
Investigations	Paracetamol level (must be taken at least 4 hours post-ingestion). LFTs (massive rise in ALT/AST), Coagulation (rising PT/INR indicates liver failure), U&Es, Venous blood gas.
Management (NICE/BNF)	Plot paracetamol level on the treatment nomogram. Give IV N-acetylcysteine (NAC) immediately if above the treatment line or if staggered/unknown time of overdose.

BNF/BNFC Dosage Guide:


- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)


 **Red Flags: Arterial pH < 7.3, severely deranged PT, or encephalopathy indicates fulminant liver failure and requires urgent discussion with a liver transplant centre.**

 *Patient Explanation: "An overdose of paracetamol is very dangerous because it silently destroys the liver over a few days. We must do a blood test and give a protective antidote drip quickly to save the liver."*

Epiglottitis


History (Symptoms)	Child (now rarer due to Hib vaccine) or adult. Rapid onset of high fever, severe sore throat, difficulty swallowing (dysphagia), and muffled voice.
Examination (Signs)	Patient appears toxic, drooling saliva, sitting forward with neck extended ('tripod' position). Inspiratory stridor.
Bedside / GP	DO NOT EXAMINE THE THROAT. Do not upset the child. Immediate call for senior help.
Investigations	No investigations should delay airway management. Done by anaesthetists in theatre.
Management (NICE/BNF)	Medical Emergency. Secure airway in theatre (intubation) by senior anaesthetist/ENT. IV antibiotics (e.g., Ceftriaxone) and IV Dexamethasone. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Dexamethasone 0.15mg/kg PO STAT (Croup)• Ceftriaxone 2g IV BD (Adult Meningitis) 80mg/kg IV OD (Child)


 **Red Flags: Examining the throat with a tongue depressor or making the child cry can cause complete, sudden airway obstruction and death.**

 **Patient Explanation:** "A severe bacterial infection causing the flap at the back of the throat to swell massively. It can block the airway completely. It requires an emergency doctor to safely secure a breathing tube."

Extradural Haemorrhage

History (Symptoms)	History of head trauma (often a blow to the side of the head/temple). Classic presentation: Initial loss of consciousness, followed by a 'lucid interval' where the patient wakes up and seems fine, followed by rapid neurological deterioration and coma.
Examination (Signs)	Falling GCS. Ipsilateral fixed dilated pupil (due to CN III compression). Contralateral hemiparesis.
Bedside / GP	Continuous GCS and pupillary assessment.
Investigations	Urgent non-contrast CT Head: shows a classic 'biconvex' (lemon-shaped) hyperdense collection of blood, restricted by skull sutures.
Management (NICE/BNF)	Neurosurgical emergency. Immediate craniotomy and evacuation of the haematoma. Ligation of the bleeding vessel (usually the middle meningeal artery).

 **Red Flags: The 'lucid interval' is dangerously deceptive. Any patient with a significant head injury who deteriorates after initially seeming well requires an immediate CT scan.**

 *Patient Explanation: "A traumatic bleed between the skull and the brain covering, usually from a torn artery. Blood builds up quickly, squashing the brain. It requires immediate emergency surgery to drill a hole and drain the blood."*

Febrile Convulsion

History (Symptoms) Child aged 6 months to 5 years. A short, generalised tonic-clonic seizure occurring during an acute illness with a high fever (e.g., viral upper respiratory infection, otitis media). Lasts <5 minutes.

Examination (Signs) During fit: unconscious, stiffening, and jerking. Post-ictal: drowsy but completely recovers to neurological baseline within an hour.


Bedside / GP Measure temperature. Check ABCDE. Look for the source of infection (ears, throat, chest).


Investigations Usually a clinical diagnosis. Bloods/urine only to find the infection source. Lumbar puncture ONLY if meningitis is suspected.

Management (NICE/BNF) During seizure: placing child in recovery position, wait it out. If lasts >5 mins: PR Diazepam or Buccal Midazolam. Treat underlying fever with Paracetamol/ Ibuprofen.

BNF/BNFC Dosage Guide:


- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)
- Ibuprofen 400mg TDS (Adult) | 10mg/kg TDS (Child)


 **Red Flags: Complex febrile seizure (lasts >15 mins, focal features, or repeats within 24 hours) or any signs of meningitis (neck stiffness, non-blanching rash).**

 *Patient Explanation: "A seizure caused by a sudden spike in body temperature, very common in young children. While incredibly frightening to watch, simple ones are harmless and don't cause brain damage or mean the child has epilepsy."*

Folliculitis


History (Symptoms)	Multiple small, itchy or mildly painful spots around hair follicles. Common on the beard area, legs (after shaving), or trunk. 'Hot tub' folliculitis occurs after using unchlorinated spas.
Examination (Signs)	Multiple small pustules centered around hair follicles, with a narrow rim of erythema. No large areas of spreading redness (unlike cellulitis).
Bedside / GP	Clinical inspection.
Investigations	Usually clinical. Swab for bacterial culture if severe or non-resolving (often Staph aureus; Pseudomonas in hot tubs).
Management (NICE/BNF)	Mild: Antibacterial washes (Chlorhexidine) or topical antibiotics (Fusidic acid). Severe/widespread: Oral Flucloxacillin. BNF/BNFC Dosage Guide: • Flucloxacillin 500mg QDS PO (Skin infections)


 **Red Flags: Progression into deeper, larger painful boils (furuncles) or clusters of boils (carbuncles), especially in diabetic patients.**

 *Patient Explanation: "A superficial infection of the hair follicles, causing tiny pimples. It often happens after shaving or friction. Keeping the area clean and using antibiotic creams usually clears it up."*

Gangrene

History (Symptoms)	History of peripheral arterial disease, diabetes, or severe trauma. Severe pain (or painless if neuropathic), dark discolouration of digits/limbs, foul-smelling discharge if 'wet' gangrene.
Examination (Signs)	Dry gangrene: hard, dry, black, mummified tissue with a clear demarcation line. Wet gangrene: swollen, soft, putrid, with systemic signs of infection/sepsis.
Bedside / GP	Check peripheral pulses, ABPI. Vital signs (check for sepsis).
Investigations	Bloods (FBC, CRP, U&Es, HbA1c). Wound swabs. X-ray of affected limb (rule out osteomyelitis/gas in soft tissues).
Management (NICE/BNF)	Urgent vascular/surgical referral. Dry: Revascularisation to heal amputation margins, then amputation. Wet: Broad-spectrum IV antibiotics and emergency surgical debridement/amputation.


 **Red Flags: Gas gangrene (crepitus in tissues) is a rapid, life-threatening clostridial infection requiring emergency extensive surgery and penicillin.**

 *Patient Explanation: "Death of body tissue due to a lack of blood supply or a severe bacterial infection. 'Dry' gangrene shrivels and turns black, while 'wet' gangrene is infected and spreads quickly, often needing urgent surgery."*

Head Lice

History (Symptoms)	Itchy scalp, especially around the nape of the neck and behind the ears. Common in school-aged children.
Examination (Signs)	Visible live lice crawling on the scalp. Nits (empty white egg casings) firmly attached to hair shafts.
Bedside / GP	Visual inspection of the scalp using a fine-toothed detection comb on wet hair.
Investigations	Clinical diagnosis. No blood tests or swabs needed.
Management (NICE/BNF)	Wet combing method (Conditioner + fine-toothed comb every 3-4 days for 2 weeks). Alternatively, topical physical insecticides (e.g., Dimeticone 4% lotion).

 **Red Flags: If scalp is heavily excoriated (scratched), monitor for secondary bacterial skin infections (Impetigo).**

 *Patient Explanation: "Tiny insects that live on the human scalp and lay eggs (nits) in the hair. They cause intense itching but are harmless. They can be cleared by meticulous wet combing or special lotions."*

Hepatitis (Viral - Acute)

History (Symptoms) Prodrome of flu-like symptoms, extreme fatigue, nausea, anorexia, right upper quadrant discomfort. Followed a few days later by jaundice, dark urine, and pale stools. Hep A/E: travel/food. Hep B/C: blood/needles/sex.

Examination (Signs) Jaundice (scleral icterus). Tender hepatomegaly.


Bedside / GP Urine dipstick (positive for bilirubin). Ask about travel, sexual, and IV drug history.


Investigations LFTs (Massively raised ALT/AST >1000). Viral hepatitis serology screen (Hep A IgM, Hep B sAg, Hep C Ab).

Management (NICE/BNF) Usually supportive for acute Hep A/B/E (fluids, rest). Notification to Public Health. Avoid alcohol and hepatotoxic drugs (like Paracetamol).

BNF/BNFC Dosage Guide:

- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)

 **Red Flags: Fulminant hepatic failure (altered mental state/encephalopathy, bruising/bleeding, hypoglycaemia).**


 *Patient Explanation: "A viral infection that inflames the liver, causing you to feel very unwell and turn yellow. Most acute cases get better on their own with rest, but we do blood tests to find exactly which virus caused it."*


Hiatus Hernia

History (Symptoms)	Often asymptomatic. Sliding hiatus hernia presents identically to GORD (heartburn, acid reflux, waterbrash). Rolling hiatus hernia may cause dysphagia or chest pain after eating.
Examination (Signs)	Usually completely normal physical examination.
Bedside / GP	Calculate BMI (obesity increases intra-abdominal pressure).
Investigations	Upper GI Endoscopy (OGD) or Barium swallow (shows stomach protruding through diaphragm).
Management (NICE/BNF)	Lifestyle: Weight loss, small meals, elevate head of bed. Medical: PPIs (Omeprazole). Surgical: Laparoscopic fundoplication if severe/refractory.

BNF/BNFC Dosage Guide:


- Omeprazole 20-40mg OD PO


 **Red Flags: Dysphagia (difficulty swallowing), unexplained weight loss, or melaena requires an urgent endoscopy to rule out oesophageal cancer.**

 *Patient Explanation: "Part of your stomach squeezes up through the gap in your diaphragm into your chest. This weakens the valve that keeps stomach acid down, causing severe heartburn. Weight loss and acid tablets help manage it."*

Hospital Acquired Infections (e.g., MRSA, C. diff, Norovirus)


History (Symptoms)	C. diff: Profuse, foul-smelling, watery diarrhoea and abdominal pain starting after a course of antibiotics. MRSA: Non-healing surgical wound. Norovirus: Sudden projectile vomiting and diarrhoea on a ward.
Examination (Signs)	Signs of dehydration, fever, or wound infection.
Bedside / GP	Immediate isolation of the patient (side room) with strict contact precautions. Fluid balance.
Investigations	C. diff: Stool sample for C. diff toxin. MRSA: Swab of wound/groin/nose. Norovirus: Stool sample for viral PCR.
Management (NICE/BNF)	C. diff: Oral Vancomycin or Fidaxomicin. Stop the offending antibiotic. MRSA: Specific antibiotics based on sensitivities (e.g., IV Vancomycin).


 **Red Flags: Toxic megacolon in C. diff (severe abdominal distension, shock) requires emergency colectomy.**

 *Patient Explanation: "Infections caught while staying in the hospital. C. diff is a bowel bug caused by other antibiotics wiping out good gut bacteria. They require strict handwashing and isolation to stop them spreading."*

Hypoparathyroidism


History (Symptoms)	History of recent neck surgery (e.g., thyroidectomy). Numbness and tingling around the mouth (perioral paraesthesia) and fingers. Muscle cramps, spasms, or tetany.
Examination (Signs)	Trousseau's sign (inflation of BP cuff causes carpopedal spasm). Chvostek's sign (tapping facial nerve causes facial twitch).
Bedside / GP	Check surgical history. Test Trousseau's and Chvostek's signs.
Investigations	Bloods: Low Calcium, High Phosphate, Low or inappropriately normal PTH (Parathyroid Hormone).
Management (NICE/BNF)	Acute/severe (tetany): IV Calcium Gluconate. Chronic: Oral Calcium supplements and active Vitamin D (Alfacalcidol/Calcitriol).


 **Red Flags: Severe hypocalcaemia can cause life-threatening arrhythmias (prolonged QT interval on ECG), seizures, and laryngeal spasm (stridor).**

 *Patient Explanation: "The tiny parathyroid glands in your neck have been damaged or removed, meaning your body cannot maintain normal calcium levels. Low calcium causes muscle cramps and tingling, treated with daily calcium and vitamin D."*

Hyposplenism / Splenectomy


History (Symptoms)	History of surgical removal of spleen (trauma/ITP) or functional hyposplenism (e.g., Sickle Cell Disease, Coeliac Disease). Usually asymptomatic, but high risk of overwhelming severe infections.
Examination (Signs)	Surgical scar in the left upper quadrant. Absence of palpable spleen.
Bedside / GP	Check vaccination history.
Investigations	Blood film shows Howell-Jolly bodies (indicates the spleen is not filtering out old red blood cell fragments).
Management (NICE/BNF)	Preventative: Lifelong prophylactic antibiotics (Phenoxymethylpenicillin). Vaccinations (Pneumococcus, Haemophilus influenzae type B, Meningococcus). Patient MUST carry a 'Spleen Card'.


 **Red Flags: Overwhelming Post-Splenectomy Infection (OPSI): A minor infection can rapidly escalate to fatal septic shock. Any fever in these patients requires immediate hospital admission and IV antibiotics.**

 *Patient Explanation: "Living without a spleen (or with one that doesn't work). The spleen is a vital part of the immune system. Without it, you are at risk of very severe bacterial infections, so you must take daily antibiotics and get special vaccines."*

Idiopathic Arthritis (Juvenile - JIA)


History (Symptoms)	Child <16 years old. Joint pain, swelling, and morning stiffness lasting >6 weeks. May have a limp. Subtypes: Oligoarticular (<5 joints), Polyarticular (>5 joints), or Systemic (spiking fevers, salmon-pink rash).
Examination (Signs)	Swollen, warm joints with restricted movement. Assess for leg length discrepancy. Systemic JIA: fever, rash, hepatosplenomegaly, lymphadenopathy.
Bedside / GP	Check child's growth charts and observe gait.
Investigations	Clinical diagnosis of exclusion. Bloods: ESR/CRP, ANA (high risk of uveitis if positive), Rheumatoid Factor (rarely positive but indicates worse prognosis).
Management (NICE/BNF)	Paediatric rheumatology referral. NSAIDs, intra-articular steroid injections. DMARDs (Methotrexate) and Biologics for severe/polyarticular disease.


 **Red Flags: Chronic anterior uveitis is very common and often asymptomatic; requires regular screening by an ophthalmologist to prevent blindness. Macrophage Activation Syndrome is a fatal complication of Systemic JIA.**

 *Patient Explanation: "An autoimmune condition in children causing painful, swollen, and stiff joints. Some forms also cause fevers and rashes. We treat it with medications to calm the immune system to prevent permanent joint damage."*

Infectious Diarrhoea / Gastroenteritis

History (Symptoms)	Sudden onset of vomiting, watery diarrhoea, abdominal cramps, and fever. Viral (Norovirus/Rotavirus): vomiting prominent. Bacterial (Campylobacter/Salmonella): higher fever, severe cramps, sometimes bloody stool.
Examination (Signs)	Assess for dehydration (dry mucous membranes, sunken eyes, tachycardia, reduced skin turgor). Mild diffuse abdominal tenderness but no rigidity.
Bedside / GP	Vital signs. Capillary refill. Assess fluid status.
Investigations	Usually self-limiting; no tests needed. Stool culture if: blood in stool, immunocompromised, recent foreign travel, or symptoms >7 days.
Management (NICE/BNF)	Oral rehydration (fluids with sugar/salt). Avoid anti-diarrhoeals (Loperamide) if fever or bloody stool is present. IV fluids if severely dehydrated. Antibiotics rarely needed.

 **Red Flags: Haemolytic Uraemic Syndrome (HUS) following E. coli O157 infection (bloody diarrhoea followed by acute kidney failure, anaemia, and bruising).**


 *Patient Explanation: "A 'tummy bug' causing vomiting and diarrhoea. The most important thing is to drink plenty of fluids to replace what you are losing. It usually clears up on its own within a few days."*


Infectious Mononucleosis (Glandular Fever)

History (Symptoms)	Teenager or young adult. Severe sore throat, profound fatigue, high fever. Symptoms last for several weeks.
Examination (Signs)	Exudative tonsillitis (white patches on tonsils). Widespread lymphadenopathy (especially posterior cervical nodes). Splenomegaly (enlarged spleen) in 50% of cases.
Bedside / GP	Examine the abdomen carefully for splenic enlargement.
Investigations	Monospot test (heterophile antibodies) is usually positive in the 2nd week. Blood film shows atypical lymphocytes. LFTs (often deranged).
Management (NICE/BNF)	Supportive: Rest, fluids, Paracetamol/NSAIDs. Avoid contact sports for 4-6 weeks to prevent splenic rupture. DO NOT give Amoxicillin (causes a widespread maculopapular rash).

BNF/BNFC Dosage Guide:

- Amoxicillin 500mg TDS (Adult) | 250mg TDS (Child 1-5y) PO
- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)

 **Red Flags: Upper airway obstruction from massively enlarged tonsils. Splenic rupture (sudden severe left upper quadrant pain and shock).**


 *Patient Explanation: "A viral infection (usually Epstein-Barr virus) that causes a very sore throat, swollen glands, and extreme tiredness that can last for months. You must avoid contact sports until your spleen shrinks back to normal size."*


Infective Endocarditis

History (Symptoms)	Fever, new heart murmur, night sweats, fatigue, unexplained weight loss. History of IV drug use, poor dental hygiene, prosthetic heart valves, or congenital heart disease.
Examination (Signs)	New/changing regurgitant murmur. Splinter haemorrhages in nails, Osler's nodes (painful finger nodules), Janeway lesions (painless palm macules), Roth spots (retina).
Bedside / GP	Vital signs (fever). Listen closely to the heart.
Investigations	THREE sets of blood cultures taken from different sites at different times BEFORE starting antibiotics. Echocardiogram (Transoesophageal/TOE is most sensitive) to look for vegetations on valves.
Management (NICE/BNF)	Prolonged IV antibiotics (4-6 weeks) based on culture results (e.g., Amoxicillin + Gentamicin initially). Cardiac surgery if valve is severely damaged or large vegetation.

BNF/BNFC Dosage Guide:


- Amoxicillin 500mg TDS (Adult) | 250mg TDS (Child 1-5y) PO


 **Red Flags: Septic emboli breaking off the valve can cause strokes, limb ischaemia, or pulmonary emboli (if right-sided heart valves involved, e.g., in IV drug users).**

 *Patient Explanation: "A life-threatening bacterial infection of the heart valves. Bacteria enter the blood and stick to the valves, growing into clumps that destroy the valve. Requires weeks of IV antibiotics in hospital."*

Influenza (The Flu)


History (Symptoms)	Abrupt onset of high fever, severe myalgia (muscle aches), extreme exhaustion, dry cough, headache, sore throat. Outbreaks typically occur in winter.
Examination (Signs)	Fever, tachycardia. Chest is usually clear on auscultation (unless secondary pneumonia has developed). Patient looks miserable.
Bedside / GP	Check SpO2. Temperature.
Investigations	Usually a clinical diagnosis during outbreaks. Viral throat/nose swab for PCR if admitted to hospital.
Management (NICE/BNF)	Healthy adults: rest, fluids, Paracetamol. At-risk groups (elderly, pregnant, immunocompromised): oral Oseltamivir (Tamiflu) if started within 48 hours of symptom onset. BNF/BNFC Dosage Guide: • Paracetamol 1g QDS (Adult) 15mg/kg QDS (Child)


 **Red Flags: Secondary bacterial pneumonia (e.g., Staph aureus) causing worsening cough, purulent sputum, and hypoxia after initial flu symptoms had started to improve.**

 **Patient Explanation:** "A severe viral illness that hits you suddenly with a high fever and extreme body aches. It is much worse than a common cold. The annual flu vaccine is the best way to prevent it."

Intestinal Obstruction and Ileus


History (Symptoms)	Mechanical Obstruction: Colicky abdominal pain, vomiting (often dark/faeculent), absolute constipation (no flatus or stool), abdominal distension. Ileus: Painless distension, no bowel movements, nausea (often post-op).
Examination (Signs)	Obstruction: Distended, resonant abdomen. High-pitched 'tinkling' bowel sounds. Ileus: Distended abdomen with ABSENT bowel sounds.
Bedside / GP	Check for hernias (common cause of obstruction) and surgical scars (adhesions). Vital signs.
Investigations	Bloods: U&Es (dehydration/AKI), Lactate. Abdominal X-ray (dilated loops of bowel). CT Abdomen/Pelvis (gold standard to find the cause and site of obstruction).
Management (NICE/BNF)	Drip and Suck: NBM, IV fluids, Nasogastric (NG) tube to decompress stomach. Surgery required if strangulated/closed-loop obstruction or no improvement.


 **Red Flags: Strangulation: Continuous (non-colicky) severe pain, localised tenderness/guarding, fever, raised lactate. Means the bowel is dying and needs immediate emergency surgery.**

 *Patient Explanation: "A physical blockage in the bowel (obstruction) or the bowel simply stopping its squeezing action (ileus). It causes your stomach to swell and makes you vomit. We treat it by resting the bowel with a tube and drips, sometimes needing surgery."*

Intussusception


History (Symptoms)	Infant (typically 6-18 months). Paroxysms of severe, colicky abdominal pain causing the child to draw their knees to their chest and cry. Between episodes, the child may look pale, lethargic, or normal. Vomiting.
Examination (Signs)	Palpable 'sausage-shaped' mass in the right upper quadrant. 'Redcurrant jelly' stool (late sign - blood mixed with mucus).
Bedside / GP	Inspect nappy for blood. Vital signs (check for shock).
Investigations	Abdominal Ultrasound is the investigation of choice (shows a 'target' or 'doughnut' sign).
Management (NICE/BNF)	Resuscitation with IV fluids. Air or liquid contrast enema reduction (radiologist pushes the bowel back out using pressure). Surgery if enema fails or bowel is perforated.


 **Red Flags: Signs of peritonitis or shock (floppy, unresponsive infant) require immediate surgical intervention.**

 *Patient Explanation: "A medical emergency in babies where one part of the bowel folds inside the next part, like a telescope. It causes severe, cramping pain and blocks the bowel. It is usually fixed by pushing air into the bowel to pop it back out."*

Joint Dislocation (e.g., Shoulder)


History (Symptoms)	History of trauma (e.g., fall onto outstretched hand or direct blow). Severe pain, inability to move the joint, feeling that the joint has 'popped out'.
Examination (Signs)	Visible deformity/loss of normal joint contour (e.g., squared-off shoulder). Arm held in fixed position. MUST assess neurovascular status distal to the injury.
Bedside / GP	Check pulses and sensation below the joint before AND after any movement.
Investigations	X-ray of the joint (e.g., AP and Y-scapular views for the shoulder) to confirm direction of dislocation and check for associated fractures.
Management (NICE/BNF)	Prompt closed reduction (manipulating the joint back into place) under analgesia/sedation. Re-check X-ray and neurovascular status post-reduction. Immobilise in a sling.


 **Red Flags: Axillary nerve injury (check sensation over the 'regimental badge' area of the shoulder). Vascular compromise (absent pulses) requires emergency reduction.**

 **Patient Explanation:** "The bones of your joint have been completely forced out of their normal position. It is incredibly painful. We give you strong painkillers and pull the bones back into their proper socket."

Intestinal (Mesenteric) Ischaemia


History (Symptoms)	Acute: Sudden, severe abdominal pain that is out of proportion to physical signs. Often accompanied by vomiting and bloody diarrhoea. High risk in patients with Atrial Fibrillation (embolus). Chronic: 'Intestinal angina' - severe pain 30 mins after eating, leading to weight loss/fear of food.
Examination (Signs)	Early on, the abdomen is surprisingly soft and non-tender despite the patient's agony. Later signs (bowel infarction): rigid abdomen, peritonitis, shock.
Bedside / GP	Vital signs. 12-lead ECG to check for AF. VBG/ABG (elevated lactate).
Investigations	CT Angiography of the abdomen is the gold standard (shows blocked mesenteric vessels).
Management (NICE/BNF)	Acute: Surgical emergency. Resuscitation, IV fluids, IV antibiotics. Urgent laparotomy to resect dead bowel or embolectomy/stent. High mortality rate.


 **Red Flags: Elevated lactate with severe pain out of proportion to examination findings is highly suspicious for dead/dying bowel.**

 *Patient Explanation: "A blood clot blocks the main artery feeding your intestines, cutting off the oxygen. It causes extreme pain but your tummy might feel normal to touch at first. Without emergency surgery, the bowel dies."*

Infective Keratitis (Corneal Ulcer)

History (Symptoms)	Unilateral severe eye pain, photophobia, red eye, reduced vision, watering. Very strongly associated with contact lens wear (especially sleeping in them or using tap water) or recent eye trauma/scratch.
Examination (Signs)	Ciliary flush (redness around the iris). A visible white spot/opacity on the cornea (ulcer). Hypopyon (pus gathering in the bottom of the anterior chamber).
Bedside / GP	Visual acuity. Check contact lens history. Fluorescein staining shows corneal epithelial defect.
Investigations	Urgent same-day ophthalmology referral. Corneal scrape for urgent microscopy and culture (watch out for Pseudomonas or Acanthamoeba).
Management (NICE/BNF)	Intensive topical antibiotic drops (e.g., Ofloxacin drops every hour day and night initially). NEVER prescribe topical steroids in primary care for a red eye.

 **Red Flags: If untreated, the infection can rapidly eat through the cornea (perforation) causing permanent blindness or loss of the eye.**

 *Patient Explanation: "A severe bacterial infection of the clear window at the front of your eye, often caused by dirty contact lenses. It causes intense pain and a white ulcer, requiring heavy hourly antibiotic eye drops to save your vision."*

Iritis / Anterior Uveitis

History (Symptoms) Unilateral dull, aching eye pain, photophobia (dislike of light), red eye, slightly blurred vision. Often associated with HLA-B27 autoimmune conditions (e.g., Ankylosing Spondylitis, Inflammatory Bowel Disease).

Examination (Signs) Ciliary flush. Constricted (miotic), poorly reactive, or irregularly shaped pupil (due to adhesions/synechiae). Cells and flare in the anterior chamber on slit-lamp exam.


Bedside / GP Visual acuity. Check pupil shape and reaction.


Investigations Same-day ophthalmology assessment (slit lamp is required). Bloods (HLA-B27, autoimmune screen) if recurrent.

Management (NICE/BNF) Topical corticosteroids (e.g., Dexamethasone eye drops) to reduce inflammation. Cyclopentolate drops (dilates the pupil to prevent painful spasms and adhesions).

BNF/BNFC Dosage Guide:


- Dexamethasone 0.15mg/kg PO STAT (Croup)


 **Red Flags: Can cause secondary glaucoma. Irregular pupil shape means the iris has stuck to the lens (posterior synechiae).**

 *Patient Explanation: "Inflammation of the coloured part of your eye (the iris). It causes an aching red eye that hates bright light. It's often linked to body-wide immune conditions like arthritis. Treated with steroid and dilating eye drops."*

Lung Cancer

History (Symptoms)	Chronic cough (>3 weeks), haemoptysis (coughing up blood), persistent breathlessness, chest pain, unexplained weight loss, fatigue. Smoking is the primary risk factor.
Examination (Signs)	Often normal early on. Finger clubbing, cervical/supraclavicular lymphadenopathy. Signs of pleural effusion (dull percussion, reduced breath sounds). Cachexia.
Bedside / GP	Assess smoking history. SpO2.
Investigations	Urgent Chest X-ray (may show a mass or effusion). If abnormal or high suspicion -> Urgent 2-week-wait CT Chest. Bronchoscopy/biopsy for tissue diagnosis.
Management (NICE/BNF)	MDT approach. Non-small cell (NSCLC): Surgery, radiotherapy, targeted therapies (e.g., EGFR inhibitors). Small cell (SCLC): Usually advanced at presentation, chemotherapy is main treatment.

 **Red Flags: Superior Vena Cava (SVC) Obstruction: Facial/neck swelling, engorged neck/chest veins, breathless when lying flat. An oncological emergency.**

 *Patient Explanation: "A serious cancer in the lungs, strongly linked to smoking. It often causes a persistent cough or coughing up blood. We need urgent scans to see the lungs and a biopsy to decide on treatments like surgery or chemotherapy."*


Lyme Disease

History (Symptoms)	History of a tick bite (often in woodland/heathland areas). Early: A slowly expanding 'bullseye' rash (Erythema Migrans), flu-like symptoms, fever, fatigue, joint pain. Late: neurological/cardiac symptoms.
Examination (Signs)	Erythema migrans (a target-like red ring with central clearing, usually >5cm). Facial nerve palsy. Joint swelling.
Bedside / GP	Ask about recent outdoor activities/tick exposure in endemic areas (e.g., Scottish Highlands, New Forest).
Investigations	If Erythema Migrans is present -> Clinical diagnosis (no tests needed, start treatment). If absent but suspected: Lyme serology (ELISA, then Immunoblot).
Management (NICE/BNF)	Oral Doxycycline for 21 days (Amoxicillin if pregnant/child <8). Severe/Neurological Lyme requires IV Ceftriaxone.

BNF/BNFC Dosage Guide:


- Amoxicillin 500mg TDS (Adult) | 250mg TDS (Child 1-5y) PO
- Ceftriaxone 2g IV BD (Adult Meningitis) | 80mg/kg IV OD (Child)
- Doxycycline 100mg OD/BD PO (Avoid in pregnancy/children)


 **Red Flags: Lyme carditis (causing heart block/arrhythmias) or neuroborreliosis (meningitis, facial palsy).**

 *Patient Explanation: "A bacterial infection spread by tick bites. It usually starts with a classic 'bullseye' rash and flu-like symptoms. A 3-week course of specific antibiotics clears it completely in most cases."*

Lymphoma (Hodgkin and Non-Hodgkin)


History (Symptoms)	Painless, rubbery, enlarging lymph nodes (often in the neck, armpit, or groin). 'B symptoms': Drenching night sweats, unexplained fever, weight loss >10% in 6 months. Hodgkin specific: lymph node pain after drinking alcohol.
Examination (Signs)	Palpable, non-tender, rubbery, asymmetrical lymphadenopathy. Hepatosplenomegaly.
Bedside / GP	Examine all lymph node stations.
Investigations	Urgent 2-week-wait referral. Excision biopsy of a whole lymph node is gold standard (Hodgkin shows Reed-Sternberg 'owl eye' cells). PET-CT for staging.
Management (NICE/BNF)	Chemotherapy (e.g., ABVD for Hodgkin, R-CHOP for Non-Hodgkin). Radiotherapy. High cure rates, especially for Hodgkin Lymphoma.


 **Red Flags: B-symptoms (night sweats, weight loss) indicate a poorer prognosis/more advanced disease. Massive mediastinal nodes causing SVC obstruction.**

 **Patient Explanation:** "A cancer of the lymphatic system (the body's infection-fighting network). It causes swollen, painless glands and drenching night sweats. We diagnose it by removing a gland for testing, and it is usually highly treatable with chemotherapy."

Malnutrition & Refeeding Syndrome


History (Symptoms)	Unintentional weight loss, very low BMI, poor dietary intake for >5 days. Risk factors: anorexia, elderly/frail, chronic alcoholism, malabsorption.
Examination (Signs)	Cachexia, muscle wasting, poor skin healing, prominent bones.
Bedside / GP	Calculate MUST (Malnutrition Universal Screening Tool) score. Check BMI.
Investigations	Bloods: baseline U&Es, Phosphate, Magnesium, Calcium (the key electrolytes to monitor).
Management (NICE/BNF)	Dietician input. ONS (Oral Nutritional Supplements) or enteral feeding (NG tube). High risk of refeeding syndrome: start feeding very slowly and give IV/oral Pabrinex (Thiamine) before feeding begins.


 **Red Flags: Refeeding syndrome: Suddenly giving food/carbs causes a massive insulin spike, which drives Phosphate, Magnesium, and Potassium into cells. This leads to fatal cardiac arrhythmias and seizures.**

 *Patient Explanation: "When someone is severely malnourished, their body adapts to starvation. If we suddenly feed them large amounts, it shocks the system and causes a dangerous drop in blood salts, which can stop the heart. We must feed them very slowly and give vitamins."*

Mastitis (Lactational)


History (Symptoms)	Breastfeeding woman. Sudden onset of a painful, red, swollen wedge of the breast. Fever, chills, and flu-like aches.
Examination (Signs)	A localized, warm, tender, erythematous, wedge-shaped area of the breast. Fever.
Bedside / GP	Check maternal temperature and pulse.
Investigations	Clinical diagnosis. Breast milk culture only if unresponsive to antibiotics or severe.
Management (NICE/BNF)	<p>KEEP BREASTFEEDING/expressing milk (prevents engorgement/abscess). Warm compresses, Paracetamol/Ibuprofen. Oral Flucloxacillin for 10-14 days if infective.</p> <p>BNF/BNFC Dosage Guide:</p> <ul style="list-style-type: none">• Paracetamol 1g QDS (Adult) 15mg/kg QDS (Child)• Ibuprofen 400mg TDS (Adult) 10mg/kg TDS (Child)• Flucloxacillin 500mg QDS PO (Skin infections)


 **Red Flags: Breast Abscess (a fluctuant, tender, swinging-fever lump) requiring surgical incision & drainage or ultrasound-guided aspiration.**

 **Patient Explanation:** "Inflammation or infection of the breast tissue while breastfeeding, usually due to a blocked milk duct. It causes a painful red patch and flu-like symptoms. You **MUST** keep feeding/pumping from that breast to clear it, alongside taking antibiotics."

Measles


History (Symptoms)	Unvaccinated child. Prodrome (the '4 Cs'): Cough, Coryza (runny nose), Conjunctivitis (red eyes), and fever. A few days later, a rash begins on the face/behind ears and spreads downwards.
Examination (Signs)	Koplik spots (tiny white spots on a red base inside the cheeks) appear before the rash. Maculopapular, non-itchy, brick-red rash starting on the head/neck and spreading to the trunk.
Bedside / GP	Check vaccination history (MMR). Examine the buccal mucosa (inside mouth).
Investigations	Notify Public Health immediately. Oral fluid (saliva) swab for Measles PCR to confirm.
Management (NICE/BNF)	Supportive (fluids, Paracetamol). Isolate to prevent spread. Vitamin A in severe cases in children. BNF/BNFC Dosage Guide: • Paracetamol 1g QDS (Adult) 15mg/kg QDS (Child)


 **Red Flags: Complications: Otitis media, Pneumonia (most common cause of death), Encephalitis, and late-onset Subacute Sclerosing Panencephalitis (SSPE).**

 *Patient Explanation: "A highly contagious viral illness that causes cold-like symptoms, sore eyes, and a widespread red rash. It is entirely preventable with the MMR vaccine. While most recover, it can cause severe lung or brain complications."*

Mesothelioma


History (Symptoms)	Older patient. History of significant asbestos exposure (often decades ago). Progressive breathlessness, unexplained chest pain, weight loss, persistent cough.
Examination (Signs)	Signs of a unilateral pleural effusion (stony dull percussion, reduced breath sounds, reduced chest expansion). Finger clubbing.
Bedside / GP	Detailed occupational history.
Investigations	Chest X-ray (large unilateral pleural effusion, pleural thickening). CT Chest. Pleural aspiration (often blood-stained fluid). Thoracoscopy and pleural biopsy (diagnostic).
Management (NICE/BNF)	Palliative approach. Chemotherapy, pleurodesis (to stop the fluid re-accumulating), Indwelling pleural catheter (Rocket drain) for symptom relief. Compensation claims.


 **Red Flags: Prognosis is extremely poor (often <12 months). The disease is incurable.**

 *Patient Explanation: "A cancer of the lining of the lung (the pleura), almost always caused by breathing in asbestos dust many years ago. It causes fluid to build up around the lung. Treatment focuses on easing breathlessness rather than curing."*

Miscarriage


History (Symptoms)	Vaginal bleeding and crampy lower abdominal pain before 24 weeks gestation. Loss of pregnancy symptoms.
Examination (Signs)	Speculum: assessing blood volume, whether the cervical os is open or closed, and looking for products of conception in the os.
Bedside / GP	Urinary Pregnancy Test. Vital signs to assess for shock if heavy bleeding.
Investigations	Transvaginal Ultrasound (TVUS) to confirm viability or empty sac. Serial serum bHCG (if falling, confirms loss). Bloods: Group & Save (need to know Rhesus status).
Management (NICE/BNF)	Expectant (let nature take its course), Medical (Vaginal Misoprostol to induce contractions), or Surgical (Manual Vacuum Aspiration / ERPC). Give Anti-D if mother is Rhesus negative.


 **Red Flags: Always rule out ectopic pregnancy. Septic miscarriage: fever, foul-smelling discharge, severe pain (needs IV antibiotics and urgent surgery).**

 *Patient Explanation: "The tragic loss of a pregnancy in the first 24 weeks. It is very common and usually caused by random genetic errors in the embryo, not by anything the mother did. We manage it safely with observation, tablets, or a minor operation."*

Motor Neurone Disease (MND / ALS)


History (Symptoms)	Progressive, painless muscle weakness. Dropping objects, tripping over (foot drop), slurred speech (dysarthria), swallowing difficulties (dysphagia). NO sensory loss (they can feel everything).
Examination (Signs)	Mixed Upper and Lower Motor Neuron signs in the SAME limb. LMN: muscle wasting, fasciculations (twitching). UMN: brisk reflexes, upgoing plantars, spasticity.
Bedside / GP	Full neurological exam. Observe for tongue fasciculations.
Investigations	Clinical diagnosis by a neurologist. Electromyography (EMG) shows typical denervation patterns. MRI to exclude structural spine/brain disease.
Management (NICE/BNF)	MDT approach (SALT, Physio, Dietician, Palliative care). Riluzole (can extend life by a few months). Non-Invasive Ventilation (NIV) for respiratory muscle weakness.


 **Red Flags: Rapid progression to respiratory failure. Dysphagia leading to aspiration pneumonia. No cure; fatal usually within 2-4 years.**

 *Patient Explanation: "A devastating, progressive disease that destroys the nerves controlling muscles, leading to severe weakness, swallowing, and breathing problems. Sensation and memory remain perfectly intact."*

Myasthenia Gravis

History (Symptoms)	Muscle weakness that gets WORSE with use (fatigability) and better with rest. Worse at the end of the day. Ptosis (drooping eyelids), diplopia (double vision), dysphagia, chewing fatigue.
Examination (Signs)	Ask patient to look up continuously for 1 minute: watch for progressive eyelid drooping (ptosis). Normal reflexes and sensation.
Bedside / GP	Tensilon (Edrophonium) test (historical) or Ice pack test (ptosis improves with ice).
Investigations	Bloods: Anti-AChR (Acetylcholine Receptor) antibodies. EMG (decremental response to repetitive nerve stimulation). CT Thorax (to look for a Thymoma).
Management (NICE/BNF)	Symptomatic: Pyridostigmine (acetylcholinesterase inhibitor). Immunosuppression: Steroids, Azathioprine. Thymectomy.

 **Red Flags: Myasthenic Crisis: Severe weakness of the respiratory muscles leading to acute respiratory failure. Requires emergency intubation/NIV, IV Immunoglobulins, or Plasmapheresis.**

 *Patient Explanation: "An autoimmune disease where the connections between nerves and muscles are blocked by antibodies. Your muscles tire out very quickly when used but recover after resting. Treated with medication to boost nerve signals."*

Myocarditis / Pericarditis

History (Symptoms) Pericarditis: Sharp, pleuritic central chest pain, worse on lying flat, BETTER when leaning forward. Often follows a viral infection. Myocarditis: chest pain, breathless, palpitations.

Examination (Signs) Pericarditis: Pericardial friction rub (scratchy sound) on auscultation. Myocarditis: Tachycardia out of proportion to fever, signs of heart failure.


Bedside / GP 12-lead ECG. Pericarditis shows widespread 'saddle-shaped' ST elevation and PR depression.


Investigations Bloods: Troponin (often elevated), CRP/ESR. Echocardiogram (to check for pericardial effusion or impaired heart pumping).

Management (NICE/BNF) Pericarditis: NSAIDs (Ibuprofen) + Colchicine for weeks/months. Myocarditis: Supportive, treat heart failure (ACEi, beta-blockers).

BNF/BNFC Dosage Guide:


- Ibuprofen 400mg TDS (Adult) | 10mg/kg TDS (Child)


 **Red Flags: Cardiac Tamponade (large pericardial effusion compressing the heart): muffled heart sounds, hypotension, raised JVP. Requires emergency pericardiocentesis.**

 *Patient Explanation: "Inflammation of the heart muscle (myocarditis) or the sac around the heart (pericarditis), usually triggered by a virus. It causes chest pain that changes when you sit forward. Most recover well with anti-inflammatory painkillers."*

Obesity


History (Symptoms)	Excess weight gain. May have symptoms of complications: breathlessness, snoring/daytime sleepiness (Sleep Apnoea), joint pain, polyuria (Diabetes).
Examination (Signs)	High BMI ($>30 \text{ kg/m}^2$). Central adiposity.
Bedside / GP	Calculate BMI. Measure blood pressure. Waist circumference.
Investigations	Screen for comorbidities: HbA1c (Diabetes), Lipid profile, TFTs (rule out hypothyroidism).
Management (NICE/BNF)	Tiered approach. Lifestyle/dietary advice, exercise. Medications (e.g., Orlistat, GLP-1 agonists like Semaglutide/Liraglutide). Bariatric surgery (Gastric bypass/sleeve) if BMI >40 or >35 with comorbidities.


 **Red Flags: Obesity Hypoventilation Syndrome and Obstructive Sleep Apnoea leading to right heart failure (cor pulmonale).**

 *Patient Explanation: "Carrying significant excess body fat, which increases the risk of numerous conditions like diabetes, heart disease, and joint problems. We can support weight loss through diet, new injectable medications, or stomach surgery."*

Oesophageal Cancer


History (Symptoms)	Progressive dysphagia (difficulty swallowing) - initially to solids, then progressing to liquids. Significant unintentional weight loss, hoarseness, persistent acid reflux, vomiting.
Examination (Signs)	Often normal early on. Late: cachexia, cervical lymphadenopathy.
Bedside / GP	Calculate MUST (malnutrition) score.
Investigations	Urgent 2-week-wait Upper GI Endoscopy (OGD) with biopsy. CT Chest/ Abdomen/Pelvis for staging. Endoscopic Ultrasound (EUS) to assess local invasion.
Management (NICE/BNF)	MDT. Surgical resection (Oesophagectomy) if fit and localized. Neoadjuvant chemo/radiotherapy. Palliative: Oesophageal stenting to allow swallowing.


 **Red Flags: Dysphagia in ANY patient is an absolute red flag for cancer and warrants an urgent endoscopy.**

 *Patient Explanation: "Cancer of the food pipe. It slowly narrows the pipe, making it hard to swallow solid food, leading to severe weight loss. We use a camera test to find it, and may treat it with surgery or by placing a tube (stent) to keep the pipe open."*

Osteomyelitis


History (Symptoms)	Severe, unremitting bone pain, fever, lethargy. Often a history of recent trauma, surgery, or a chronic non-healing diabetic foot ulcer. Usually <i>Staphylococcus aureus</i> .
Examination (Signs)	Fever. Affected area is warm, swollen, erythematous, and extremely tender to palpation. Deep ulcers where you can 'probe to bone'.
Bedside / GP	Probe diabetic ulcers with a sterile blunt probe; if you hit hard bone, osteomyelitis is highly likely.
Investigations	MRI is the gold standard imaging (X-rays are often normal for the first 10-14 days). Bloods: raised WBC, CRP, ESR. Bone biopsy/cultures.
Management (NICE/BNF)	Prolonged IV antibiotics (often 6 weeks) via a PICC line. Surgical debridement of dead, infected bone.


 **Red Flags: Spinal osteomyelitis/discitis: presents with severe back pain and fever, can cause spinal cord compression.**

 *Patient Explanation: "A deep, severe bacterial infection inside the bone itself. It usually requires weeks of strong antibiotics directly into the vein, and sometimes surgery to scrape away the infected bone."*

Perianal Abscesses and Fistulae


History (Symptoms)	Abscess: Severe, throbbing, continuous pain around the anus, worse on sitting. Fever. Fistula: Chronic intermittent discharge (pus/blood) from a small hole near the anus, history of previous abscess.
Examination (Signs)	Abscess: Red, hot, tender, fluctuant lump next to the anus. Fistula: Small opening in the perianal skin, discharging pus.
Bedside / GP	Inspection of the perianal area. Check temperature.
Investigations	Abscess: Clinical diagnosis. Fistula: MRI Pelvis is the gold standard to map the fistula tract.
Management (NICE/BNF)	Abscess: Urgent surgical Incision and Drainage (I&D). Fistula: Surgical fistulotomy or placement of a seton string to allow it to drain and heal.


 **Red Flags: Fournier's Gangrene: Rapidly spreading, necrotizing infection of the perineum/scrotum. Medical emergency requiring immediate massive surgical debridement.**

 *Patient Explanation: "A painful collection of pus next to the back passage. It needs to be cut open and drained under anaesthetic. Sometimes it leaves a tiny tunnel (fistula) connecting the bowel to the skin, which leaks pus and needs another operation."*

Placenta Praevia


History (Symptoms)	Pregnancy >20 weeks. Sudden, PAINLESS, bright red vaginal bleeding. Often identified asymptotically on the 20-week anomaly scan.
Examination (Signs)	Uterus is NOT tender and feels soft/relaxed (unlike abruption). Fetal heart rate is usually normal. DO NOT PERFORM A DIGITAL VAGINAL EXAMINATION.
Bedside / GP	Vital signs (assess mother for shock). CTG for fetal wellbeing.
Investigations	Transvaginal/Transabdominal Ultrasound confirms the placenta is covering or lying very close to the internal cervical os. Bloods: Group and Save, FBC, Clotting.
Management (NICE/BNF)	If heavy bleeding: admit, resuscitate, emergency Caesarean. If stable: conservative management, admit for observation, elective Caesarean at 37-38 weeks.


 **Red Flags: Digital vaginal examination can provoke massive, catastrophic haemorrhage. Placenta Accreta (placenta deeply invades the uterine wall) is a major risk if mother has had previous C-sections.**

 *Patient Explanation: "The placenta has attached itself very low down in the womb, covering the exit (cervix). It causes sudden, painless bleeding. The baby cannot be born naturally and must be delivered safely by a planned Caesarean section."*

Placental Abruption


History (Symptoms)	Pregnancy >20 weeks. Sudden, severe, CONTINUOUS abdominal pain, with or without dark vaginal bleeding (bleeding can be concealed inside). Risk factors: trauma, pre-eclampsia, cocaine use, smoking.
Examination (Signs)	The uterus is 'woody' (hard, tense) and exquisitely tender. Fetal distress on CTG.
Bedside / GP	Immediate vital signs. Continuous CTG monitoring.
Investigations	Clinical diagnosis! Ultrasound is NOT reliable for ruling it out. Bloods: Group and Save, crossmatch, FBC, clotting (high risk of DIC).
Management (NICE/BNF)	Obstetric emergency. Resuscitation (IV fluids/blood). Urgent delivery: Emergency Caesarean section (if fetal distress/heavy bleeding) or induction of labour if fetus is stable or has tragically died.


 **Red Flags: High risk of Disseminated Intravascular Coagulation (DIC), major maternal shock, and fetal death. Do not delay delivery waiting for an ultrasound.**

 *Patient Explanation: "The placenta has prematurely torn away from the wall of the womb. It causes extreme pain and dangerous internal bleeding, cutting off the baby's oxygen. It requires emergency delivery, usually by a crash Caesarean."*

Peritonitis


History (Symptoms)	Sudden onset, severe, continuous, generalised abdominal pain. Pain is dramatically worsened by any movement, coughing, or even the bed being bumped. Associated with fever, nausea, and vomiting. Often follows a perforated organ (e.g., appendix, ulcer, diverticulum).
Examination (Signs)	Patient lies absolutely still. Board-like abdominal rigidity, severe guarding, rebound tenderness. Absent bowel sounds. Signs of sepsis/shock (tachycardia, hypotension, fever).
Bedside / GP	Immediate vital signs (NEWS2 score). Do not delay transfer to hospital.
Investigations	Urgent CT Abdomen/Pelvis (shows free air/fluid in the abdomen). Bloods (raised Lactate, WBC, CRP). Erect Chest X-ray (may show air under the diaphragm).
Management (NICE/BNF)	Surgical emergency. NBM, aggressive IV fluid resuscitation, broad-spectrum IV antibiotics. Urgent laparotomy to wash out the abdomen and fix the underlying perforation.


 **Red Flags: Septic shock and multi-organ failure develop rapidly. High mortality if surgery is delayed.**

 *Patient Explanation: "A life-threatening infection of the lining of the whole tummy cavity, usually because a hole has developed in the bowel or stomach, leaking contents inside. It causes extreme pain with any movement and needs emergency surgery to wash it out."*

Pleural Effusion


History (Symptoms)	Progressive breathlessness, pleuritic chest pain (if inflammatory), dry cough. Risk factors depend on cause: heart failure, pneumonia, cancer, or liver disease.
Examination (Signs)	Stony dull percussion note over the effusion. Reduced or absent breath sounds and reduced vocal resonance on the affected side. Reduced chest expansion.
Bedside / GP	SpO2 monitoring. Assess for signs of heart failure (e.g., pitting oedema, raised JVP).
Investigations	Erect Chest X-ray (blunting of the costophrenic angle, dense white shadow with a meniscus). Diagnostic pleural tap (aspiration) using ultrasound guidance to determine if it is a transudate or exudate (Light's criteria).
Management (NICE/BNF)	Treat the underlying cause (e.g., diuretics for heart failure, antibiotics for infection). Therapeutic aspiration or chest drain insertion if the patient is severely breathless.


 **Red Flags: Empyema (pus in the pleural space): persistent fever, raised inflammatory markers despite antibiotics. Requires urgent drainage.**

 **Patient Explanation:** "Fluid has built up in the space between your lung and your ribcage, squashing the lung and making it hard to breathe. We diagnose it with an X-ray and sometimes drain the fluid with a small needle to help you breathe and find out what caused it."

Pre-eclampsia


History (Symptoms)	Pregnant woman (>20 weeks gestation). Often asymptomatic initially. Severe cases: severe frontal headache, visual disturbances (flashing lights/blurring), severe epigastric pain, vomiting, sudden swelling of face/hands.
Examination (Signs)	Hypertension (BP > 140/90). Hyperreflexia and clonus (in severe cases). Right upper quadrant or epigastric tenderness. Papilloedema.
Bedside / GP	Urine dipstick MUST be done at every antenatal visit (checking for Proteinuria). Blood pressure measurement.
Investigations	Urine PCR (Protein:Creatinine ratio). Bloods (FBC, U&Es, LFTs, Clotting). Placental Growth Factor (PIGF) testing.
Management (NICE/BNF)	Mild/Moderate: Labetalol to control BP, close monitoring. Severe/Eclampsia risk: IV Magnesium Sulphate to prevent seizures. Definitive cure: Delivery of the baby and placenta.


 **Red Flags: Eclampsia (seizures). HELLP syndrome (Haemolysis, Elevated Liver enzymes, Low Platelets). Both are absolute obstetric emergencies requiring immediate delivery.**

 *Patient Explanation: "A dangerous condition in pregnancy caused by a problem with the placenta. It causes high blood pressure and protein leaking into the urine. If left untreated, it can cause seizures and harm both mother and baby. The only true cure is delivering the baby."*

Prematurity / Pre-term Labour


History (Symptoms)	Regular, painful uterine contractions before 37 weeks of pregnancy. May have a 'show' (mucus plug passing) or rupture of membranes (waters breaking early). Backache, pelvic pressure.
Examination (Signs)	Speculum examination to assess for ruptured membranes or cervical dilation. DO NOT perform digital examination if placenta praevia has not been ruled out or if membranes ruptured (infection risk).
Bedside / GP	CTG to monitor fetal heart rate and contraction frequency. Swab for fetal fibronectin (if negative, pre-term delivery is highly unlikely in the next week).
Investigations	Transvaginal ultrasound to measure cervical length (short cervix increases risk). High vaginal swab for infection (a common trigger).
Management (NICE/BNF)	Tocolytics (e.g., Nifedipine) to delay labour by 48 hours. This buys time to give IM Corticosteroids (to mature baby's lungs) and IV Magnesium Sulphate (to protect baby's brain/prevent cerebral palsy).


 **Red Flags: Signs of chorioamnionitis (maternal fever, foul-smelling discharge, fetal tachycardia) mean labour MUST NOT be delayed, and the baby must be delivered due to severe infection risk.**

 **Patient Explanation:** "Going into labour too early, before the baby is fully ready. We use medicines to temporarily stop the contractions so we can give the mother steroid injections, which rapidly help the baby's lungs mature before they are born."

Pulmonary Hypertension


History (Symptoms)	Progressive exertional breathlessness, fatigue, syncope (fainting on exertion), exertional chest pain. Often a history of chronic lung disease (COPD), recurrent PEs, or left heart failure.
Examination (Signs)	Signs of Right Heart Failure (Cor Pulmonale): Raised JVP with prominent 'a' wave, right ventricular heave, loud P2 (second heart sound), peripheral oedema, hepatomegaly.
Bedside / GP	12-lead ECG (shows Right Ventricular Hypertrophy, Right Axis Deviation). SpO2 monitoring.
Investigations	Echocardiogram (estimates pulmonary artery pressure). Right Heart Catheterisation is the gold standard diagnostic test. CTPA to rule out chronic thromboembolic disease.
Management (NICE/BNF)	Treat underlying lung/heart disease. Long-term Oxygen Therapy (LTOT) if hypoxic. Specialist medications: Phosphodiesterase-5 inhibitors (Sildenafil), Endothelin receptor antagonists, Prostacyclins.


 **Red Flags: Syncope on exertion is a major red flag indicating the right heart is failing to pump enough blood through the stiff lungs to maintain brain perfusion.**

 *Patient Explanation: "High blood pressure specifically in the blood vessels of your lungs. It makes the right side of your heart work extremely hard to push blood through, eventually causing the right heart to fail. Treated with oxygen and special blood vessel-opening tablets."*

Radiculopathy / Sciatica


History (Symptoms)	Unilateral shooting, burning, or 'electric shock' pain radiating down the leg (past the knee) or arm. Associated with numbness, tingling, or weakness in a specific dermatome. Often triggered by lifting/bending.
Examination (Signs)	Positive Straight Leg Raise test (reproduces shooting pain down the leg at <60 degrees). Reduced reflexes (e.g., absent ankle jerk). Sensory loss in specific dermatome. Motor weakness in specific myotome.
Bedside / GP	Detailed neurological examination of the limbs. Assess gait (e.g., foot drop).
Investigations	Clinical diagnosis initially. MRI Spine if symptoms persist >6 weeks, or if there are red flags, or prior to surgical intervention.
Management (NICE/BNF)	Conservative: Keep active, physiotherapy, neuropathic analgesia (Amitriptyline, Duloxetine). Epidural steroid injections. Surgery (Microdiscectomy) if severe/progressive weakness.


 **Red Flags: Cauda Equina Syndrome: Saddle anaesthesia (numbness around genitals/anus), recent onset urinary retention/incontinence, faecal incontinence, bilateral leg weakness. An absolute neurosurgical emergency.**

 *Patient Explanation: "A nerve root in your spine is being pinched, often by a bulging ('slipped') disc. The brain feels this as shooting pain, numbness, or weakness all the way down the arm or leg the nerve supplies. It usually improves with time and physiotherapy."*

Raised Intracranial Pressure (Idiopathic/General)

History (Symptoms)	Headache that is worse in the morning, worse when lying flat, coughing, or straining. Associated with nausea, projectile vomiting, and transient visual obscurations (vision briefly goes black when standing).
Examination (Signs)	Papilloedema on fundoscopy (swollen optic discs). Reduced visual fields (enlarged blind spot). Unilateral or bilateral 6th nerve palsy (inability to look outwards, causing double vision).
Bedside / GP	Fundoscopy is MANDATORY. Check visual acuity and visual fields.
Investigations	Urgent MRI or CT Head (to rule out a space-occupying lesion like a tumour). If clear, Lumbar Puncture with pressure measurement (diagnostic for Idiopathic Intracranial Hypertension).
Management (NICE/BNF)	Treat underlying cause if mass lesion. For Idiopathic (IIH): Weight loss (highly effective), Acetazolamide to reduce CSF production. Surgical shunting or optic nerve sheath fenestration if vision is threatened.


 **Red Flags: Rapidly deteriorating GCS, irregular breathing, and bradycardia with hypertension (Cushing's triad) indicates imminent fatal brain herniation (coning).**

 **Patient Explanation:** "The pressure inside your skull is too high. This can be due to a growth, bleeding, or sometimes just too much brain fluid (Idiopathic). It causes morning headaches and pushes on the back of the eyes, which can damage your vision if not treated."

Respiratory Arrest


History (Symptoms)	Patient has stopped breathing or is only gasping (agonal breathing). Often preceded by severe respiratory distress, choking, drug overdose (opiates), or head trauma.
Examination (Signs)	Apnoea (no chest movement). Central cyanosis (blue lips/tongue). Unresponsive. Pulse MAY initially be present (unlike cardiac arrest) but will quickly disappear if oxygen is not restored.
Bedside / GP	Immediate ABCDE assessment. Look, listen, and feel for breathing for no more than 10 seconds.
Investigations	None acutely. Action is required immediately.
Management (NICE/BNF)	Basic Life Support. Open the airway (head tilt/chin lift or jaw thrust). Give rescue breaths via a bag-valve-mask (BVM) attached to high-flow oxygen. Reverse causes (e.g., IV Naloxone for opiate overdose). Proceed to CPR if pulse is lost.


 **Red Flags: Failure to recognise and act immediately will result in hypoxic brain injury and secondary cardiac arrest within minutes.**

 *Patient Explanation: "The patient has completely stopped breathing but their heart might still be beating. We must immediately open their airway and breathe for them using a special mask and oxygen bag, or they will go into full cardiac arrest."*

Rhinosinusitis (Acute and Chronic)


History (Symptoms)	Nasal congestion, thick purulent (green/yellow) nasal discharge, facial pain/pressure (worse on bending forward), loss of smell (anosmia). Acute <12 weeks (usually post-viral). Chronic >12 weeks.
Examination (Signs)	Tenderness on palpating the maxillary or frontal sinuses. Nasal polyps may be visible in chronic cases. Inflamed, boggy nasal mucosa.
Bedside / GP	Check temperature to rule out systemic infection.
Investigations	Usually a clinical diagnosis. Nasendoscopy (by ENT) for chronic cases. CT Sinuses if surgery is being considered or complications suspected.
Management (NICE/BNF)	Acute (mostly viral): Analgesia, saline nasal douches, topical decongestants (max 7 days). Antibiotics ONLY if severely systemically unwell or >10 days. Chronic: Intranasal corticosteroids (fluticasone).


 **Red Flags: Unilateral symptoms (especially blood-stained discharge) could indicate a nasal tumour. Orbital cellulitis (red, swollen, painful eye with double vision) is a dangerous complication requiring admission.**

 *Patient Explanation: "Inflammation of the hollow spaces in your facial bones (sinuses). They fill with mucus, causing pressure, pain, and a blocked nose. Most cases follow a cold and clear up without antibiotics, helped by steroid nasal sprays and painkillers."*

Right Heart Valve Disease (Tricuspid/Pulmonary)

History (Symptoms)	Often secondary to left-sided heart failure or pulmonary hypertension. Fatigue, breathlessness, abdominal swelling, ankle swelling, palpitations.
Examination (Signs)	Tricuspid Regurgitation (most common): Pan-systolic murmur at the lower left sternal edge, prominent 'v' waves in the JVP, pulsatile enlarged liver, severe peripheral pitting oedema.
Bedside / GP	12-lead ECG, assess JVP and peripheral oedema.
Investigations	Echocardiogram (diagnostic to assess valve structure and right ventricular function). Bloods: U&Es, LFTs (liver congestion).
Management (NICE/BNF)	Mainly medical management: Diuretics (Furosemide) to offload fluid, treat underlying lung disease or left heart failure. Surgical repair/replacement is rare and high-risk. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Furosemide 40mg OD PO (Titrate to symptoms)

 **Red Flags: Development of cardiac cirrhosis (liver failure due to severe chronic right-sided heart failure backing up blood into the liver).**

 **Patient Explanation:** "The valves on the right side of the heart have become leaky or stiff. Because the right heart pumps blood to the lungs and receives blood from the body, a failing valve causes fluid to back up into your liver and legs, causing swelling."

Rubella (German Measles)

History (Symptoms) Often mild or asymptomatic. Low-grade fever, mild coryza, swollen glands (especially behind the ears/suboccipital), followed by a pinkish maculopapular rash.

Examination (Signs) Prominent suboccipital and postauricular lymphadenopathy. A fine, pink, non-confluent rash starting on the face and spreading to the trunk (fades within 3-5 days).


Bedside / GP Check vaccination history (MMR).


Investigations Notify Public Health. Oral fluid (saliva) swab or blood test for Rubella IgM/IgG to confirm.

Management (NICE/BNF) Supportive (fluids, Paracetamol). Keep away from school/work for 5 days from the onset of the rash.

BNF/BNFC Dosage Guide:

- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)

 **Red Flags: Congenital Rubella Syndrome: If a pregnant woman catches rubella in the first 20 weeks, it causes devastating fetal defects (sensorineural deafness, cataracts, congenital heart disease).**


 **Patient Explanation:** "A mild viral illness that causes a brief rash and swollen glands. It is harmless to children and adults, but highly dangerous to unborn babies. The MMR vaccine has almost eradicated it in the UK."


Sarcoidosis

History (Symptoms)	Often asymptomatic (incidental finding on CXR). Dry cough, progressive breathlessness, fatigue, joint pain, painful red lumps on shins (Erythema Nodosum). More common in Afro-Caribbean patients.
Examination (Signs)	Erythema Nodosum on legs. Lupus pernio (purple rash on nose/cheeks). May have crackles in lungs, lymphadenopathy, or uveitis (red eye).
Bedside / GP	Check calcium levels (sarcoid granulomas produce active Vitamin D, causing hypercalcaemia).
Investigations	Chest X-ray (Bilateral Hilar Lymphadenopathy - BHL). High-resolution CT chest. Tissue biopsy (e.g., lymph node) showing NON-caseating granulomas. High serum ACE levels.
Management (NICE/BNF)	Asymptomatic BHL requires no treatment (often spontaneously resolves). Symptomatic/progressive disease: Oral Corticosteroids (Prednisolone) for 6-24 months. Methotrexate if steroid-sparing needed.

BNF/BNFC Dosage Guide:


- Prednisolone 40mg OD PO (Adult Acute Asthma) | 1-2mg/kg PO (Child)


 **Red Flags: Cardiac sarcoidosis (causing fatal arrhythmias/heart block) or neurosarcoidosis (nerve palsies/seizures).**

 *Patient Explanation: "An immune system disorder that causes tiny clumps of inflammatory cells (granulomas) to form in organs, most commonly the lungs and lymph nodes. It often goes away on its own, but severe cases need steroid tablets to protect the organs."*

Scabies


History (Symptoms)	Intense, widespread itching that is significantly WORSE AT NIGHT. Other household members or close contacts are often also itching. Rash affects web spaces of fingers, wrists, and genitals.
Examination (Signs)	Small, silvery-grey linear burrows visible in the web spaces of fingers/toes and flexor surfaces of wrists. Excoriations (scratch marks) and generalized red papules.
Bedside / GP	Examine the hands, wrists, and genitalia very closely. Use a dermatoscope to look for the mite at the end of a burrow.
Investigations	Clinical diagnosis.
Management (NICE/BNF)	Topical Permethrin 5% cream (applied to the ENTIRE body from the neck down, left for 8-12 hours, then washed off. Repeat exactly 1 week later). ALL household contacts must be treated simultaneously, even if asymptomatic. Wash all bedding/clothes at 60 degrees.


 **Red Flags: Crusted (Norwegian) Scabies: A hyper-infestation in immunocompromised/elderly patients causing thick, crusty plaques. Highly contagious, requires Ivermectin and isolation.**

 **Patient Explanation:** "A skin infestation caused by tiny mites that burrow under the skin to lay eggs. It causes extreme itching, especially at night. You and everyone you live with must apply a special cream all over your bodies to kill the mites."

Scleritis


History (Symptoms)	Severe, boring, deep eye pain that radiates to the forehead/jaw and is worse at night (often waking the patient). Pain worsens with eye movement. Blurred vision. Associated with Rheumatoid Arthritis / Vasculitis.
Examination (Signs)	The eye is deeply red with a 'bluish/purplish' hue. The redness does NOT blanch (turn white) when phenylephrine drops are applied (unlike the milder condition, episcleritis). Globe is very tender to palpation.
Bedside / GP	Visual acuity. Phenylephrine drop test (differentiates episcleritis from scleritis).
Investigations	Urgent same-day ophthalmology review. Autoimmune blood screen (Rheumatoid Factor, ANA, ANCA).
Management (NICE/BNF)	Oral NSAIDs (Flurbiprofen) for mild cases. High-dose oral Corticosteroids or immunosuppressants (Methotrexate) for severe or necrotizing cases.


 **Red Flags: Necrotizing scleritis can melt the sclera, causing the eye to perforate and leading to permanent blindness.**

 *Patient Explanation: "A severe, deep inflammation of the tough white outer layer of your eye. It is extremely painful and often linked to arthritis conditions. It requires urgent specialist treatment with strong anti-inflammatory tablets to prevent permanent damage to the eye."*

Septic Arthritis


History (Symptoms)	Rapid onset of severe pain, swelling, and redness in a single joint (most commonly the knee). The patient is unable to bear weight or move the joint. Fever and systemic malaise. Often in patients with existing joint disease or prosthetics.
Examination (Signs)	Joint is hot, red, and visibly swollen (effusion). SEVERE pain on even the slightest active or passive movement. Fever.
Bedside / GP	Vital signs (sepsis check). Do NOT attempt to move the joint excessively if they are in agony.
Investigations	Joint aspiration MUST be done BEFORE starting antibiotics. Fluid is sent for urgent Gram stain and culture (usually Staphylococcus aureus). Bloods: very high CRP/ESR, blood cultures.
Management (NICE/BNF)	Medical emergency. Admission for prolonged IV antibiotics (e.g., Flucloxacillin) for 4-6 weeks. Urgent orthopaedic surgical washout/lavage of the joint. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Flucloxacillin 500mg QDS PO (Skin infections)


 **Red Flags: Any acute, hot, swollen, painful joint is Septic Arthritis until proven otherwise by aspiration. Delays in antibiotics/washout lead to rapid, irreversible destruction of the joint cartilage within days.**

 **Patient Explanation:** "A highly dangerous bacterial infection inside a joint space. It causes intense pain and swelling and will rapidly destroy the joint if not treated. It requires emergency hospital admission, joint drainage, and weeks of IV antibiotics."

Somatisation (Somatic Symptom Disorder)


History (Symptoms)	Multiple, chronic, medically unexplained physical symptoms (e.g., pain, GI upset, fatigue) causing significant distress and impairment in daily life. Constant worry about the symptoms.
Examination (Signs)	Physical examination is generally normal, or findings do not match the severity of the symptoms described.
Bedside / GP	Thoroughly review previous investigations to avoid unnecessary repetition.
Investigations	Rule out organic causes with targeted, evidence-based tests. ONCE ruled out, stop ordering further invasive tests to 'prove' nothing is wrong.
Management (NICE/BNF)	Validation of the patient's distress (the pain is real to them). Regular, scheduled appointments with a single trusted GP. Cognitive Behavioural Therapy (CBT). Treat co-morbid depression/anxiety with SSRIs.


 **Red Flags: Missing a genuine, rare organic pathology by misattributing new red-flag symptoms to their somatic disorder.**

 *Patient Explanation: "A condition where psychological distress and anxiety are experienced as very real, severe physical symptoms. Your body is sounding an alarm, but there is no physical disease. Talking therapies and a strong doctor-patient relationship help manage the distress."*

Spinal Cord Compression


History (Symptoms)	Gradually worsening severe back pain, spreading in a 'band-like' fashion around the chest/abdomen. Followed by weakness/heaviness in the legs, sensory loss, and finally bowel/bladder incontinence or retention. Often a history of cancer (prostate, breast, lung).
Examination (Signs)	Upper Motor Neuron (UMN) signs BELOW the level of compression: Spastic weakness, hyperreflexia, upgoing plantars (Babinski positive). Sensory level (loss of sensation below a specific dermatome). Palpable bladder.
Bedside / GP	Full neurological examination of legs. Bladder scan for urinary retention. DRE for anal tone.
Investigations	URGENT whole-spine MRI within 24 hours (or immediately if neurologically compromised).
Management (NICE/BNF)	Medical Emergency. Immediate high-dose oral/IV Dexamethasone (16mg) to reduce swelling. Urgent neurosurgical decompression or palliative radiotherapy. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Dexamethasone 0.15mg/kg PO STAT (Croup)


 **Red Flags: Any cancer patient presenting with new, severe back pain or any leg weakness/sensory change must be treated as cord compression until proven otherwise.**

 **Patient Explanation:** "A tumour or bone fragment is pressing heavily on your spinal cord. This cuts off nerve signals, causing back pain and leg weakness. It is a major emergency; without immediate high-dose steroids and surgery/radiotherapy, it will cause permanent paralysis."

Spinal Fracture / Injury


History (Symptoms)	Major trauma (RTC, fall from height) or minor trauma in elderly/osteoporotic patients. Severe, localised back/neck pain. May have numbness, tingling, or inability to move limbs.
Examination (Signs)	Midline bony tenderness on palpation of the spine. Step deformity or gap in the spinous processes. Neurological deficits (weakness, absent reflexes, priapism in severe trauma).
Bedside / GP	Immobilise the spine IMMEDIATELY (cervical collar, blocks, spinal board). Do not move the patient without log-rolling.
Investigations	Trauma CT scan of the spine (head/neck/thorax/abdomen/pelvis). Plain X-rays if low-impact.
Management (NICE/BNF)	Strict spinal immobilization. Analgesia. Neurosurgery/Orthopaedic referral for surgical fixation or conservative management with rigid bracing (e.g., TLSO brace).


 **Red Flags: Neurogenic shock (hypotension with BRADYCARDIA) due to loss of sympathetic tone in high spinal cord injuries. Requires ICU support.**

 *Patient Explanation: "A break in one of the bones in your spine. We must keep you absolutely flat and still using special boards and collars to prevent the broken bone from moving and slicing through the spinal cord, which would cause paralysis."*

Cutaneous Fungal Infection (Tinea / Ringworm)


History (Symptoms)	Itchy, red, flaky rash. Tinea corporis (body): ring-shaped. Tinea pedis (athlete's foot): between the toes, peeling skin. Tinea capitis (scalp): hair loss, scaling. History of contact with animals, damp environments, or gym use.
Examination (Signs)	Annular (ring-shaped) erythematous lesions with a scaly, raised, active leading edge and central clearing. Boggy swelling on the scalp (kerion) in severe Tinea capitis.
Bedside / GP	Wood's lamp examination (some fungal strains fluoresce, though not all).
Investigations	Skin scrapings, hair plucks, or nail clippings sent for fungal microscopy and culture (mycology).
Management (NICE/BNF)	Localised (skin): Topical antifungal creams (Terbinafine, Miconazole, Clotrimazole) for 1-2 weeks after rash clears. Scalp/Nails/Widespread: Oral antifungals (Oral Terbinafine or Itraconazole).


 **Red Flags: DO NOT use topical corticosteroids (e.g., Hydrocortisone) alone on a fungal infection; it masks the inflammation but feeds the fungus, causing 'Tinea Incognito' (a deep, atypical spreading infection).**

 **Patient Explanation:** "A common, harmless but itchy infection of the skin, nails, or scalp caused by a fungus (not an actual worm). It often forms a red ring on the skin. Antifungal creams usually clear it up, but nail or scalp infections need tablets."

Cutaneous Warts (Verrucae)


History (Symptoms)	Small, rough lumps on the skin. Often painless, but verrucae on the soles of the feet can be painful when walking/standing. Caused by Human Papillomavirus (HPV). Very common in children and young adults.
Examination (Signs)	Firm, hyperkeratotic (rough/scaly) papules. Scraping the surface reveals tiny black dots (thrombosed capillaries), which differentiates them from corns/calluses.
Bedside / GP	Clinical inspection. Paring down the wart with a scalpel to look for thrombosed capillaries.
Investigations	Clinical diagnosis. Biopsy only if the lesion is atypical, bleeding, or suspect for malignancy (e.g., squamous cell carcinoma).
Management (NICE/BNF)	Watch and wait (most resolve spontaneously within 1-2 years). Daily application of topical Salicylic acid (requires patience). Cryotherapy (freezing with liquid nitrogen) in clinic.


 **Red Flags: Rapidly growing, bleeding, or unusually pigmented warts must be referred to rule out skin cancer, particularly in immunocompromised patients.**

 *Patient Explanation: "Hard, rough lumps on the skin caused by a common virus. They are harmless and usually go away on their own eventually as your immune system fights them off, but we can treat them with freezing or acid paints if they are bothersome."*

Developmental Delay

History (Symptoms)	Child failing to reach expected milestones in one or more domains: Gross Motor (e.g., not walking by 18m), Fine Motor/Vision (e.g., no pincer grip by 12m), Speech/Language (e.g., no words by 18m), or Social/Emotional (e.g., no social smile by 8 weeks).
Examination (Signs)	Assess dysmorphic features, muscle tone (spasticity or hypotonia), squint, or hearing deficits. Observe child at play.
Bedside / GP	Check the child's 'Red Book' (Personal Child Health Record). Plot height, weight, and head circumference.
Investigations	Formal audiology assessment (ALWAYS rule out hearing loss for speech delay). Vision check. Bloods (Thyroid, Creatine Kinase for muscular dystrophy), Genetic testing (Microarray).
Management (NICE/BNF)	Multidisciplinary approach: Paediatrician, Speech and Language Therapy (SALT), Physiotherapy, Occupational Therapy, Health Visitor support. Educational support.

 **Red Flags: Loss of previously acquired skills (regression) is an absolute red flag for a progressive neurological or metabolic disorder and requires urgent specialist referral.**

 *Patient Explanation: "When a child takes longer than expected to reach specific learning, movement, or speaking milestones. We check their hearing and vision first, and involve specialists like speech therapists to help them catch up or identify any underlying conditions."*

Kawasaki Disease

History (Symptoms) Prolonged high fever (>5 days) in a child (usually <5 years old) that does not respond well to Paracetamol. Extreme irritability, rash, red eyes, and peeling skin.

Examination (Signs) CRASH and Burn: Conjunctivitis (bilateral, non-purulent), Rash (polymorphous), Adenopathy (cervical lymph node >1.5cm), Strawberry tongue/cracked lips, Hands/feet swelling or peeling. 'Burn' = Fever >5 days.


Bedside / GP Urine dipstick, vital signs.


Investigations Urgent Paediatric assessment. Echocardiogram is critical (to check for coronary artery aneurysms). Bloods: markedly raised CRP/ESR, high platelets (thrombocytosis) in the second week.

Management (NICE/BNF) Hospital admission. High-dose IV Immunoglobulin (IVIG) and high-dose oral Aspirin to reduce inflammation and prevent coronary artery damage.

BNF/BNFC Dosage Guide:

- Aspirin 300mg STAT (Emergency) or 75mg OD (Maintenance)

 **Red Flags: Coronary artery aneurysms are the most feared complication, leading to myocardial infarction (heart attacks) in young children if IVIG is not given promptly.**


 *Patient Explanation: "A rare but serious inflammatory illness in young children that causes a prolonged high fever, red eyes, a rash, and a 'strawberry' tongue. It requires urgent hospital treatment to protect the blood vessels around the heart from permanent damage."*


Liver Failure (Acute)

History (Symptoms)	Rapid onset of severe jaundice, profound fatigue, nausea, vomiting, confusion, and easy bruising/bleeding. No prior history of chronic liver disease. Causes: Paracetamol overdose, acute viral hepatitis (A, B, E), autoimmune hepatitis.
Examination (Signs)	Hepatic encephalopathy (altered GCS, confusion, asterixis/flapping tremor). Jaundice. Signs of bleeding. Ascites may develop rapidly.
Bedside / GP	Urgent ABCDE. Capillary blood glucose (liver fails to store glycogen, leading to severe hypoglycaemia).
Investigations	Markedly prolonged PT/INR (first indicator of failure). Massive rise in LFTs (ALT/AST). Bilirubin high. Renal function (high risk of hepatorenal syndrome). Paracetamol level, Hepatitis serology.
Management (NICE/BNF)	ICU admission. Treat cause (N-acetylcysteine for paracetamol toxicity). Correct hypoglycaemia with IV Dextrose. Lactulose for encephalopathy. Urgent discussion with a liver transplant centre.

BNF/BNFC Dosage Guide:


- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)


 **Red Flags: Development of hepatic encephalopathy or severe coagulopathy (bleeding) is the defining feature distinguishing liver 'injury' from liver 'failure'. High mortality rate.**

 *Patient Explanation: "A rare, life-threatening emergency where a previously healthy liver rapidly stops working, often due to an overdose or severe virus. Toxins build up in the blood causing confusion, and blood stops clotting properly. It often requires care in intensive care and possibly a liver transplant."*

Lower Limb Fractures (Neck of Femur)


History (Symptoms)	Elderly patient. History of a fall. Severe pain in the hip/groin. Unable to bear weight or move the leg.
Examination (Signs)	The affected leg is typically SHORTENED and EXTERNALLY ROTATED. Pain on any attempt to move the hip.
Bedside / GP	Assess ABCDE (elderly patients may have fallen due to a medical cause like MI, stroke, or infection). Do not move the leg unnecessarily.
Investigations	X-ray Pelvis and affected hip (AP and Lateral views). Pre-op bloods (FBC, U&Es, Clotting, Group and Save). ECG and CXR for surgical fitness.
Management (NICE/BNF)	Adequate analgesia (e.g., Fascia Iliaca block). Surgery within 36 hours. Intracapsular fracture: Hemiarthroplasty or Total Hip Replacement. Extracapsular: Dynamic Hip Screw (DHS) or Intramedullary Nail.


 **Red Flags: High risk of deep vein thrombosis (DVT), pneumonia, and delirium post-operatively. Must actively prevent pressure sores.**

 *Patient Explanation: "A broken hip, very common in older people after a fall. The leg usually looks shorter and turned outwards. It almost always requires surgery to fix the bone or replace the joint so the patient can walk again."*

Lower Limb Soft Tissue Injury (ACL Tear)


History (Symptoms)	Sports injury (often football/skiing). Sudden deceleration, pivoting, or twisting injury. The patient often hears or feels a loud 'POP'. Rapid swelling (haemarthrosis) within 1-2 hours. Inability to continue playing. Instability/'giving way' later on.
Examination (Signs)	Grossly swollen knee. Positive Lachman test (increased forward translation of the tibia with a soft end-point). Positive Anterior Drawer test.
Bedside / GP	Examine the uninjured knee first for comparison. Assess neurovascular status of the foot.
Investigations	Plain X-ray to rule out fractures (e.g., tibial plateau, Segond fracture). MRI is the gold standard for diagnosing ligament and meniscal tears.
Management (NICE/BNF)	Acute: RICE (Rest, Ice, Compression, Elevation), analgesia. Long-term: Physiotherapy to strengthen quadriceps/hamstrings. Surgical reconstruction (using hamstring/patellar tendon graft) for young/active patients experiencing instability.


 **Red Flags: A locked knee (unable to fully straighten) suggests an associated 'bucket-handle' meniscal tear flipped into the joint, which requires urgent arthroscopic surgery.**

 **Patient Explanation:** "A tear of the main stabilising ligament in the centre of the knee, usually from a twisting sports injury. It causes immediate severe swelling and makes the knee feel wobbly. It is managed with intense physio and sometimes a surgical rebuild."

Malabsorption (e.g., Chronic Pancreatitis / Coeliac)


History (Symptoms)	Chronic diarrhoea, steatorrhoea (pale, greasy, foul-smelling stools that are difficult to flush), unintentional weight loss, abdominal bloating. Symptoms of nutritional deficiencies: fatigue (anaemia), easy bruising (Vit K), bone pain (Vit D).
Examination (Signs)	Signs of weight loss, cachexia. Pallor. Glossitis (smooth red tongue from B12 deficiency), angular stomatitis. Easy bruising.
Bedside / GP	Calculate BMI. Inspect stool if possible.
Investigations	Faecal Elastase (low in pancreatic exocrine insufficiency). Coeliac screen (Anti-tTG antibodies). Bloods: FBC, B12, Folate, Iron, Calcium, Vitamin D, clotting profile.
Management (NICE/BNF)	Depends on cause. Pancreatic insufficiency: Creon (pancreatic enzyme replacement therapy) taken with meals. Coeliac: strict gluten-free diet. Replace missing vitamins/minerals.


 **Red Flags: Unexplained weight loss and steatorrhoea in older patients requires urgent imaging (CT Pancreas) to rule out Pancreatic Cancer.**

 **Patient Explanation:** "The bowel is failing to absorb nutrients and fats from food properly, causing weight loss, vitamin deficiencies, and pale, greasy bowel movements. We need to find the cause (like a pancreas problem or gluten allergy) to treat it."

Neuropathies (Guillain-Barré Syndrome)


History (Symptoms)	History of a recent GI infection (typically <i>Campylobacter jejuni</i>) or respiratory tract infection 1-3 weeks prior. Symmetrical, progressive weakness starting in the feet and legs, ascending upwards to the arms and face. Tingling in hands/feet.
Examination (Signs)	Lower Motor Neuron signs: Flaccid weakness (reduced tone), profoundly ABSENT reflexes (areflexia) in the affected limbs. Sensation is often relatively preserved compared to the severe motor weakness.
Bedside / GP	Regular monitoring of Forced Vital Capacity (FVC) using a spirometer at the bedside to check for respiratory muscle weakness.
Investigations	Lumbar Puncture: shows classic 'cytoalbuminologic dissociation' (high protein, normal white cell count). Nerve Conduction Studies show slowed conduction (demyelination).
Management (NICE/BNF)	Medical Emergency. IV Immunoglobulins (IVIG) or Plasmapheresis. Intensive care support for mechanical ventilation if respiratory muscles fail.


 **Red Flags: Respiratory failure and autonomic dysfunction (dangerous swings in blood pressure and heart rate) can occur rapidly and are the main causes of death.**

 *Patient Explanation: "A rare condition where your immune system attacks your peripheral nerves after a minor infection. It causes rapid weakness starting in the legs and moving up the body. Patients need close hospital monitoring as it can affect breathing muscles, but most eventually recover."*

Non-Accidental Injury (Child Safeguarding)


History (Symptoms)	Injury mechanism described by parents is inconsistent with the child's developmental stage (e.g., a 2-month-old 'rolling off' a sofa). Delayed presentation to healthcare. Changing or vague stories. Frequent A&E attendances.
Examination (Signs)	Bruises in non-mobile infants ('those who don't cruise rarely bruise'). Bruises on protected areas (ears, neck, abdomen, inner thighs). Bite marks, cigarette burns, retinal haemorrhages.
Bedside / GP	Thoroughly document the exact size, shape, and colour of all injuries. Use body maps. Examine the child completely undressed.
Investigations	Skeletal survey (full body X-rays looking for occult/healing fractures, especially rib or spiral long-bone fractures). CT Head if under 1 or head injury suspected. Ophthalmology review for retinal haemorrhages.
Management (NICE/BNF)	ADMIT the child to a paediatric ward for safety if there is any suspicion. Immediate referral to senior Paediatrician and hospital Safeguarding Team. Involve Social Services and Police.


 **Red Flags: Failing to recognize NAI can result in the child being sent back to a dangerous environment, leading to severe injury or death. ALWAYS trust your instinct and escalate concerns.**

 *Patient Explanation: "Injuries in a child that raise suspicion they were not caused by an accident. Certain patterns, like bruises on babies who can't walk, or stories that don't make sense, must be taken extremely seriously by doctors to keep the child safe."*

Pelvic Organ Prolapse


History (Symptoms)	Older or multiparous woman. Sensation of a 'lump' or 'dragging' feeling coming down in the vagina. Urinary symptoms (stress incontinence, incomplete emptying), bowel symptoms (need to press on vagina to defecate), dyspareunia.
Examination (Signs)	Sims speculum examination (assessing anterior and posterior walls). May see prolapse of the bladder (cystocele), rectum (rectocele), or uterus protruding into or out of the vagina. Assess with patient bearing down/coughing.
Bedside / GP	Urine dipstick to rule out concurrent UTI. Assess BMI.
Investigations	Usually a clinical diagnosis. Urodynamic studies if concurrent complex urinary incontinence is planned for surgery.
Management (NICE/BNF)	Conservative: Weight loss, smoking cessation (reduces coughing), pelvic floor exercises, vaginal ring pessaries. Surgical: Anterior/posterior colporrhaphy, vaginal hysterectomy.


 **Red Flags: Complete uterine procidentia (uterus fully outside the vagina) can lead to severe ulceration, bleeding, and urinary retention due to kinking of the urethra.**

 **Patient Explanation:** "The muscles and ligaments supporting the pelvic organs (bladder, womb, or bowel) have weakened, allowing them to bulge down into the vagina. It causes a dragging sensation but can be helped with exercises, support devices, or surgery."

Personality Disorders (e.g., Emotionally Unstable / Borderline)


History (Symptoms)	Long-standing, pervasive patterns of inner experience and behaviour. EUPD/ Borderline: intense fear of abandonment, unstable intense relationships, chronic feelings of emptiness, emotional lability, impulsivity, recurrent self-harm or suicidal threats.
Examination (Signs)	Patient may exhibit intense, shifting emotions during consultation. Evidence of self-harm scars (e.g., cutting). May split staff (idealizing some, demonizing others).
Bedside / GP	Risk assessment for suicide, self-harm, and vulnerability.
Investigations	Psychiatric evaluation using structured clinical interviews. Rule out bipolar disorder or substance abuse, which often co-occur.
Management (NICE/BNF)	Psychological therapies are first-line: Dialectical Behaviour Therapy (DBT) is most effective for EUPD. Medications (e.g., SSRIs, low-dose antipsychotics) are only used for specific co-morbidities like depression, NOT the personality disorder itself.


 **Red Flags: High risk of completed suicide, especially during times of crisis or relationship breakdown. High risk of substance abuse and accidental overdose.**

 *Patient Explanation: "Deeply ingrained patterns of thinking and behaving that make relationships and managing emotions extremely difficult. People with borderline personality disorder feel emotions very intensely and may self-harm. Specific talking therapies are the main treatment."*

Retinopathy (Diabetic)


History (Symptoms)	Early stages: Completely asymptomatic (picked up on annual screening). Late stages: blurred vision, sudden vision loss (vitreous haemorrhage), 'floaters'. Poorly controlled diabetes.
Examination (Signs)	Background: microaneurysms, dot-and-blot haemorrhages, hard exudates. Pre-proliferative: Cotton wool spots. Proliferative: Neovascularisation (new, fragile blood vessels growing on the retina or optic disc). Maculopathy: exudates near the macula.
Bedside / GP	Visual acuity. Check HbA1c and Blood Pressure.
Investigations	Digital retinal photography (routine screening). Optical Coherence Tomography (OCT) to assess macular oedema. Fluorescein angiography.
Management (NICE/BNF)	Optimise blood sugar and blood pressure. Background: routine monitoring. Proliferative: Urgent Pan-Retinal Photocoagulation (PRP) laser treatment. Maculopathy: Anti-VEGF injections.


 **Red Flags: Neovascularisation (Proliferative retinopathy) is a major red flag as these fragile vessels can suddenly bleed into the eye or detach the retina, causing permanent blindness.**

 *Patient Explanation: "High blood sugar over many years damages the tiny blood vessels at the back of the eye. It doesn't cause symptoms until late, which is why annual eye screening is vital. If severe, laser treatment stops the vessels bleeding and saves sight."*

Sexual Dysfunction (Erectile Dysfunction)


History (Symptoms)	Inability to achieve or maintain an erection sufficient for sexual intercourse. Loss of early morning erections suggests a physical cause. Presence of morning erections with situational ED suggests a psychological cause. Ask about cardiovascular risk factors, smoking, alcohol, and medications.
Examination (Signs)	Check peripheral pulses and blood pressure (cardiovascular disease). Testicular examination (size/atrophy). Secondary sexual characteristics.
Bedside / GP	Calculate QRISK3 (ED is heavily linked to underlying cardiovascular disease).
Investigations	Fasting glucose/HbA1c, Lipid profile, early morning Testosterone, LH/FSH. TFTs.
Management (NICE/BNF)	Address modifiable risks (smoking, weight). First line medical: Phosphodiesterase-5 (PDE5) inhibitors (e.g., Sildenafil/Viagra). Vacuum erection devices, intracavernosal injections, or psychological therapy if appropriate.


 **Red Flags: ED is often a 'sentinel symptom' for coronary artery disease. A man presenting with new ED needs a full cardiovascular risk assessment, as a heart attack could follow in 3-5 years.**

 **Patient Explanation:** "Difficulty getting or keeping an erection. While it can be related to stress, it is very often an early warning sign of narrowed blood vessels (which also affects the heart). We check your heart health and can prescribe tablets to improve blood flow."

Sleep Disorders (Obstructive Sleep Apnoea)


History (Symptoms)	Loud snoring, witnessed apnoeas (partner reports they stop breathing during sleep then gasp/snort). Excessive daytime sleepiness (falling asleep at the wheel/desk), morning headaches, unrefreshing sleep. High BMI, large neck circumference.
Examination (Signs)	Obesity (especially thick neck >43cm). Enlarged tonsils, crowded oropharynx.
Bedside / GP	Epworth Sleepiness Scale questionnaire. STOP-BANG questionnaire. Check BMI and blood pressure.
Investigations	Overnight polysomnography (Sleep Study) or home oximetry looking for recurrent desaturations during the night.
Management (NICE/BNF)	Weight loss, smoking cessation, avoid alcohol before bed. Gold standard: Continuous Positive Airway Pressure (CPAP) machine worn at night. Mandibular advancement devices.


 **Red Flags: Severe daytime sleepiness with a history of falling asleep while driving. The patient MUST be advised to stop driving and inform the DVLA until the condition is controlled.**

 *Patient Explanation: "The muscles in your throat relax too much during sleep, blocking your airway. You stop breathing briefly and wake up slightly to gasp for air, ruining your sleep quality. Weight loss and a CPAP breathing mask keep the airway open."*

Substance Use Disorder (Alcohol Dependence)

History (Symptoms)	Strong desire/compulsion to drink. Difficulty controlling intake. Physiological withdrawal state when drinking stops (tremor, sweating, anxiety). Tolerance (needs more to get the same effect). Neglect of other interests. Continued use despite harmful consequences.
Examination (Signs)	May smell of alcohol. Look for stigmata of chronic liver disease (spider naevi, jaundice, hepatomegaly). Tremor, sweating, tachycardia (signs of withdrawal).
Bedside / GP	CAGE questionnaire, AUDIT score. Check vital signs for withdrawal.
Investigations	LFTs (raised GGT, AST, ALT), FBC (Macrocytic anaemia/high MCV), U&Es, Clotting profile.
Management (NICE/BNF)	Community detoxification (reducing regimen of Chlordiazepoxide) if mild. Inpatient detox if severe. MUST prescribe Pabrinex (IV Thiamine) to prevent Wernicke's encephalopathy. Support groups (AA), psychological therapy.

 **Red Flags: Delirium Tremens (DTs): A severe, life-threatening withdrawal state characterized by confusion, visual hallucinations (seeing insects), severe tremor, and seizures. Medical emergency.**

 *Patient Explanation: "A chronic condition where a person is physically and psychologically addicted to alcohol. Stopping suddenly can be dangerous, causing shaking and seizures. Treatment involves a medically supervised detox with specific vitamins to protect the brain, followed by long-term support."*

Surgical Site Infection

History (Symptoms) Recent surgery (usually within 30 days). Increasing pain at the wound site, redness, swelling, discharge of pus. Systemic symptoms like fever and chills.

Examination (Signs) Erythema extending beyond the wound margins, localized warmth, tenderness, purulent discharge, wound dehiscence (wound edges opening up). Fever.


Bedside / GP Vital signs (check for sepsis). Inspect the wound.


Investigations Wound swab for microscopy, culture, and sensitivities (often *Staphylococcus aureus*). Bloods: raised WBC and CRP. Blood cultures if fever present.

Management (NICE/BNF) Remove sutures/staples if pus is present to allow drainage. Mild/superficial: Oral antibiotics (e.g., Flucloxacillin). Deep/severe: IV antibiotics, surgical exploration, and debridement.

BNF/BNFC Dosage Guide:


- Flucloxacillin 500mg QDS PO (Skin infections)


 **Red Flags: Necrotising fasciitis (pain out of proportion, purple/black skin, crepitus) or systemic sepsis. Deep organ space infection (e.g., intra-abdominal abscess after bowel surgery).**

 *Patient Explanation: "An infection in the cut made during an operation. The wound becomes red, hot, painful, and leaks pus. Mild cases need antibiotic tablets, but deeper infections might mean opening the wound to clean it out."*

Syphilis

History (Symptoms)	Primary: Painless ulcer (chancre) on genitals/mouth 3 weeks post-exposure. Secondary (weeks later): Widespread non-itchy maculopapular rash (affecting palms and soles), condylomata lata (wart-like lesions in groin), fever, lymphadenopathy. Latent: asymptomatic. Tertiary (years later): Neurosyphilis, aortic aneurysms, gummas.
Examination (Signs)	Primary: Firm, painless, punched-out ulcer. Secondary: Rash on palms/soles is classic. Tertiary: Argyll Robertson pupil (accommodates but does not react to light).
Bedside / GP	Full sexual health history and STI screen.
Investigations	Dark-field microscopy of ulcer exudate (shows <i>Treponema pallidum</i> spirochetes). Serology: Treponemal specific tests (EIA/TPPA, remain positive for life) and Non-treponemal tests (VDRL/RPR, indicate disease activity/treatment response).
Management (NICE/BNF)	First line: Intramuscular Benzathine Penicillin G (single dose for early syphilis, 3 doses for late latent).

 **Red Flags: Jarisch-Herxheimer reaction: Acute febrile illness with headache and myalgia within 24 hours of starting penicillin due to massive destruction of bacteria. It is self-limiting but warn the patient.**

 **Patient Explanation:** "A sexually transmitted bacterial infection. It starts as a painless sore, then progresses to a full-body rash (especially on the hands and feet). If left untreated for years, it severely damages the brain and heart. It is cured with a penicillin injection."

Tension Headache

History (Symptoms) Bilateral, mild to moderate, 'tight band' or 'pressing' headache. No throbbing. No nausea/vomiting. Not worsened by routine physical activity. Can last for hours or days. Often triggered by stress, poor posture, or lack of sleep.

Examination (Signs) Normal neurological examination. Pericranial muscle tenderness (scalp, neck, and shoulders may feel tight or tender to palpation).


Bedside / GP Fundoscopy and neuro exam to rule out serious pathology.


Investigations Clinical diagnosis. No imaging required if history is typical and exam is normal.

Management (NICE/BNF) Simple analgesia (Paracetamol, Ibuprofen). Reassurance. Stress management, physiotherapy for neck tension, adequate hydration/sleep. Prophylaxis (low dose Amitriptyline) if chronic (>15 days/month).

BNF/BNFC Dosage Guide:


- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)
- Ibuprofen 400mg TDS (Adult) | 10mg/kg TDS (Child)


 **Red Flags: Increasing frequency and reliance on painkillers can lead to Medication Overuse Headache (rebound headaches). Sudden 'thunderclap' headache or headache with fever/stiff neck are red flags for SAH or meningitis.**

 **Patient Explanation:** "The most common type of headache, feeling like a tight band squeezing the head. It's often linked to stress or tight neck muscles. It is not dangerous and responds well to simple painkillers and relaxation."

Termination of Pregnancy


History (Symptoms)	Patient requests an abortion. Must establish exact gestation (date of last menstrual period). Assess reasons, support network, and ensure there is no coercion.
Examination (Signs)	General assessment. Speculum/bimanual examination may be done in clinic to assess uterine size.
Bedside / GP	Urinary pregnancy test. Screen for STIs (Chlamydia swab).
Investigations	Ultrasound scan to confirm gestation and rule out ectopic pregnancy. Bloods: Group and Save (crucial for Rhesus status), FBC.
Management (NICE/BNF)	Medical (<9-10 weeks): Mifepristone (blocks progesterone) followed 24-48h later by Misoprostol (causes contractions/expulsion). Surgical: Manual Vacuum Aspiration (MVA) under local anaesthetic or surgical dilatation and evacuation (D&E) under general.


 **Red Flags: Heavy prolonged bleeding (soaking >2 pads an hour), severe pain, or fever post-procedure suggests retained products of conception or infection, requiring urgent review. Ectopic pregnancy must be ruled out beforehand.**

 **Patient Explanation:** "The medical process of ending a pregnancy. Early on, it is usually done with two sets of tablets that cause the womb to empty like a heavy period. Later on, a minor surgical procedure is used. Support and contraception advice are always provided."

Cutaneous Fungal Infection (Tinea / Ringworm)


History (Symptoms)	Itchy, red, flaky rash. Tinea corporis (body): ring-shaped. Tinea pedis (athlete's foot): between the toes, peeling skin. Tinea capitis (scalp): hair loss, scaling. History of contact with animals, damp environments, or gym use.
Examination (Signs)	Annular (ring-shaped) erythematous lesions with a scaly, raised, active leading edge and central clearing. Boggy swelling on the scalp (kerion) in severe Tinea capitis.
Bedside / GP	Wood's lamp examination (some fungal strains fluoresce, though not all).
Investigations	Skin scrapings, hair plucks, or nail clippings sent for fungal microscopy and culture (mycology).
Management (NICE/BNF)	Localised (skin): Topical antifungal creams (Terbinafine, Miconazole, Clotrimazole) for 1-2 weeks after rash clears. Scalp/Nails/Widespread: Oral antifungals (Oral Terbinafine or Itraconazole).


 **Red Flags: DO NOT use topical corticosteroids (e.g., Hydrocortisone) alone on a fungal infection; it masks the inflammation but feeds the fungus, causing 'Tinea Incognito' (a deep, atypical spreading infection).**

 **Patient Explanation:** "A common, harmless but itchy infection of the skin, nails, or scalp caused by a fungus (not an actual worm). It often forms a red ring on the skin. Antifungal creams usually clear it up, but nail or scalp infections need tablets."

Cutaneous Warts (Verrucae)


History (Symptoms)	Small, rough lumps on the skin. Often painless, but verrucae on the soles of the feet can be painful when walking/standing. Caused by Human Papillomavirus (HPV). Very common in children and young adults.
Examination (Signs)	Firm, hyperkeratotic (rough/scaly) papules. Scraping the surface reveals tiny black dots (thrombosed capillaries), which differentiates them from corns/calluses.
Bedside / GP	Clinical inspection. Paring down the wart with a scalpel to look for thrombosed capillaries.
Investigations	Clinical diagnosis. Biopsy only if the lesion is atypical, bleeding, or suspect for malignancy (e.g., squamous cell carcinoma).
Management (NICE/BNF)	Watch and wait (most resolve spontaneously within 1-2 years). Daily application of topical Salicylic acid (requires patience). Cryotherapy (freezing with liquid nitrogen) in clinic.


 **Red Flags: Rapidly growing, bleeding, or unusually pigmented warts must be referred to rule out skin cancer, particularly in immunocompromised patients.**

 *Patient Explanation: "Hard, rough lumps on the skin caused by a common virus. They are harmless and usually go away on their own eventually as your immune system fights them off, but we can treat them with freezing or acid paints if they are bothersome."*

Developmental Delay

History (Symptoms)	Child failing to reach expected milestones in one or more domains: Gross Motor (e.g., not walking by 18m), Fine Motor/Vision (e.g., no pincer grip by 12m), Speech/Language (e.g., no words by 18m), or Social/Emotional (e.g., no social smile by 8 weeks).
Examination (Signs)	Assess dysmorphic features, muscle tone (spasticity or hypotonia), squint, or hearing deficits. Observe child at play.
Bedside / GP	Check the child's 'Red Book' (Personal Child Health Record). Plot height, weight, and head circumference.
Investigations	Formal audiology assessment (ALWAYS rule out hearing loss for speech delay). Vision check. Bloods (Thyroid, Creatine Kinase for muscular dystrophy), Genetic testing (Microarray).
Management (NICE/BNF)	Multidisciplinary approach: Paediatrician, Speech and Language Therapy (SALT), Physiotherapy, Occupational Therapy, Health Visitor support. Educational support.

 **Red Flags: Loss of previously acquired skills (regression) is an absolute red flag for a progressive neurological or metabolic disorder and requires urgent specialist referral.**

 **Patient Explanation:** "When a child takes longer than expected to reach specific learning, movement, or speaking milestones. We check their hearing and vision first, and involve specialists like speech therapists to help them catch up or identify any underlying conditions."

Kawasaki Disease

History (Symptoms) Prolonged high fever (>5 days) in a child (usually <5 years old) that does not respond well to Paracetamol. Extreme irritability, rash, red eyes, and peeling skin.

Examination (Signs) CRASH and Burn: Conjunctivitis (bilateral, non-purulent), Rash (polymorphous), Adenopathy (cervical lymph node >1.5cm), Strawberry tongue/cracked lips, Hands/feet swelling or peeling. 'Burn' = Fever >5 days.


Bedside / GP Urine dipstick, vital signs.


Investigations Urgent Paediatric assessment. Echocardiogram is critical (to check for coronary artery aneurysms). Bloods: markedly raised CRP/ESR, high platelets (thrombocytosis) in the second week.

Management (NICE/BNF) Hospital admission. High-dose IV Immunoglobulin (IVIG) and high-dose oral Aspirin to reduce inflammation and prevent coronary artery damage.

BNF/BNFC Dosage Guide:

- Aspirin 300mg STAT (Emergency) or 75mg OD (Maintenance)

 **Red Flags: Coronary artery aneurysms are the most feared complication, leading to myocardial infarction (heart attacks) in young children if IVIG is not given promptly.**


 *Patient Explanation: "A rare but serious inflammatory illness in young children that causes a prolonged high fever, red eyes, a rash, and a 'strawberry' tongue. It requires urgent hospital treatment to protect the blood vessels around the heart from permanent damage."*


Liver Failure (Acute)

History (Symptoms)	Rapid onset of severe jaundice, profound fatigue, nausea, vomiting, confusion, and easy bruising/bleeding. No prior history of chronic liver disease. Causes: Paracetamol overdose, acute viral hepatitis (A, B, E), autoimmune hepatitis.
Examination (Signs)	Hepatic encephalopathy (altered GCS, confusion, asterixis/flapping tremor). Jaundice. Signs of bleeding. Ascites may develop rapidly.
Bedside / GP	Urgent ABCDE. Capillary blood glucose (liver fails to store glycogen, leading to severe hypoglycaemia).
Investigations	Markedly prolonged PT/INR (first indicator of failure). Massive rise in LFTs (ALT/AST). Bilirubin high. Renal function (high risk of hepatorenal syndrome). Paracetamol level, Hepatitis serology.
Management (NICE/BNF)	ICU admission. Treat cause (N-acetylcysteine for paracetamol toxicity). Correct hypoglycaemia with IV Dextrose. Lactulose for encephalopathy. Urgent discussion with a liver transplant centre.

BNF/BNFC Dosage Guide:


- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)


 **Red Flags: Development of hepatic encephalopathy or severe coagulopathy (bleeding) is the defining feature distinguishing liver 'injury' from liver 'failure'. High mortality rate.**

 *Patient Explanation: "A rare, life-threatening emergency where a previously healthy liver rapidly stops working, often due to an overdose or severe virus. Toxins build up in the blood causing confusion, and blood stops clotting properly. It often requires care in intensive care and possibly a liver transplant."*

Lower Limb Fractures (Neck of Femur)


History (Symptoms)	Elderly patient. History of a fall. Severe pain in the hip/groin. Unable to bear weight or move the leg.
Examination (Signs)	The affected leg is typically SHORTENED and EXTERNALLY ROTATED. Pain on any attempt to move the hip.
Bedside / GP	Assess ABCDE (elderly patients may have fallen due to a medical cause like MI, stroke, or infection). Do not move the leg unnecessarily.
Investigations	X-ray Pelvis and affected hip (AP and Lateral views). Pre-op bloods (FBC, U&Es, Clotting, Group and Save). ECG and CXR for surgical fitness.
Management (NICE/BNF)	Adequate analgesia (e.g., Fascia Iliaca block). Surgery within 36 hours. Intracapsular fracture: Hemiarthroplasty or Total Hip Replacement. Extracapsular: Dynamic Hip Screw (DHS) or Intramedullary Nail.


 **Red Flags: High risk of deep vein thrombosis (DVT), pneumonia, and delirium post-operatively. Must actively prevent pressure sores.**

 *Patient Explanation: "A broken hip, very common in older people after a fall. The leg usually looks shorter and turned outwards. It almost always requires surgery to fix the bone or replace the joint so the patient can walk again."*

Lower Limb Soft Tissue Injury (ACL Tear)


History (Symptoms)	Sports injury (often football/skiing). Sudden deceleration, pivoting, or twisting injury. The patient often hears or feels a loud 'POP'. Rapid swelling (haemarthrosis) within 1-2 hours. Inability to continue playing. Instability/'giving way' later on.
Examination (Signs)	Grossly swollen knee. Positive Lachman test (increased forward translation of the tibia with a soft end-point). Positive Anterior Drawer test.
Bedside / GP	Examine the uninjured knee first for comparison. Assess neurovascular status of the foot.
Investigations	Plain X-ray to rule out fractures (e.g., tibial plateau, Segond fracture). MRI is the gold standard for diagnosing ligament and meniscal tears.
Management (NICE/BNF)	Acute: RICE (Rest, Ice, Compression, Elevation), analgesia. Long-term: Physiotherapy to strengthen quadriceps/hamstrings. Surgical reconstruction (using hamstring/patellar tendon graft) for young/active patients experiencing instability.


 **Red Flags: A locked knee (unable to fully straighten) suggests an associated 'bucket-handle' meniscal tear flipped into the joint, which requires urgent arthroscopic surgery.**

 **Patient Explanation:** "A tear of the main stabilising ligament in the centre of the knee, usually from a twisting sports injury. It causes immediate severe swelling and makes the knee feel wobbly. It is managed with intense physio and sometimes a surgical rebuild."

Malabsorption (e.g., Chronic Pancreatitis / Coeliac)


History (Symptoms)	Chronic diarrhoea, steatorrhea (pale, greasy, foul-smelling stools that are difficult to flush), unintentional weight loss, abdominal bloating. Symptoms of nutritional deficiencies: fatigue (anaemia), easy bruising (Vit K), bone pain (Vit D).
Examination (Signs)	Signs of weight loss, cachexia. Pallor. Glossitis (smooth red tongue from B12 deficiency), angular stomatitis. Easy bruising.
Bedside / GP	Calculate BMI. Inspect stool if possible.
Investigations	Faecal Elastase (low in pancreatic exocrine insufficiency). Coeliac screen (Anti-tTG antibodies). Bloods: FBC, B12, Folate, Iron, Calcium, Vitamin D, clotting profile.
Management (NICE/BNF)	Depends on cause. Pancreatic insufficiency: Creon (pancreatic enzyme replacement therapy) taken with meals. Coeliac: strict gluten-free diet. Replace missing vitamins/minerals.


 **Red Flags: Unexplained weight loss and steatorrhea in older patients requires urgent imaging (CT Pancreas) to rule out Pancreatic Cancer.**

 *Patient Explanation: "The bowel is failing to absorb nutrients and fats from food properly, causing weight loss, vitamin deficiencies, and pale, greasy bowel movements. We need to find the cause (like a pancreas problem or gluten allergy) to treat it."*

Neuropathies (Guillain-Barré Syndrome)


History (Symptoms)	History of a recent GI infection (typically <i>Campylobacter jejuni</i>) or respiratory tract infection 1-3 weeks prior. Symmetrical, progressive weakness starting in the feet and legs, ascending upwards to the arms and face. Tingling in hands/feet.
Examination (Signs)	Lower Motor Neuron signs: Flaccid weakness (reduced tone), profoundly ABSENT reflexes (areflexia) in the affected limbs. Sensation is often relatively preserved compared to the severe motor weakness.
Bedside / GP	Regular monitoring of Forced Vital Capacity (FVC) using a spirometer at the bedside to check for respiratory muscle weakness.
Investigations	Lumbar Puncture: shows classic 'cytoalbuminologic dissociation' (high protein, normal white cell count). Nerve Conduction Studies show slowed conduction (demyelination).
Management (NICE/BNF)	Medical Emergency. IV Immunoglobulins (IVIG) or Plasmapheresis. Intensive care support for mechanical ventilation if respiratory muscles fail.


 **Red Flags: Respiratory failure and autonomic dysfunction (dangerous swings in blood pressure and heart rate) can occur rapidly and are the main causes of death.**

 *Patient Explanation: "A rare condition where your immune system attacks your peripheral nerves after a minor infection. It causes rapid weakness starting in the legs and moving up the body. Patients need close hospital monitoring as it can affect breathing muscles, but most eventually recover."*

Non-Accidental Injury (Child Safeguarding)


History (Symptoms)	Injury mechanism described by parents is inconsistent with the child's developmental stage (e.g., a 2-month-old 'rolling off' a sofa). Delayed presentation to healthcare. Changing or vague stories. Frequent A&E attendances.
Examination (Signs)	Bruises in non-mobile infants ('those who don't cruise rarely bruise'). Bruises on protected areas (ears, neck, abdomen, inner thighs). Bite marks, cigarette burns, retinal haemorrhages.
Bedside / GP	Thoroughly document the exact size, shape, and colour of all injuries. Use body maps. Examine the child completely undressed.
Investigations	Skeletal survey (full body X-rays looking for occult/healing fractures, especially rib or spiral long-bone fractures). CT Head if under 1 or head injury suspected. Ophthalmology review for retinal haemorrhages.
Management (NICE/BNF)	ADMIT the child to a paediatric ward for safety if there is any suspicion. Immediate referral to senior Paediatrician and hospital Safeguarding Team. Involve Social Services and Police.


 **Red Flags: Failing to recognize NAI can result in the child being sent back to a dangerous environment, leading to severe injury or death. ALWAYS trust your instinct and escalate concerns.**

 *Patient Explanation: "Injuries in a child that raise suspicion they were not caused by an accident. Certain patterns, like bruises on babies who can't walk, or stories that don't make sense, must be taken extremely seriously by doctors to keep the child safe."*

Pelvic Organ Prolapse


History (Symptoms)	Older or multiparous woman. Sensation of a 'lump' or 'dragging' feeling coming down in the vagina. Urinary symptoms (stress incontinence, incomplete emptying), bowel symptoms (need to press on vagina to defecate), dyspareunia.
Examination (Signs)	Sims speculum examination (assessing anterior and posterior walls). May see prolapse of the bladder (cystocele), rectum (rectocele), or uterus protruding into or out of the vagina. Assess with patient bearing down/coughing.
Bedside / GP	Urine dipstick to rule out concurrent UTI. Assess BMI.
Investigations	Usually a clinical diagnosis. Urodynamic studies if concurrent complex urinary incontinence is planned for surgery.
Management (NICE/BNF)	Conservative: Weight loss, smoking cessation (reduces coughing), pelvic floor exercises, vaginal ring pessaries. Surgical: Anterior/posterior colporrhaphy, vaginal hysterectomy.


 **Red Flags: Complete uterine procidentia (uterus fully outside the vagina) can lead to severe ulceration, bleeding, and urinary retention due to kinking of the urethra.**

 **Patient Explanation:** "The muscles and ligaments supporting the pelvic organs (bladder, womb, or bowel) have weakened, allowing them to bulge down into the vagina. It causes a dragging sensation but can be helped with exercises, support devices, or surgery."

Personality Disorders (e.g., Emotionally Unstable / Borderline)


History (Symptoms)	Long-standing, pervasive patterns of inner experience and behaviour. EUPD/ Borderline: intense fear of abandonment, unstable intense relationships, chronic feelings of emptiness, emotional lability, impulsivity, recurrent self-harm or suicidal threats.
Examination (Signs)	Patient may exhibit intense, shifting emotions during consultation. Evidence of self-harm scars (e.g., cutting). May split staff (idealizing some, demonizing others).
Bedside / GP	Risk assessment for suicide, self-harm, and vulnerability.
Investigations	Psychiatric evaluation using structured clinical interviews. Rule out bipolar disorder or substance abuse, which often co-occur.
Management (NICE/BNF)	Psychological therapies are first-line: Dialectical Behaviour Therapy (DBT) is most effective for EUPD. Medications (e.g., SSRIs, low-dose antipsychotics) are only used for specific co-morbidities like depression, NOT the personality disorder itself.


 **Red Flags: High risk of completed suicide, especially during times of crisis or relationship breakdown. High risk of substance abuse and accidental overdose.**

 *Patient Explanation: "Deeply ingrained patterns of thinking and behaving that make relationships and managing emotions extremely difficult. People with borderline personality disorder feel emotions very intensely and may self-harm. Specific talking therapies are the main treatment."*

Retinopathy (Diabetic)


History (Symptoms)	Early stages: Completely asymptomatic (picked up on annual screening). Late stages: blurred vision, sudden vision loss (vitreous haemorrhage), 'floaters'. Poorly controlled diabetes.
Examination (Signs)	Background: microaneurysms, dot-and-blot haemorrhages, hard exudates. Pre-proliferative: Cotton wool spots. Proliferative: Neovascularisation (new, fragile blood vessels growing on the retina or optic disc). Maculopathy: exudates near the macula.
Bedside / GP	Visual acuity. Check HbA1c and Blood Pressure.
Investigations	Digital retinal photography (routine screening). Optical Coherence Tomography (OCT) to assess macular oedema. Fluorescein angiography.
Management (NICE/BNF)	Optimise blood sugar and blood pressure. Background: routine monitoring. Proliferative: Urgent Pan-Retinal Photocoagulation (PRP) laser treatment. Maculopathy: Anti-VEGF injections.


 **Red Flags: Neovascularisation (Proliferative retinopathy) is a major red flag as these fragile vessels can suddenly bleed into the eye or detach the retina, causing permanent blindness.**

 *Patient Explanation: "High blood sugar over many years damages the tiny blood vessels at the back of the eye. It doesn't cause symptoms until late, which is why annual eye screening is vital. If severe, laser treatment stops the vessels bleeding and saves sight."*

Sexual Dysfunction (Erectile Dysfunction)


History (Symptoms)	Inability to achieve or maintain an erection sufficient for sexual intercourse. Loss of early morning erections suggests a physical cause. Presence of morning erections with situational ED suggests a psychological cause. Ask about cardiovascular risk factors, smoking, alcohol, and medications.
Examination (Signs)	Check peripheral pulses and blood pressure (cardiovascular disease). Testicular examination (size/atrophy). Secondary sexual characteristics.
Bedside / GP	Calculate QRISK3 (ED is heavily linked to underlying cardiovascular disease).
Investigations	Fasting glucose/HbA1c, Lipid profile, early morning Testosterone, LH/FSH. TFTs.
Management (NICE/BNF)	Address modifiable risks (smoking, weight). First line medical: Phosphodiesterase-5 (PDE5) inhibitors (e.g., Sildenafil/Viagra). Vacuum erection devices, intracavernosal injections, or psychological therapy if appropriate.


 **Red Flags: ED is often a 'sentinel symptom' for coronary artery disease. A man presenting with new ED needs a full cardiovascular risk assessment, as a heart attack could follow in 3-5 years.**

 **Patient Explanation:** "Difficulty getting or keeping an erection. While it can be related to stress, it is very often an early warning sign of narrowed blood vessels (which also affects the heart). We check your heart health and can prescribe tablets to improve blood flow."

Sleep Disorders (Obstructive Sleep Apnoea)


History (Symptoms)	Loud snoring, witnessed apnoeas (partner reports they stop breathing during sleep then gasp/snort). Excessive daytime sleepiness (falling asleep at the wheel/desk), morning headaches, unrefreshing sleep. High BMI, large neck circumference.
Examination (Signs)	Obesity (especially thick neck >43cm). Enlarged tonsils, crowded oropharynx.
Bedside / GP	Epworth Sleepiness Scale questionnaire. STOP-BANG questionnaire. Check BMI and blood pressure.
Investigations	Overnight polysomnography (Sleep Study) or home oximetry looking for recurrent desaturations during the night.
Management (NICE/BNF)	Weight loss, smoking cessation, avoid alcohol before bed. Gold standard: Continuous Positive Airway Pressure (CPAP) machine worn at night. Mandibular advancement devices.


 **Red Flags: Severe daytime sleepiness with a history of falling asleep while driving. The patient MUST be advised to stop driving and inform the DVLA until the condition is controlled.**

 *Patient Explanation: "The muscles in your throat relax too much during sleep, blocking your airway. You stop breathing briefly and wake up slightly to gasp for air, ruining your sleep quality. Weight loss and a CPAP breathing mask keep the airway open."*

Substance Use Disorder (Alcohol Dependence)

History (Symptoms)	Strong desire/compulsion to drink. Difficulty controlling intake. Physiological withdrawal state when drinking stops (tremor, sweating, anxiety). Tolerance (needs more to get the same effect). Neglect of other interests. Continued use despite harmful consequences.
Examination (Signs)	May smell of alcohol. Look for stigmata of chronic liver disease (spider naevi, jaundice, hepatomegaly). Tremor, sweating, tachycardia (signs of withdrawal).
Bedside / GP	CAGE questionnaire, AUDIT score. Check vital signs for withdrawal.
Investigations	LFTs (raised GGT, AST, ALT), FBC (Macrocytic anaemia/high MCV), U&Es, Clotting profile.
Management (NICE/BNF)	Community detoxification (reducing regimen of Chlordiazepoxide) if mild. Inpatient detox if severe. MUST prescribe Pabrinex (IV Thiamine) to prevent Wernicke's encephalopathy. Support groups (AA), psychological therapy.

 **Red Flags: Delirium Tremens (DTs): A severe, life-threatening withdrawal state characterized by confusion, visual hallucinations (seeing insects), severe tremor, and seizures. Medical emergency.**

 *Patient Explanation: "A chronic condition where a person is physically and psychologically addicted to alcohol. Stopping suddenly can be dangerous, causing shaking and seizures. Treatment involves a medically supervised detox with specific vitamins to protect the brain, followed by long-term support."*

Surgical Site Infection

History (Symptoms) Recent surgery (usually within 30 days). Increasing pain at the wound site, redness, swelling, discharge of pus. Systemic symptoms like fever and chills.

Examination (Signs) Erythema extending beyond the wound margins, localized warmth, tenderness, purulent discharge, wound dehiscence (wound edges opening up). Fever.


Bedside / GP Vital signs (check for sepsis). Inspect the wound.


Investigations Wound swab for microscopy, culture, and sensitivities (often *Staphylococcus aureus*). Bloods: raised WBC and CRP. Blood cultures if fever present.

Management (NICE/BNF) Remove sutures/staples if pus is present to allow drainage. Mild/superficial: Oral antibiotics (e.g., Flucloxacillin). Deep/severe: IV antibiotics, surgical exploration, and debridement.

BNF/BNFC Dosage Guide:


- Flucloxacillin 500mg QDS PO (Skin infections)


 **Red Flags: Necrotising fasciitis (pain out of proportion, purple/black skin, crepitus) or systemic sepsis. Deep organ space infection (e.g., intra-abdominal abscess after bowel surgery).**

 *Patient Explanation: "An infection in the cut made during an operation. The wound becomes red, hot, painful, and leaks pus. Mild cases need antibiotic tablets, but deeper infections might mean opening the wound to clean it out."*

Syphilis

History (Symptoms)	Primary: Painless ulcer (chancre) on genitals/mouth 3 weeks post-exposure. Secondary (weeks later): Widespread non-itchy maculopapular rash (affecting palms and soles), condylomata lata (wart-like lesions in groin), fever, lymphadenopathy. Latent: asymptomatic. Tertiary (years later): Neurosyphilis, aortic aneurysms, gummas.
Examination (Signs)	Primary: Firm, painless, punched-out ulcer. Secondary: Rash on palms/soles is classic. Tertiary: Argyll Robertson pupil (accommodates but does not react to light).
Bedside / GP	Full sexual health history and STI screen.
Investigations	Dark-field microscopy of ulcer exudate (shows <i>Treponema pallidum</i> spirochetes). Serology: Treponemal specific tests (EIA/TPPA, remain positive for life) and Non-treponemal tests (VDRL/RPR, indicate disease activity/treatment response).
Management (NICE/BNF)	First line: Intramuscular Benzathine Penicillin G (single dose for early syphilis, 3 doses for late latent).

 **Red Flags: Jarisch-Herxheimer reaction: Acute febrile illness with headache and myalgia within 24 hours of starting penicillin due to massive destruction of bacteria. It is self-limiting but warn the patient.**

 **Patient Explanation:** "A sexually transmitted bacterial infection. It starts as a painless sore, then progresses to a full-body rash (especially on the hands and feet). If left untreated for years, it severely damages the brain and heart. It is cured with a penicillin injection."

Tension Headache

History (Symptoms) Bilateral, mild to moderate, 'tight band' or 'pressing' headache. No throbbing. No nausea/vomiting. Not worsened by routine physical activity. Can last for hours or days. Often triggered by stress, poor posture, or lack of sleep.

Examination (Signs) Normal neurological examination. Pericranial muscle tenderness (scalp, neck, and shoulders may feel tight or tender to palpation).


Bedside / GP Fundoscopy and neuro exam to rule out serious pathology.


Investigations Clinical diagnosis. No imaging required if history is typical and exam is normal.

Management (NICE/BNF) Simple analgesia (Paracetamol, Ibuprofen). Reassurance. Stress management, physiotherapy for neck tension, adequate hydration/sleep. Prophylaxis (low dose Amitriptyline) if chronic (>15 days/month).

BNF/BNFC Dosage Guide:


- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)
- Ibuprofen 400mg TDS (Adult) | 10mg/kg TDS (Child)


 **Red Flags: Increasing frequency and reliance on painkillers can lead to Medication Overuse Headache (rebound headaches). Sudden 'thunderclap' headache or headache with fever/stiff neck are red flags for SAH or meningitis.**

 *Patient Explanation: "The most common type of headache, feeling like a tight band squeezing the head. It's often linked to stress or tight neck muscles. It is not dangerous and responds well to simple painkillers and relaxation."*

Termination of Pregnancy


History (Symptoms)	Patient requests an abortion. Must establish exact gestation (date of last menstrual period). Assess reasons, support network, and ensure there is no coercion.
Examination (Signs)	General assessment. Speculum/bimanual examination may be done in clinic to assess uterine size.
Bedside / GP	Urinary pregnancy test. Screen for STIs (Chlamydia swab).
Investigations	Ultrasound scan to confirm gestation and rule out ectopic pregnancy. Bloods: Group and Save (crucial for Rhesus status), FBC.
Management (NICE/BNF)	Medical (<9-10 weeks): Mifepristone (blocks progesterone) followed 24-48h later by Misoprostol (causes contractions/expulsion). Surgical: Manual Vacuum Aspiration (MVA) under local anaesthetic or surgical dilatation and evacuation (D&E) under general.


 **Red Flags: Heavy prolonged bleeding (soaking >2 pads an hour), severe pain, or fever post-procedure suggests retained products of conception or infection, requiring urgent review. Ectopic pregnancy must be ruled out beforehand.**

 **Patient Explanation:** "The medical process of ending a pregnancy. Early on, it is usually done with two sets of tablets that cause the womb to empty like a heavy period. Later on, a minor surgical procedure is used. Support and contraception advice are always provided."

Muscular Dystrophies (e.g., Duchenne)

History (Symptoms)	Young boy (X-linked recessive). Delayed walking, frequent falls. Difficulty getting up from the floor. Progressive muscle weakness.
Examination (Signs)	Gowers' sign (uses hands to 'walk' up his own legs to stand from the floor). Pseudohypertrophy of the calves (they look large but are filled with fat/scar tissue, not muscle). Proximal muscle weakness.
Bedside / GP	Observe the child standing up from the floor.
Investigations	Creatine Kinase (CK) blood test is massively elevated (>10,000). Genetic testing confirms dystrophin gene mutation. Muscle biopsy.
Management (NICE/BNF)	No cure. MDT approach (Physio, OT). Oral Corticosteroids delay progression. Eventually requires wheelchair and Non-Invasive Ventilation (NIV) for respiratory failure.


 **Red Flags: Fatal condition; patients usually die of respiratory failure or dilated cardiomyopathy in their 20s/30s.**

 *Patient Explanation: "A genetic disease affecting boys that causes muscles to gradually weaken and break down over time. It starts with difficulty walking and eventually affects the breathing and heart muscles."*

Necrotising Enterocolitis (NEC)


History (Symptoms)	Premature/low-birth-weight neonate. Feeding intolerance, vomiting (often bilious/green), bloody stools, lethargy, apnoea, and temperature instability.
Examination (Signs)	Distended, tense, shiny, and erythematous (red) abdomen. Absent bowel sounds.
Bedside / GP	Stop enteral feeding immediately if NEC suspected. Vital signs.
Investigations	Abdominal X-ray: shows dilated bowel loops, bowel wall thickening, and pneumatosis intestinalis (gas in the bowel wall). Free air if perforated.
Management (NICE/BNF)	NBM, total parenteral nutrition (TPN), IV fluids, broad-spectrum IV antibiotics. Surgical resection of the necrotic (dead) bowel and stoma formation if perforated or not improving.


 **Red Flags: Rapidly fatal if not treated aggressively. Causes massive bowel necrosis and systemic sepsis in highly vulnerable premature babies.**

 *Patient Explanation: "A very serious disease in premature babies where the tissue lining the intestines becomes inflamed and starts to die. It causes a swollen, red tummy and needs emergency antibiotics and often surgery to remove the dead bowel."*

Necrotising Fasciitis

History (Symptoms)	Recent minor skin trauma/surgery. Rapid onset of SEVERE, unremitting pain that is completely out of proportion to the visible skin changes. Fever, confusion.
Examination (Signs)	Initially looks like simple cellulitis, but rapidly progresses to purple/black skin, blistering, and necrosis. Crepitus (crackling feeling under the skin due to gas). Patient is systemically toxic.
Bedside / GP	Immediate ABCDE and Sepsis 6. Assess pain out of proportion.
Investigations	Clinical diagnosis. DO NOT delay surgery for imaging. Bloods: high WBC, CRP, Lactate. LRINEC score used to risk stratify.
Management (NICE/BNF)	Absolute Surgical Emergency. Immediate, aggressive, radical surgical debridement of all dead tissue (often requiring amputation). High-dose broad-spectrum IV antibiotics.

 **Red Flags: The bacteria spread along the deep fascia (muscle lining) at an incredibly fast rate (inches per hour). Delays in surgery are fatal.**

 *Patient Explanation: "The 'flesh-eating' bug. A terrifying, rapid bacterial infection deep under the skin that kills tissue within hours. The pain is extreme. The only way to stop it is emergency surgery to cut away all the infected flesh, combined with heavy IV antibiotics."*

Nephrotic Syndrome

History (Symptoms) Classic triad: 1. Massive Proteinuria, 2. Hypoalbuminaemia, 3. Oedema. Frothy urine. Severe swelling around the eyes (periorbital oedema, worse in morning) and pitting oedema in the legs/genitals.

Examination (Signs) Periorbital oedema, ascites, gross peripheral oedema. Look for signs of underlying cause (e.g., lupus rash, diabetes).


Bedside / GP Urine dipstick (+++ or ++++ protein). Blood pressure.


Investigations Urine PCR (Protein:Creatinine ratio >300 mg/mmol). Bloods: Low Albumin (<25g/L), High Lipids. Renal biopsy (to determine exact cause, e.g., Minimal Change Disease in kids).

Management (NICE/BNF) High-dose Corticosteroids (first line, especially for children). Diuretics (Furosemide) for oedema. ACE inhibitors to reduce proteinuria. Prophylactic anticoagulation (high clot risk).

BNF/BNFC Dosage Guide:


- Furosemide 40mg OD PO (Titrate to symptoms)


 **Red Flags: High risk of Deep Vein Thrombosis/PE (due to loss of anti-clotting proteins in the urine) and high risk of severe infections (due to loss of immunoglobulins).**

 *Patient Explanation: "The filters in the kidneys are damaged and leaking massive amounts of protein from the blood into the urine. This causes fluid to leak into the tissues, causing severe puffiness around the eyes and legs. Treated primarily with strong steroids."*

Obstructive Sleep Apnoea


History (Symptoms)	Loud snoring, witnessed apnoeas (partner reports they stop breathing during sleep then gasp/snort). Excessive daytime sleepiness (falling asleep at the wheel/desk), morning headaches, unrefreshing sleep. High BMI, large neck circumference.
Examination (Signs)	Obesity (especially thick neck >43cm). Enlarged tonsils, crowded oropharynx.
Bedside / GP	Epworth Sleepiness Scale questionnaire. STOP-BANG questionnaire. Check BMI and blood pressure.
Investigations	Overnight polysomnography (Sleep Study) or home oximetry looking for recurrent desaturations during the night.
Management (NICE/BNF)	Weight loss, smoking cessation, avoid alcohol before bed. Gold standard: Continuous Positive Airway Pressure (CPAP) machine worn at night. Mandibular advancement devices.


 **Red Flags: Severe daytime sleepiness with a history of falling asleep while driving. The patient MUST be advised to stop driving and inform the DVLA until the condition is controlled.**

 *Patient Explanation: "The muscles in your throat relax too much during sleep, blocking your airway. You stop breathing briefly and wake up slightly to gasp for air, ruining your sleep quality. Weight loss and a CPAP breathing mask keep the airway open."*

Occupational Lung Disease (Silicosis/Coal Worker's)

History (Symptoms)	Occupational history of mining, quarrying, sandblasting, or pottery. Progressive exertional breathlessness, chronic dry cough.
Examination (Signs)	Usually unremarkable early on. Late: signs of cor pulmonale (right heart failure).
Bedside / GP	Detailed occupational history.
Investigations	Chest X-ray: Silicosis shows 'eggshell calcification' of hilar lymph nodes and upper zone nodular opacities. Spirometry (restrictive pattern).
Management (NICE/BNF)	No cure. Avoid further exposure. Industrial compensation. Symptomatic relief (bronchodilators, oxygen).


 **Red Flags: Silicosis massively increases the risk of developing Tuberculosis (Silicotuberculosis). Always investigate a new fever or weight loss.**

 *Patient Explanation: "Lung scarring caused by breathing in silica or coal dust over many years at work. The dust causes hard nodules to form in the lungs. There is no cure, so preventing exposure with masks at work is the only defence."*

Optic Neuritis

History (Symptoms)	Young female. Unilateral, subacute (over hours/days) loss of vision, blurring, or colour desaturation (reds look 'washed out'). Pain behind the eye that is WORSE on moving the eye.
Examination (Signs)	Reduced visual acuity. Reduced colour vision (Ishihara plates). Relative Afferent Pupillary Defect (RAPD). Fundoscopy may be normal (retrobulbar) or show a swollen optic disc.
Bedside / GP	Test pupils for RAPD (swinging flashlight test). Test colour vision.
Investigations	Urgent ophthalmology and neurology referral. MRI Brain (looking for demyelinating plaques).
Management (NICE/BNF)	High-dose IV Methylprednisolone to speed up visual recovery (does not change long-term visual outcome). BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Prednisolone 40mg OD PO (Adult Acute Asthma) 1-2mg/kg PO (Child)

 **Red Flags: Optic neuritis is often the first presenting symptom of Multiple Sclerosis (MS).**


 **Patient Explanation:** "Inflammation of the main nerve carrying vision from the eye to the brain. It causes a painful, blurred eye that hurts to move, and washes out colours. It is a strong warning sign for Multiple Sclerosis, requiring an urgent brain scan."


Otitis Externa (Swimmer's Ear)

History (Symptoms)	Itchy, painful ear. Watery or purulent discharge. Hearing loss if the canal is swollen shut. History of swimming, using cotton buds (Q-tips), or eczema.
Examination (Signs)	Very painful to touch the tragus or pull the pinna. Erythematous, swollen ear canal filled with debris/pus. Tympanic membrane may be normal but hard to see.
Bedside / GP	Otoscopy (clean the debris carefully to visualize the canal).
Investigations	Clinical diagnosis. Ear swab for culture only if severe or unresponsive to first-line treatment (often Pseudomonas).
Management (NICE/BNF)	Keep ear completely dry. Topical antibiotic/steroid ear drops (e.g., Sofradex or Ciprofloxacin/Dexamethasone). If canal is swollen shut, insert a Pope wick to draw drops in.

BNF/BNFC Dosage Guide:

- Dexamethasone 0.15mg/kg PO STAT (Croup)


 **Red Flags: Malignant Otitis Externa: severe, unremitting pain radiating to the jaw/head in an elderly diabetic patient. This is a fatal osteomyelitis of the skull base needing IV antibiotics and urgent ENT referral.**

 *Patient Explanation: "An infection of the skin lining the ear canal, often caused by water getting trapped or scratching with cotton buds. The ear canal swells and becomes incredibly painful. We treat it with antibiotic/steroid drops directly into the ear."*

Otitis Media (Acute)


History (Symptoms)	Young child. Earache (pulling/rubbing at the ear), fever, irritability, crying, coryzal symptoms. Hearing loss. If the eardrum bursts, the pain suddenly improves and pus discharges from the ear.
Examination (Signs)	Otoscopy: Bulging, red, inflamed, opaque tympanic membrane. Loss of the normal light reflex.
Bedside / GP	Otoscopy. Check temperature.
Investigations	Clinical diagnosis.
Management (NICE/BNF)	<p>Most are viral or self-limiting bacterial. Give regular Paracetamol/Ibuprofen for pain. Prescribe antibiotics (Amoxicillin) ONLY if symptomatically severe, lasting >4 days, or bilateral in <2 years old.</p> <p>BNF/BNFC Dosage Guide:</p> <ul style="list-style-type: none">• Amoxicillin 500mg TDS (Adult) 250mg TDS (Child 1-5y) PO• Paracetamol 1g QDS (Adult) 15mg/kg QDS (Child)• Ibuprofen 400mg TDS (Adult) 10mg/kg TDS (Child)


 **Red Flags: Mastoiditis: Red, tender, swollen area behind the ear pushing the pinna forwards. Medical emergency requiring admission and IV antibiotics.**

 **Patient Explanation:** "An infection in the middle ear space behind the eardrum, very common in toddlers after a cold. The eardrum bulges and causes intense pain. It usually gets better by itself with painkillers; antibiotics are only used if it doesn't improve."

Pancytopenia


History (Symptoms)	Symptoms of all three cell lines failing: Fatigue/shortness of breath (low red cells - Anaemia), recurrent/severe infections (low white cells - Neutropenia), easy bruising/bleeding/petechiae (low platelets - Thrombocytopenia).
Examination (Signs)	Pallor, fever/signs of infection, purpura/petechiae. Look for lymphadenopathy or splenomegaly.
Bedside / GP	Check vital signs (sepsis is a major risk).
Investigations	FBC (low Hb, low WBC, low PLT). Blood film. Urgent Bone Marrow Biopsy to determine the cause (e.g., Aplastic Anaemia, Leukaemia, Myelodysplasia, B12 deficiency).
Management (NICE/BNF)	Treat the underlying cause. Supportive care: blood transfusions, platelet transfusions, broad-spectrum IV antibiotics for neutropenic sepsis.


 **Red Flags: Neutropenic Sepsis (temperature >38 in a patient with neutropenia) is a life-threatening emergency requiring IV Piperacillin-Tazobactam immediately.**

 *Patient Explanation: "A condition where the bone marrow fails to produce all three types of blood cells (red, white, and platelets). It leaves you exhausted, bleeding easily, and defenseless against infections. We must do a bone marrow test to find out why it stopped working."*

Peptic Ulcer Disease


History (Symptoms)	Epigastric burning/aching pain. Gastric ulcer: pain worsens WITH eating (leads to weight loss). Duodenal ulcer: pain improves with eating but wakes the patient at night. Risk factors: H. pylori infection, NSAIDs, smoking.
Examination (Signs)	Epigastric tenderness on palpation. Signs of anaemia if chronically bleeding.
Bedside / GP	Review medications (stop NSAIDs/Aspirin if possible).
Investigations	Non-invasive: Stool antigen test or 13C Urea breath test for H. pylori. Invasive: Upper GI Endoscopy (OGD) is gold standard to visualize and biopsy the ulcer (to rule out gastric cancer).
Management (NICE/BNF)	Stop NSAIDs. Eradicate H. pylori if positive (Triple therapy: PPI + Amoxicillin + Clarithromycin for 7 days). High dose PPI (Omeprazole) to allow healing. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Amoxicillin 500mg TDS (Adult) 250mg TDS (Child 1-5y) PO• Clarithromycin 500mg BD PO• Omeprazole 20-40mg OD PO


 **Red Flags: Perforated ulcer: Sudden, excruciating, rigid abdominal pain (peritonitis). Bleeding ulcer: Haematemesis (vomiting blood/coffee grounds) or Melaena (black tarry stool). Both are emergencies.**

 **Patient Explanation:** "A raw sore in the lining of the stomach or the first part of the small bowel, usually caused by a bacterial infection (H. pylori) or painkillers like Ibuprofen. It causes burning tummy pain. We treat it with strong acid-lowering tablets and antibiotics."

Peripheral Vascular Disease


History (Symptoms)	Intermittent Claudication: cramping pain in the calf/thigh triggered by walking a set distance, relieved by rest. Severe/late: Rest pain (worse at night, hanging foot out of bed relieves it).
Examination (Signs)	Weak or absent pedal pulses. Cold, pale, hairless, shiny skin. Buerger's angle <20 degrees (leg goes pale when elevated, turns dusky red 'reactive hyperaemia' when lowered). Arterial ulcers on toes.
Bedside / GP	Palpate pulses. Ankle-Brachial Pressure Index (ABPI): 0.5-0.9 = claudication, <0.5 = critical limb ischaemia.
Investigations	Arterial Duplex Ultrasound. MR or CT Angiography to plan surgical intervention.
Management (NICE/BNF)	First line: Stop smoking, supervised exercise program, Atorvastatin 80mg, Clopidogrel 75mg. Second line: Angioplasty/stenting or surgical bypass. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Clopidogrel 300mg STAT, then 75mg OD• Atorvastatin 20mg OD (Primary) or 80mg OD (Secondary prevention)


 **Red Flags: Critical Limb Ischaemia (CLI): Rest pain for >2 weeks, or tissue loss (ulcers/gangrene) with an ABPI <0.5. High risk of amputation.**

 **Patient Explanation:** "The arteries carrying blood to your legs have become furred up and narrowed. It causes a severe cramping pain when you walk. Stopping smoking and taking cholesterol tablets are crucial to stop it progressing to gangrene."

Pituitary Tumours (Adenomas)


History (Symptoms)	Mass effect: Bitemporal hemianopia (tunnel vision), headaches. Hormonal effect: Prolactinoma (galactorrhoea, amenorrhoea, erectile dysfunction), Acromegaly (large hands/jaw, sweating), Cushing's (weight gain).
Examination (Signs)	Visual field defects (bitemporal hemianopia). Signs of specific hormonal excess (e.g., coarse facial features in acromegaly).
Bedside / GP	Formal visual field testing by confrontation. Check blood pressure.
Investigations	MRI Pituitary with contrast. Endocrine blood panel (Prolactin, IGF-1, 9am Cortisol, TFTs, LH/FSH, Testosterone).
Management (NICE/BNF)	Prolactinomas: Medical treatment first-line (Dopamine agonists like Cabergoline/Bromocriptine shrink the tumour). Others/causing visual loss: Trans-sphenoidal surgical resection (through the nose).


 **Red Flags: Pituitary Apoplexy: Sudden haemorrhage into the tumour causing a thunderclap headache, sudden blindness, and cardiovascular collapse (due to acute lack of cortisol). Emergency steroids needed.**

 *Patient Explanation: "A benign growth on the master hormone gland at the base of the brain. It can cause problems by overproducing hormones or by growing so large it squashes the optic nerves, causing tunnel vision. Many are treated with tablets, but some need surgery through the nose."*

Polymyalgia Rheumatica (PMR)


History (Symptoms)	Patient >50 years old. Subacute onset of severe bilateral aching, stiffness, and pain in the PROXIMAL muscles (shoulders, neck, and pelvic girdle). Prominent morning stiffness (>45 mins). No true muscle weakness.
Examination (Signs)	Tenderness over shoulders and hips. Reduced active range of movement due to pain, but passive movement is often normal. Normal muscle strength (differentiates from myositis).
Bedside / GP	Assess for signs of Temporal Arteritis.
Investigations	Bloods: Markedly raised ESR and CRP. Normal CK (rules out muscle damage). Normal Rheumatoid Factor/CCP.
Management (NICE/BNF)	Low-dose oral Corticosteroids (e.g., Prednisolone 15mg daily). Symptoms should improve dramatically within 24-48 hours (this is virtually diagnostic). Slowly taper over 1-2 years.
	BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Prednisolone 40mg OD PO (Adult Acute Asthma) 1-2mg/kg PO (Child)


 **Red Flags: Giant Cell Arteritis (Temporal Arteritis): Temporal headache, scalp tenderness, jaw claudication, visual loss. About 15% of PMR patients develop this, requiring immediate high-dose steroids to prevent blindness.**

 *Patient Explanation: "An inflammatory condition in older adults causing severe pain and stiffness in the shoulders and hips, especially in the morning. A low dose of steroid tablets usually acts like a 'magic bullet', relieving symptoms within a day."*

Postpartum Haemorrhage (PPH)


History (Symptoms)	Primary: >500ml blood loss within 24 hours of delivery. Secondary: Heavy bleeding 24 hours to 12 weeks post-delivery. The 4 Ts: Tone (uterine atony), Trauma (tears), Tissue (retained placenta), Thrombin (clotting disorder).
Examination (Signs)	Assess for hypovolaemic shock (tachycardia, hypotension). Palpate the abdomen: a 'boggy' (soft), high uterus indicates uterine atony (most common cause). Speculum to check for tears.
Bedside / GP	Activate massive obstetric haemorrhage protocol. Immediate fundal massage.
Investigations	Bloods: Group and Save, Crossmatch 4 units, FBC, Clotting profile.
Management (NICE/BNF)	Resuscitation (Oxygen, 2 large-bore IV cannulae, IV fluids/blood). Medical: IV Oxytocin (Syntocinon), Ergometrine, Carboprost, TXA, Misoprostol. Surgical: Balloon tamponade (Bakri), B-Lynch suture, or Hysterectomy.


 **Red Flags: PPH can be catastrophically rapid. Delays in recognizing shock and calling for senior help lead to maternal death. Treat aggressively.**

 *Patient Explanation: "Heavy, dangerous bleeding immediately after giving birth. Most often, the womb fails to clamp down hard enough after the baby is born. We must rapidly massage the womb and use strong IV drugs to make it contract and stop the bleeding."*

Aneurysms, ischaemic limb and occlusions

History (Symptoms)	Sudden or chronic pain in the leg. Claudication (cramping pain in calf when walking, relieved by rest). Sudden cold, pale, painful, pulseless leg (acute ischaemia). Aneurysm may be asymptomatic or cause a pulsatile mass.
Examination (Signs)	Absent or weak peripheral pulses. Bruits over arteries. Acute ischaemia: The 6 Ps (Pale, Pulseless, Painful, Paralysed, Paraesthetic, Perishingly cold).
Bedside / GP	Ankle-Brachial Pressure Index (ABPI). Handheld doppler to find pulses.
Investigations	Arterial Duplex Ultrasound, CT Angiography or MR Angiography to locate the blockage or aneurysm.
Management (NICE/BNF)	Acute occlusion: Emergency Heparin and surgical embolectomy/bypass. Claudication: Supervised exercise, Aspirin, Statin. Aneurysm: Surveillance or surgical repair.
	BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Aspirin 300mg STAT (Emergency) or 75mg OD (Maintenance)

 **Red Flags: Acute limb ischaemia is a surgical emergency with a 4-6 hour window to save the limb before irreversible muscle/nerve death occurs.**


 **Patient Explanation:** "Blockages or dangerous swellings (aneurysms) in your arteries. Blockages cause extreme pain because your leg isn't getting oxygen. An aneurysm is a bulge that risks bursting. Both require urgent vascular specialist care."


Ascites

History (Symptoms)	Progressive abdominal swelling, weight gain, feeling full quickly, breathlessness (splinting of diaphragm), swollen ankles. Associated with liver cirrhosis, heart failure, or abdominal cancers.
Examination (Signs)	Distended abdomen with shifting dullness on percussion. Fluid thrill (in massive ascites). Check for signs of portal hypertension (caput medusae) or liver disease.
Bedside / GP	Measure abdominal girth. Weigh the patient. Assess for alcohol use.
Investigations	Ultrasound abdomen confirms fluid. Diagnostic ascitic tap (paracentesis) to calculate Serum-Ascites Albumin Gradient (SAAG) >11g/L means portal hypertension.
Management (NICE/BNF)	Low sodium diet. Diuretics (Spironolactone +/- Furosemide). Therapeutic large-volume paracentesis for symptomatic relief (draining the fluid). TIPS procedure.

BNF/BNFC Dosage Guide:


- Furosemide 40mg OD PO (Titrate to symptoms)


 **Red Flags: Spontaneous Bacterial Peritonitis (SBP): A patient with ascites presenting with fever and abdominal pain. Requires urgent diagnostic tap and IV antibiotics.**

 *Patient Explanation: "A large build-up of fluid inside the tummy cavity, usually because of severe liver scarring (cirrhosis) or cancer. We can drain the fluid with a needle to make breathing and eating more comfortable."*

Fibroadenoma


History (Symptoms)	Young woman (typically 15-30). A painless, smooth, highly mobile lump in the breast. Often noticed incidentally while washing.
Examination (Signs)	A firm, smooth, well-circumscribed, highly mobile ('mouse') lump. Not tethered to skin or underlying muscle. No axillary lymphadenopathy.
Bedside / GP	Clinical breast examination.
Investigations	Must refer on 2-week wait if new lump to be safe. Triple assessment: Clinical exam, Ultrasound (as young breast is dense), and Core biopsy/FNA.
Management (NICE/BNF)	Reassurance once confirmed. They are entirely benign. Can be surgically excised if large (>3cm) or causing significant cosmetic/physical discomfort.


 **Red Flags: Rapid growth, skin dimpling, nipple inversion, or hard/irregular lumps are red flags for breast cancer and are NOT features of a fibroadenoma.**

 *Patient Explanation: "A very common, completely harmless breast lump made of fibrous and glandular tissue. It feels like a smooth marble that moves around easily. It does not turn into cancer."*

Fibrotic Lung Disease (Idiopathic Pulmonary Fibrosis)


History (Symptoms)	Older patient (>60). Chronic, progressive, worsening breathlessness on exertion and a persistent dry cough. No wheeze. May have a history of smoking.
Examination (Signs)	Fine, end-inspiratory 'Velcro-like' crackles at the lung bases. Finger clubbing is prominent.
Bedside / GP	SpO ₂ (may desaturate significantly on exertion).
Investigations	High-Resolution CT (HRCT) of the chest is gold standard (shows 'honeycombing' and traction bronchiectasis at the lung bases). Spirometry shows a restrictive defect.
Management (NICE/BNF)	No cure. Antifibrotic medications (Pirfenidone, Nintedanib) can slow progression. Pulmonary rehabilitation, long-term oxygen therapy. Lung transplant in highly selected patients.


 **Red Flags: Progressive rapid decline in lung function leading to Type 1 Respiratory Failure. Very poor overall prognosis (often 3-5 years).**

 *Patient Explanation: "Severe, progressive scarring of the lung tissue for unknown reasons. The lungs become stiff, making it hard to breathe in. There is no cure, but special tablets can slow down the scarring."*

Haemoglobinopathies (Thalassaemia)


History (Symptoms)	Beta-Thalassaemia Major presents in the first year of life: severe anaemia, failure to thrive, jaundice. Thalassaemia Minor/Trait is usually asymptomatic. Common in Mediterranean/Asian descent.
Examination (Signs)	Pallor, jaundice, massive hepatosplenomegaly, skeletal deformities (frontal bossing, maxillary overgrowth) due to bone marrow expansion.
Bedside / GP	Assess growth parameters in children.
Investigations	FBC (microcytic, hypochromic anaemia). Haemoglobin electrophoresis (confirms absent or reduced HbA and high HbF).
Management (NICE/BNF)	Major: Lifelong regular blood transfusions every 3-4 weeks. Iron chelation therapy (e.g., Deferasirox) is crucial to prevent fatal iron overload. Stem cell transplant is the only cure.


 **Red Flags: Iron overload from repeated transfusions destroys the heart (heart failure), liver (cirrhosis), and endocrine glands. Requires strict adherence to chelation.**

 *Patient Explanation: "A genetic blood disorder where the body cannot make normal haemoglobin (the oxygen carrier). Severe forms require lifelong blood transfusions to survive, along with medications to remove excess iron."*

Haemophilia (A and B)


History (Symptoms)	X-linked recessive (affects boys). Excessive bleeding after minor trauma or surgery. Spontaneous bleeding into joints (haemarthrosis) causing severe joint pain and swelling, or into muscles.
Examination (Signs)	Hot, swollen, painful joint with restricted movement (due to blood in the joint). Extensive bruising.
Bedside / GP	Examine the joints for bleeds.
Investigations	Coagulation screen: Prolonged APTT, normal PT and Platelets. Specific factor assays (Factor VIII low in Haemophilia A; Factor IX low in Haemophilia B).
Management (NICE/BNF)	Prophylactic or on-demand IV infusions of the missing recombinant clotting factor (Factor VIII or IX). Desmopressin (DDAVP) for mild Haemophilia A.


 **Red Flags: Intracranial haemorrhage after minimal head trauma. Recurrent joint bleeds completely destroy the joint cartilage over time (haemophilic arthropathy).**

 **Patient Explanation:** "A genetic condition where the blood lacks a specific protein needed to form clots. Patients can bleed internally, especially into their joints, requiring injections of the missing clotting protein to stop the bleeding."

Hypercalcaemia of Malignancy


History (Symptoms)	Patient with known cancer (e.g., breast, lung, myeloma). 'Bones, stones, abdominal groans, and psychic moans': polyuria, severe thirst, constipation, nausea, abdominal pain, confusion, extreme lethargy.
Examination (Signs)	Dehydration (dry mouth, reduced skin turgor). Altered mental state (drowsiness/confusion).
Bedside / GP	Assess fluid status and GCS. 12-lead ECG (short QT interval).
Investigations	Bloods: High Calcium (adjusted), Low or suppressed PTH (Parathyroid Hormone distinguishes it from primary hyperparathyroidism). U&Es (often AKI).
Management (NICE/BNF)	Medical emergency. Vigorous IV fluid resuscitation (0.9% Saline 3-4L over 24h) to flush calcium through kidneys. Then IV Bisphosphonates (Zoledronic acid) to stop bone breakdown.


 **Red Flags: Severe hypercalcaemia (>3.5 mmol/L) can cause cardiac arrhythmias, coma, and death. Rapid fluid resuscitation is critical.**

 *Patient Explanation: "Cancer is causing too much calcium to be released from your bones into your blood. This makes you very confused, thirsty, and sick. We use strong fluid drips and special bone-protecting drugs to lower the calcium levels quickly."*

Hyperparathyroidism (Primary)


History (Symptoms)	Often asymptomatic and picked up on routine bloods. If symptomatic ('bones, stones, groans'): kidney stones, bone pain, constipation, depression, fatigue. Usually caused by a single benign parathyroid adenoma.
Examination (Signs)	Usually completely normal physical exam.
Bedside / GP	Check blood pressure (often associated with hypertension).
Investigations	Bloods: HIGH Calcium, inappropriately HIGH or NORMAL Parathyroid Hormone (PTH). Low phosphate. Ultrasound/Sestamibi scan of the neck to locate the adenoma.
Management (NICE/BNF)	If symptomatic or very high calcium: Surgical removal of the parathyroid adenoma (parathyroidectomy). If unfit for surgery: Calcimimetics (Cinacalcet).


 **Red Flags: Severe hypercalcaemia causing confusion or arrhythmias (requires emergency fluids).**

 *Patient Explanation: "One of the tiny parathyroid glands in your neck has become overactive and is pumping out too much hormone. This pulls calcium out of your bones and into your blood, risking kidney stones and weak bones. It's usually cured with minor surgery."*

Hyperthermia and Hypothermia


History (Symptoms)	Hyper: Exposure to extreme heat, excessive exertion, confusion, no sweating (heat stroke). Hypo: Exposure to cold, shivering (stops in severe cases), confusion, lethargy.
Examination (Signs)	Hyper: Core temp $>40^{\circ}\text{C}$, hot dry skin, tachycardia, altered GCS. Hypo: Core temp $<35^{\circ}\text{C}$, bradycardia, J-waves on ECG, pale/cold skin, coma.
Bedside / GP	Continuous core temperature monitoring (rectal or bladder probe). ECG.
Investigations	Bloods: U&Es, CK (rhabdomyolysis in hyperthermia), clotting (DIC risk). ABG.
Management (NICE/BNF)	Hyper: Rapid active cooling (ice packs, tepid sponging, fans). Hypo: Active rewarming (Bair hugger, warmed IV fluids). Do not declare dead until 'warm and dead' in hypothermia.


 **Red Flags: Heat stroke with altered mental status is a life-threatening emergency causing multi-organ failure. Severe hypothermia causes fatal ventricular fibrillation (VF).**

 *Patient Explanation: "Dangerous extremes of body temperature. Heat stroke happens when the body's cooling system fails completely, while hypothermia is dangerous chilling of the core. Both require immediate, specialized medical heating or cooling."*

Meniere's Disease

History (Symptoms)	Episodic attacks consisting of a classic triad: 1. Intense vertigo (lasting 20 mins to hours), 2. Tinnitus (ringing/roaring), 3. Fluctuating sensorineural hearing loss. Plus a feeling of 'fullness' or pressure in the ear.
Examination (Signs)	During attack: Nystagmus. Hearing loss on Rinne/Weber testing. Normal neuro exam otherwise.
Bedside / GP	Cranial nerve exam. Otoscopy (tympanic membrane is normal).
Investigations	Pure tone audiometry (shows low-frequency sensorineural hearing loss). ENT specialist assessment.
Management (NICE/BNF)	Acute: Buccal Prochlorperazine to stop vomiting/vertigo. Prevention: Low salt diet. Betahistine. Severe cases: intra-tympanic gentamicin or surgery.

 **Red Flags: If the hearing loss or tinnitus is constant, unilateral, and progressive, an Acoustic Neuroma must be ruled out with an MRI head.**

 *Patient Explanation: "A chronic inner ear condition where fluid builds up, causing sudden, unpredictable attacks of severe dizziness, ringing in the ears, and temporary hearing loss. A low-salt diet and specific tablets can help prevent attacks."*

Mesenteric Adenitis

History (Symptoms) Child/Adolescent. Lower right-sided abdominal pain (mimics appendicitis), fever. Often preceded by a recent viral upper respiratory tract infection or sore throat.

Examination (Signs) Tenderness in the right iliac fossa, but the child is usually less 'toxic' looking than in appendicitis. Generalized lymphadenopathy (e.g., in the neck) may be present.


Bedside / GP Urine dipstick, vital signs, check throat/ears.


Investigations Usually diagnosed when an ultrasound or CT done for suspected appendicitis shows enlarged mesenteric lymph nodes and a normal appendix.

Management (NICE/BNF) Self-limiting viral condition. Analgesia (Paracetamol/Ibuprofen) and reassurance. Observe.

BNF/BNFC Dosage Guide:


- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)
- Ibuprofen 400mg TDS (Adult) | 10mg/kg TDS (Child)


 **Red Flags: It is extremely difficult to distinguish clinically from acute appendicitis. If there are signs of peritonitis, it must be treated as appendicitis until proven otherwise.**

 *Patient Explanation: "Swollen lymph glands in the tummy, usually caused by a recent viral cold. It causes pain that feels exactly like appendicitis, but it is harmless and goes away on its own with simple painkillers."*

Mitral Valve Disease (Stenosis/Regurgitation)


History (Symptoms)	Stenosis (often from childhood Rheumatic Fever): Exertional breathlessness, orthopnoea, haemoptysis. Regurgitation (post-MI or prolapse): Breathlessness, fatigue, palpitations.
Examination (Signs)	Stenosis: Malar flush, tapping apex beat, mid-diastolic rumble murmur. Regurgitation: Displaced apex beat, pan-systolic murmur radiating to the axilla. Both can cause Atrial Fibrillation.
Bedside / GP	12-lead ECG (look for AF or 'P-mitrale' bifid P waves).
Investigations	Echocardiogram is diagnostic to assess valve leaflets and heart chamber sizes. CXR (left atrial enlargement).
Management (NICE/BNF)	Medical: Diuretics for heart failure symptoms, rate control/anticoagulation for AF. Surgical: Valve repair or replacement (TAVI is generally for Aortic, not Mitral).


 **Red Flags: Acute severe mitral regurgitation (e.g., papillary muscle rupture after a heart attack) causes rapid, flash pulmonary oedema and cardiogenic shock. Emergency surgery needed.**

 *Patient Explanation: "The valve between the top and bottom chambers on the left side of the heart is either too stiff (stenosis) or leaks backwards (regurgitation). It leads to fluid backing up into your lungs. Fixing it often requires open-heart surgery."*

Multi-organ Dysfunction Syndrome (MODS)

History (Symptoms)	A critically ill patient in ICU (usually due to severe sepsis, major trauma, or severe burns). Failure of 2 or more organ systems.
Examination (Signs)	Hypotension (cardiovascular failure), hypoxia (respiratory failure/ARDS), anuria/oliguria (renal failure), jaundice (liver failure), altered GCS.
Bedside / GP	Continuous advanced ICU monitoring (arterial lines, central venous pressure).
Investigations	ABG (severe hypoxia/acidosis), U&Es (AKI), LFTs, Coagulation (DIC), continuous lactate monitoring.
Management (NICE/BNF)	<p>Total Intensive Care support. Mechanical ventilation, vasopressors/inotropes (Noradrenaline) to support blood pressure, renal replacement therapy (dialysis), and aggressive treatment of the underlying cause.</p> <p>BNF/BNFC Dosage Guide:</p> <ul style="list-style-type: none">• Adrenaline 1:1000 0.5mg (0.5mL) IM (Adult Anaphylaxis) 0.15-0.3mg IM (Child)

 **Red Flags: A terminal pathway of severe illness. Highly lethal even with maximum medical therapy.**


 **Patient Explanation:** "The most severe state of illness where the body's major organs (lungs, kidneys, heart, liver) all begin to shut down at the same time, usually due to massive infection or trauma. It requires life support machines in Intensive Care."


Mumps

History (Symptoms)	Child/Young adult (often unvaccinated). Fever, malaise, headache, followed by painful swelling of the parotid glands (cheeks/jaw line).
Examination (Signs)	Unilateral or bilateral parotid gland swelling (earlobes pushed upwards and outwards). Redness of the parotid duct opening inside the mouth.
Bedside / GP	Check MMR vaccination status.
Investigations	Notify Public Health. Oral fluid swab for Mumps PCR to confirm.
Management (NICE/BNF)	Self-limiting. Rest, hydration, Paracetamol. Isolate for 5 days after the swelling starts.

BNF/BNFC Dosage Guide:

- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)

 **Red Flags: Complications: Orchitis (painful, swollen testicles occurring a week later, risk of infertility), Meningitis/Encephalitis, or sudden sensorineural hearing loss.**

 *Patient Explanation: "A contagious viral infection causing painful, swollen 'hamster cheeks' (parotid glands). While it usually goes away on its own, it can cause painful swollen testicles in men or viral meningitis. It is prevented by the MMR vaccine."*

Myeloproliferative Disorders (Polycythaemia Vera, Essential Thrombocythaemia, Myelofibrosis)

History (Symptoms) Polycythaemia: Itching after a hot bath, ruddy complexion, headaches, blurry vision. ET: Bleeding or clotting episodes, throbbing in fingers. Myelofibrosis: Massive fatigue, weight loss, huge spleen.

Examination (Signs) Splenomegaly (can be massive in myelofibrosis). Plethora (red face) in Polycythaemia.


Bedside / GP Assess for signs of hyperviscosity (confusion, visual changes) or stroke.


Investigations FBC (very high Hb in PV, high platelets in ET). JAK2 mutation test (positive in >95% of PV). Bone marrow biopsy.

Management (NICE/BNF) PV: Venesection (taking blood off regularly), Aspirin. ET: Hydroxycarbamide, Aspirin. Myelofibrosis: Ruxolitinib, supportive care.

BNF/BNFC Dosage Guide:

- Aspirin 300mg STAT (Emergency) or 75mg OD (Maintenance)


 **Red Flags: High risk of transforming into acute myeloid leukaemia (AML) or suffering a major thrombotic event (stroke, DVT, MI).**

 **Patient Explanation:** "A group of slow-growing blood cancers where the bone marrow produces too many red blood cells or platelets. This makes the blood thick and prone to clotting. Treated with blood-thinning medicines or regular blood removal."

Pressure Sores (Decubitus Ulcers)


History (Symptoms)	Immobile patient (bedbound, wheelchair user, paraplegic). Painful area over a bony prominence (sacrum, heels, elbows, occiput).
Examination (Signs)	Grade 1: Non-blanching erythema (intact skin). Grade 2: Partial thickness skin loss (blister/abrasion). Grade 3: Full thickness loss (subcutaneous fat visible). Grade 4: Muscle/bone visible.
Bedside / GP	Waterlow Score to assess risk. Full skin check of all bony prominences.
Investigations	Wound swab if infected. Bloods for nutritional status (Albumin). X-ray/MRI if underlying osteomyelitis is suspected (bone visible/probe to bone).
Management (NICE/BNF)	PREVENTION: regular repositioning (every 2 hours), pressure-relieving mattresses. Treatment: specialized dressings (hydrocolloid), optimization of nutrition, surgical debridement if necrotic.


 **Red Flags: Sepsis arising from an infected sore. Osteomyelitis if the sore tracks deep to the bone.**

 *Patient Explanation: "Skin damage caused by constant pressure on one area, stopping blood flow. Common in bedbound patients. They can become deep, infected holes. Moving the patient regularly and using special mattresses prevents them."*

Pyloric Stenosis


History (Symptoms)	Infant (typically 2-6 weeks old, often firstborn male). Projectile, forceful, NON-bilious vomiting immediately after feeding. The baby is always hungry afterward.
Examination (Signs)	Visible gastric peristalsis (waves moving across the stomach before vomiting). A palpable 'olive-sized' mass in the right upper quadrant of the abdomen.
Bedside / GP	Test feed the baby to observe the projectile vomiting and feel for the olive mass. Check for dehydration.
Investigations	Venous blood gas (classic: hypochloreaemic, hypokalaemic metabolic alkalosis from vomiting stomach acid). Ultrasound abdomen confirms thickened pylorus muscle.
Management (NICE/BNF)	Urgent IV fluid resuscitation to correct the severe electrolyte imbalance FIRST. Then surgical Ramstedt's pyloromyotomy (cutting the tight muscle).


 **Red Flags: Severe dehydration and electrolyte shock. Do NOT operate until the electrolytes are completely normal.**

 *Patient Explanation: "The muscle valve at the exit of the baby's stomach has grown too thick, completely blocking milk from entering the bowel. It causes violent, projectile vomiting. It is fixed with a very quick, routine operation."*

Subdural Haemorrhage


History (Symptoms)	Elderly or alcoholic patient. History of minor head trauma (often weeks ago, which they may have forgotten). Fluctuating confusion, gradual cognitive decline, headaches, mild unilateral weakness.
Examination (Signs)	Fluctuating GCS. Mild focal neurological deficits. May present identically to dementia, but with a faster onset.
Bedside / GP	Full neurological exam. Ask family about recent falls.
Investigations	Non-contrast CT Head: shows a classic 'crescent-shaped' collection of blood, which crosses skull sutures. (Acute = white/hyperdense, Chronic = dark/hypodense).
Management (NICE/BNF)	If small and asymptomatic: conservative watch and wait. If symptomatic or midline shift on CT: Neurosurgical evacuation via Burr Holes.


 **Red Flags: Progressive drowsiness and neurological decline indicating dangerous pressure on the brain.**

 *Patient Explanation: "A slow bleed between the brain and the skull, usually from fragile veins tearing after a minor bump to the head in older people. It causes confusion that comes and goes. We can drain the fluid through a small hole in the skull."*

Thyroid Nodules / Thyroid Eye Disease


History (Symptoms)	Nodules: Often an asymptomatic lump in the neck, sometimes difficulty swallowing/breathing if very large. Eye Disease: Gritty, red, bulging eyes (exophthalmos), double vision, often in a patient with Graves' disease.
Examination (Signs)	Nodules: A discrete lump moving UP on swallowing. Eye disease: Proptosis (bulging), lid retraction, lid lag, restricted eye movements.
Bedside / GP	Palpate the thyroid from behind while patient swallows water. Check visual acuity and eye movements.
Investigations	Nodules: Ultrasound of the neck and Fine Needle Aspiration (FNA) biopsy to rule out cancer. TFTs. Eye disease: Autoantibodies (TRAb), MRI Orbits.
Management (NICE/BNF)	Nodules: Benign = observe. Suspicious = surgical removal (hemithyroidectomy). Eye disease: Artificial tears, smoking cessation (crucial), oral Corticosteroids, orbital decompression surgery if sight-threatening.


 **Red Flags: Nodule: A hard, fixed, rapidly growing lump or one causing voice hoarseness suggests thyroid cancer. Eye disease: Loss of colour vision or reduced acuity indicates optic nerve compression (emergency).**

 **Patient Explanation: "Nodules are lumps in the thyroid gland; most are harmless but we test them to be sure they aren't cancer. Thyroid eye disease is an immune reaction causing bulging, dry, painful eyes, usually linked to an overactive thyroid."**

Toxic Shock Syndrome


History (Symptoms)	Sudden onset of high fever, vomiting, watery diarrhoea, severe muscle aches, and confusion. Often associated with retained tampons, recent surgery, or skin infections (Staph aureus or Strep pyogenes).
Examination (Signs)	Profound hypotension (shock). A widespread, 'sunburn-like' macular rash. Strawberry tongue. Peeling of skin (desquamation) on palms and soles occurs 1-2 weeks later.
Bedside / GP	Immediate ABCDE. Remove any retained tampons/packings.
Investigations	Bloods: Sepsis 6 (high WBC, CRP, Lactate, impaired renal/liver function). Blood cultures. Vaginal/wound swabs.
Management (NICE/BNF)	Medical Emergency (ICU admission). Aggressive IV fluid resuscitation, Vasopressors for shock, broad-spectrum IV antibiotics (including Clindamycin to stop toxin production). Source control (remove tampon/debride wound).


 **Red Flags: Rapidly fatal multi-organ failure if not identified and treated aggressively with fluids and toxin-suppressing antibiotics.**

 *Patient Explanation: "A rare, life-threatening reaction to toxins produced by certain bacteria. It causes shock, a sunburn-like rash, and organ failure. It requires emergency intensive care, massive fluid drips, and strong antibiotics."*

Transfusion Reactions

History (Symptoms)	Occurs during or shortly after a blood transfusion. Fever, chills, back/flank pain (ABO incompatibility), breathlessness, hives/itching (allergic).
Examination (Signs)	Fever, tachycardia, hypotension. Wheeze/stridor (anaphylaxis). Pulmonary oedema/crackles if fluid overloaded (TACO).
Bedside / GP	IMMEDIATELY STOP THE TRANSFUSION. Keep the IV line open with normal saline. Check the patient's ID band against the blood product label.
Investigations	Send the blood unit back to the lab. Take blood from patient for Direct Antiglobulin Test (DAT/Coombs), repeat Group and Save, FBC, Coagulation, U&Es.
Management (NICE/BNF)	ABO Incompatibility: Emergency resuscitation, IV fluids to protect kidneys. Allergic: Antihistamines. TACO (fluid overload): Diuretics and oxygen. Anaphylaxis: IM Adrenaline. BNF/BNFC Dosage Guide: • Adrenaline 1:1000 0.5mg (0.5mL) IM (Adult Anaphylaxis) 0.15-0.3mg IM (Child)

 **Red Flags: Acute Haemolytic Transfusion Reaction (given wrong blood type) causes rapid shock, kidney failure, and DIC. This is a 'Never Event'.**


 *Patient Explanation: "A severe reaction to receiving a blood transfusion. It can be a simple allergy, or a life-threatening reaction if the blood type was wrong. The transfusion must be stopped instantly and emergency treatments given."*


Trigeminal Neuralgia

History (Symptoms)	Unilateral, severe, sharp, 'electric shock-like' pain in the face (usually lower jaw or cheek). Attacks last seconds to minutes. Triggered by light touch, washing face, shaving, chewing, or cold wind.
Examination (Signs)	Neurological examination of the face is completely NORMAL (no sensory loss, no facial weakness). If there is sensory loss, it is NOT classic trigeminal neuralgia.
Bedside / GP	Test cranial nerves V and VII carefully.
Investigations	Clinical diagnosis. MRI Brain to rule out secondary causes (e.g., Multiple Sclerosis, tumour pressing on the nerve) especially if patient is <40 or has atypical features.
Management (NICE/BNF)	First line: Carbamazepine (anti-epileptic drug). Standard painkillers (Paracetamol/Opioids) are completely ineffective. Surgical: Microvascular decompression if medical therapy fails.

BNF/BNFC Dosage Guide:


- Paracetamol 1g QDS (Adult) | 15mg/kg QDS (Child)


 **Red Flags: Pain accompanied by numbness/weakness, or occurring in a young patient, warrants urgent investigation for a structural brain lesion or MS.**

 *Patient Explanation: "A nerve condition causing excruciating, sudden, shock-like pain in one side of the face, triggered by just touching the skin. Standard painkillers don't work, but specific nerve-calming tablets are very effective."*

Upper/Lower Limb Fractures & Soft Tissue Injuries


History (Symptoms)	History of trauma, fall, or sports injury. Severe pain, swelling, inability to bear weight or move the limb. 'Popping' or 'snapping' sound.
Examination (Signs)	Deformity, severe swelling, bruising, bony tenderness. Check range of motion if safe. ALWAYS check neurovascular status (pulses, capillary refill, sensation) distal to the injury.
Bedside / GP	Immobilise the limb. Check distal pulses and sensation.
Investigations	Plain X-rays (AP and Lateral views) of the injured area including the joints above and below. MRI for soft tissue/ligament injuries (e.g., ACL tears, rotator cuff).
Management (NICE/BNF)	Fractures: Reduction (if displaced) and immobilisation (cast, splint) or surgical fixation (ORIF). Soft Tissue: RICE (Rest, Ice, Compression, Elevation), physiotherapy. Compartment syndrome requires urgent fasciotomy.


 **Red Flags: Open fractures (bone breaking the skin) require urgent IV antibiotics and surgical washout to prevent osteomyelitis. Absent pulses indicate arterial injury (emergency).**

 *Patient Explanation: "A broken bone or torn ligament/muscle. We use X-rays to see the bones and MRIs for the softer tissues. Treatment ranges from rest and casts to surgery with plates and screws to hold everything together."*

Upper Respiratory Tract Infection (URTI) & Tonsillitis


History (Symptoms)	URTI: Runny nose, sneezing, mild cough, low-grade fever. Tonsillitis: Severe sore throat, painful swallowing, high fever, swollen neck glands. No cough in bacterial tonsillitis.
Examination (Signs)	Tonsillitis: Red, swollen tonsils covered in white pus (exudate). Tender cervical lymph nodes. URTI: congested nasal passages, clear chest.
Bedside / GP	Calculate Centor or FeverPAIN score for tonsillitis to determine if it is likely bacterial.
Investigations	Usually clinical. Throat swab only if recurrent or atypical.
Management (NICE/BNF)	URTI: Supportive (fluids, Paracetamol). Tonsillitis: Phenoxymethylpenicillin (Penicillin V) for 10 days if Centor score 3-4 (bacterial). Tonsillectomy if recurrent (>7 times a year).
	BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Paracetamol 1g QDS (Adult) 15mg/kg QDS (Child)


 **Red Flags: Quinsy (Peritonsillar abscess): Severe unilateral throat pain, muffled 'hot potato' voice, deviation of the uvula. Requires urgent ENT admission for needle aspiration and IV antibiotics.**

 *Patient Explanation: "Common colds and sore throats. Most are viral and just need rest and painkillers. If the tonsils are covered in white pus and there is no cough, it might be bacterial and need a course of penicillin."*

Urticaria, Varicella, & Viral Exanthema


History (Symptoms)	Urticaria: migrating, intensely itchy raised red wheals (hives). Varicella (Chickenpox): fever followed by intensely itchy, blistering spots. Exanthema (e.g. Parvovirus): mild fever followed by a widespread rash (e.g. slapped cheeks).
Examination (Signs)	Urticaria: raised wheals with central pallor that vanish within 24h. Varicella: macules, papules, and vesicles in varying stages. Exanthema: maculopapular rash.
Bedside / GP	Check ABCDE for urticaria (rule out anaphylaxis).
Investigations	Clinical diagnosis.
Management (NICE/BNF)	Urticaria: High-dose antihistamines. Varicella: Calamine lotion, avoid Ibuprofen, Aciclovir if adult/shingles. Exanthema: Supportive.
	BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Ibuprofen 400mg TDS (Adult) 10mg/kg TDS (Child)


 **Red Flags: Varicella in pregnancy/immunocompromised is dangerous. Anaphylaxis with urticaria. Slapped cheek syndrome in a patient with Sickle Cell Disease (causes aplastic crisis).**

 **Patient Explanation:** "Common itchy or spotty rashes. Hives are an allergic reaction treated with antihistamines. Chickenpox and other viral rashes just need time and soothing lotions, but adults or pregnant women might need specific antiviral tablets."

Varicose Veins, Venous Ulcers, & VTE


History (Symptoms)	Varicose: aching, heavy legs with visible twisted veins. Venous ulcer: painless/mildly aching chronic wound on the inner ankle. VTE (DVT/PE): sudden unilateral painful swollen calf, or sudden breathlessness/pleuritic chest pain.
Examination (Signs)	Varicose: Dilated superficial veins, brown skin staining. Ulcer: shallow, weeping wound above medial malleolus. DVT: Unilateral calf swelling >3cm difference. PE: tachycardia, hypoxia.
Bedside / GP	Venous disease: ABPI (to rule out arterial disease). VTE: Wells score, ECG.
Investigations	Venous: Duplex ultrasound. DVT: Leg ultrasound. PE: CTPA or V/Q scan. D-Dimer if Wells score is unlikely.
Management (NICE/BNF)	Varicose/Ulcers: Compression bandaging (if ABPI >0.8), vein ablation surgery. VTE: Anticoagulation (DOACs like Apixaban for 3-6 months). BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Apixaban 5mg BD PO (Stroke prevention in AF)


 **Red Flags: Massive PE causing shock/hypotension (requires emergency thrombolysis). Putting tight compression bandages on a leg with poor arteries (ABPI <0.8) will cause gangrene.**

 **Patient Explanation:** "Problems with the veins returning blood to the heart. Faulty valves cause swollen varicose veins and chronic ankle ulcers, treated with compression and surgery. A blood clot in the vein (DVT/PE) is dangerous and needs blood thinners."

Visual Field Defects, Vasovagal Syncope, & Wernicke's


History (Symptoms)	Visual field: bumping into things on one side. Syncope: fainting triggered by standing/pain/stress, quick recovery. Wernicke's: alcoholic with sudden confusion and wobbliness.
Examination (Signs)	Visual field: Hemianopia on confrontation testing. Syncope: normal exam between faints. Wernicke's: Confusion, Ataxia, Nystagmus (eye flickering).
Bedside / GP	Visual testing. Syncope: Lying/standing BP, ECG. Wernicke's: Neuro exam.
Investigations	Visual fields: Perimetry, MRI Brain. Syncope: Clinical, tilt-table. Wernicke's: Clinical diagnosis, MRI.
Management (NICE/BNF)	Visual fields: Treat underlying stroke/tumour. Syncope: Reassurance, avoid triggers. Wernicke's: EMERGENCY IV Pabrinex (Thiamine) BEFORE any glucose.


 **Red Flags: Syncope during exercise (cardiac risk). Wernicke's must be treated instantly or it progresses to permanent, irreversible Korsakoff's dementia.**

 *Patient Explanation: "Losing half your vision is usually due to a stroke or brain tumour. Simple fainting is harmless and happens when your blood pressure drops suddenly. Wernicke's is a severe brain injury from vitamin lack in alcoholics, needing urgent drips."*

Volvulus & Whooping Cough


History (Symptoms)	Volvulus: Elderly (sigmoid) or young (caecal) with severe colicky abdo pain, massive swelling, no stool passing. Whooping Cough: Long bouts of severe coughing followed by a gasping 'whoop' sound, lasting months.
Examination (Signs)	Volvulus: Massively distended, drum-like abdomen. Whooping cough: red face/vomiting during cough, otherwise normal.
Bedside / GP	Volvulus: Vitals (shock check). Whooping cough: Swab/PCR.
Investigations	Volvulus: Abdominal X-ray ('coffee bean' sign). Whooping cough: PCR swab. Notify Public Health.
Management (NICE/BNF)	Volvulus: Flatus tube decompression (sigmoid) or emergency surgery. Whooping cough: Macrolide antibiotics if caught early, mostly supportive.


 **Red Flags: Volvulus can cut off its own blood supply, dying and bursting (peritonitis) if not fixed quickly. Whooping cough is fatal in unvaccinated babies under 6 months.**

 **Patient Explanation:** "Volvulus is the bowel twisting on itself, blocking gas and stool, causing a huge tummy. It needs a tube or surgery to untwist. Whooping cough is a severe bacterial cough that lasts for 100 days; it's very dangerous for tiny babies."

Acute Stress Reaction / PTSD


History (Symptoms)	Exposure to a severe, life-threatening traumatic event. Symptoms occur within 1 month (Acute Stress Reaction) or persist >1 month (PTSD). Flashbacks, nightmares, avoidance, hyperarousal, emotional numbness.
Examination (Signs)	Visible distress, hypervigilance, tachycardia, diaphoresis when discussing the event.
Bedside / GP	Assess for risk of self-harm or suicide. Evaluate impact on daily functioning.
Investigations	Clinical diagnosis based on psychiatric history. Rule out substance misuse or underlying physical injury.
Management (NICE/BNF)	ASR: Watchful waiting, psychological first aid. PTSD: Trauma-focused CBT, Eye Movement Desensitisation and Reprocessing (EMDR). SSRIs (e.g., Sertraline) if therapies ineffective.


 **Red Flags: High risk of suicide or severe self-neglect. Dangerous impulsive behaviour or substance abuse to cope.**

 *Patient Explanation: "A severe emotional reaction after a terrifying event. Acute stress reaction happens right away, while PTSD lasts for months or years, causing nightmares and flashbacks. Specific talking therapies are highly effective."*

Human Papillomavirus Infection (Genital Warts)


History (Symptoms)	Painless lumps around the vulva, penis, or anus. May cause mild itching or bleeding during sex. Caused by HPV types 6 and 11. (Note: HPV 16/18 cause cervical cancer but are asymptomatic).
Examination (Signs)	Fleshy, cauliflower-like (exophytic) growths or flat papules on the anogenital skin/mucosa.
Bedside / GP	Full sexual health screen to check for concurrent STIs.
Investigations	Clinical diagnosis. Cervical smear (for high-risk HPV types 16/18) according to national screening guidelines.
Management (NICE/BNF)	Topical Podophyllotoxin (if soft/non-keratinized) or Imiquimod cream. Cryotherapy or surgical excision/ablation in clinic. HPV vaccination (Gardasil) prevents infection.


 **Red Flags: Atypical, bleeding, or rapidly growing warts must be biopsied to rule out squamous cell carcinoma.**

 *Patient Explanation: "Small, fleshy lumps in the genital area caused by a virus transmitted during sex. They are mostly harmless but can be a nuisance. They can be treated with freezing or special creams, and the HPV vaccine prevents them."*

Notifiable Diseases (Public Health)

History (Symptoms)	Presentation depends on the disease (e.g., Measles, Meningitis, TB, Food poisoning, COVID-19). Any strong suspicion of an outbreak or a legally notifiable infectious disease.
Examination (Signs)	Varies by disease (e.g., purpuric rash for meningococcal septicaemia).
Bedside / GP	Immediate isolation of the patient if highly infectious (e.g., negative pressure room for TB).
Investigations	Do NOT wait for laboratory confirmation to notify the local Health Protection Team (HPT). Prompt notification is a legal duty on clinical suspicion.
Management (NICE/BNF)	Varies. Public Health teams will trace contacts, provide post-exposure prophylaxis (e.g., antibiotics for meningitis contacts), and manage outbreaks.


 **Red Flags: Failing to notify Public Health promptly can lead to preventable outbreaks and deaths in the community (e.g., a meningitis cluster in a school).**

 *Patient Explanation: "Certain infectious diseases (like tuberculosis, meningitis, or measles) are so dangerous or spread so easily that doctors are legally required to report them to public health teams immediately to stop outbreaks."*

Osteomalacia / Rickets

History (Symptoms)	Adults (Osteomalacia): Widespread bone pain (dull ache), muscle weakness (waddling gait), easily fractured bones. Children (Rickets): Bowed legs, delayed walking, bone pain. Usually due to severe Vitamin D deficiency.
Examination (Signs)	Bone tenderness on palpation. Proximal myopathy (difficulty standing from a chair). Children: Genu varum (bow legs), rachitic rosary (swollen costochondral joints on chest).
Bedside / GP	Assess dietary history and sunlight exposure.
Investigations	Bloods: Low Vitamin D, Low Calcium, Low Phosphate, HIGH Alkaline Phosphatase (ALP). X-rays show looser zones (pseudofractures) in adults.
Management (NICE/BNF)	High-dose Vitamin D replacement (e.g., Colecalciferol). Calcium supplements. Ensure adequate sunlight exposure and dietary calcium.

 **Red Flags: Symptomatic hypocalcaemia (tetany, muscle spasms, arrhythmias) requires urgent IV calcium replacement.**


 *Patient Explanation: "A condition where bones become soft and weak because the body doesn't have enough Vitamin D (usually from lack of sunlight). It causes bone pain and weak muscles, but is easily fixed with Vitamin D supplements."*


Patient on Anticoagulant / Antiplatelet Therapy

History (Symptoms)	Patient taking Warfarin, DOACs (Apixaban, Rivaroxaban), Aspirin, or Clopidogrel. Presenting with minor trauma, needing surgery, or signs of bleeding (bruising, epistaxis, melaena, haematuria).
Examination (Signs)	Check for signs of significant bleeding/haemorrhage, shock (tachycardia, hypotension). Full neurological exam if head injury (risk of intracranial bleed).
Bedside / GP	Vital signs. Medication review. Assess indication for blood thinners (e.g., AF, mechanical heart valve).
Investigations	INR (crucial for Warfarin; normal target 2-3). FBC (check Hb), Coagulation screen, Renal function (U&Es affect DOAC clearance).
Management (NICE/BNF)	Minor bleeding: local measures. Major bleeding: Stop anticoagulant. Warfarin reversal: IV Vitamin K and Prothrombin Complex Concentrate (Octaplex). DOAC reversal: Andexanet alfa (for Apixaban/Rivaroxaban) or Idarucizumab (for Dabigatran).

BNF/BNFC Dosage Guide:

- Apixaban 5mg BD PO (Stroke prevention in AF)

 **Red Flags: Any head injury in a patient on anticoagulants mandates an urgent CT Head, even if asymptomatic, due to the high risk of fatal intracranial haemorrhage.**


 *Patient Explanation: "Patients on blood-thinning medications bleed much more easily. If they have a serious bleed or need an operation, we must temporarily stop the medication and sometimes give specific antidotes to help their blood clot normally again."*


Periorbital and Orbital Cellulitis

History (Symptoms)	Painful, swollen, red eye. Often preceded by a sinus infection, insect bite, or local skin trauma.
Examination (Signs)	Periorbital: Swollen, red eyelids, but eye movement is normal and painless. Orbital (MEDICAL EMERGENCY): Proptosis (bulging eye), pain on eye movement, restricted eye movement (ophthalmoplegia), reduced vision.
Bedside / GP	MUST test visual acuity, pupillary reflexes, and full extraocular movements.
Investigations	Urgent CT scan of the orbits/sinuses to differentiate between periorbital and orbital cellulitis and look for abscesses.
Management (NICE/BNF)	Periorbital: Oral antibiotics (Co-amoxiclav). Orbital: Emergency admission, IV antibiotics, urgent ophthalmology and ENT review (may need surgical drainage of sinuses).

BNF/BNFC Dosage Guide:


- Co-amoxiclav 625mg TDS PO or 1.2g IV TDS


 **Red Flags: Orbital cellulitis (pain on moving the eye, bulging eye, or vision loss) can rapidly spread to the brain (meningitis, cavernous sinus thrombosis) causing blindness or death.**

 *Patient Explanation: "A bacterial infection of the tissues around the eye. If the infection spreads deep behind the eye (orbital cellulitis), it causes pain when looking around and is a major emergency requiring IV antibiotics to save vision and prevent brain infection."*

Self-Harm


History (Symptoms)	Intentional self-injury (cutting, burning, overdose, scratching). Patient may report overwhelming distress, emotional numbness, or a desire to punish themselves. Not always associated with suicidal intent.
Examination (Signs)	Fresh wounds, scars in varying stages of healing (often on forearms, thighs, or abdomen).
Bedside / GP	Immediate triage of physical injuries (e.g., toxidrome for overdose, wound care). COMPREHENSIVE psychiatric risk assessment.
Investigations	Paracetamol level (mandatory in any intentional overdose), toxicology screen, ECG. Baseline bloods (U&Es, LFTs).
Management (NICE/BNF)	Medical stabilization of injuries. Psychosocial assessment by the liaison psychiatry team before discharge. Harm-minimization advice. Referral to community mental health teams or DBT therapies.


 **Red Flags: High intent to die (e.g., writing a note, taking precautions against discovery, violent methods) indicates a severe risk of completed suicide and requires urgent psychiatric admission.**

 *Patient Explanation: "Deliberately injuring oneself as a way of coping with overwhelming emotional pain. It must always be taken seriously. After treating any physical injuries, the priority is a thorough mental health assessment to provide proper support and therapy."*

Trichomonas Vaginalis


History (Symptoms)	Women: Frothy, yellow-green, foul-smelling vaginal discharge. Vulval itching, dysuria, superficial dyspareunia (painful sex). Men: Usually asymptomatic, but may have mild urethral discharge/dysuria.
Examination (Signs)	Vulvovaginitis (erythema). Speculum exam: Frothy discharge. Classic 'strawberry cervix' (punctate haemorrhages on the cervix) seen in ~2% of cases.
Bedside / GP	Vaginal pH > 4.5.
Investigations	High vaginal swab for NAAT (Nucleic Acid Amplification Test) or direct wet mount microscopy (shows motile, flagellated protozoa).
Management (NICE/BNF)	Oral Metronidazole (either a single 2g dose or 400mg twice daily for 5-7 days). MUST treat all current sexual partners simultaneously.


 **Red Flags: Increased risk of acquiring/transmitting HIV. Can cause premature rupture of membranes and preterm delivery in pregnant women.**

 *Patient Explanation: "A sexually transmitted infection caused by a tiny parasite. It causes a frothy, smelly discharge and itching in women, but often has no symptoms in men. It is easily cured with a specific antibiotic, but partners must also be treated."*

Anxiety, phobias, OCD


History (Symptoms)	OCD: Intrusive, distressing thoughts (obsessions) and repetitive behaviours/mental acts (compulsions) performed to relieve anxiety. Phobias: Disproportionate, irrational fear of a specific object/situation leading to avoidance. Panic attacks.
Examination (Signs)	Observed anxiety, autonomic arousal (sweating, tachycardia). Skin excoriation or chapped hands (from OCD hand washing).
Bedside / GP	Psychiatric questionnaires (e.g., Y-BOCS for OCD). Assess impact on daily functioning.
Investigations	Clinical diagnosis. Rule out hyperthyroidism or substance misuse.
Management (NICE/BNF)	CBT with Exposure and Response Prevention (ERP) is gold standard for OCD/Phobias. High-dose SSRIs (e.g., Sertraline or Fluoxetine) are first-line pharmacological treatments.


 **Red Flags: High risk of severe social isolation, depression, and suicide if untreated. Obsessions involving harm to self/others require careful risk assessment.**

 *Patient Explanation: "Mental health conditions driven by intense fear or anxiety. OCD causes repetitive, distressing thoughts that you try to fix with repetitive actions. Phobias are extreme fears of specific things. Both are very treatable with specific talking therapies and medications."*

Benign Eyelid Disorders (e.g., Chalazion, Stye/Hordeolum)

History (Symptoms)	Chalazion: Painless, firm, slow-growing lump in the eyelid. Hordeolum (Stye): Acute, painful, red lump at the edge of the eyelid (near eyelash follicle).
Examination (Signs)	Chalazion: Non-tender nodule within the tarsal plate. Stye: Tender, erythematous, pus-filled swelling at the lid margin.
Bedside / GP	External eye exam. Visual acuity (should be normal).
Investigations	Clinical diagnosis. No swabs needed unless systemically unwell.
Management (NICE/BNF)	First line: Warm compresses 3-4 times a day and lid massage to unblock the gland. Antibiotic ointment (Chloramphenicol) ONLY if infected. Incision and curettage if a chalazion persists >1 month.

 **Red Flags: Recurrent chalazia in exactly the same spot in an older patient -> must rule out Sebaceous Gland Carcinoma (requires biopsy).**


 *Patient Explanation: "Harmless lumps on the eyelids caused by blocked oil glands or minor infections. A stye is painful and like a pimple, while a chalazion is painless and firm. Warm wet flannels and gentle massage usually clear them up."*


Breast Abscess / Mastitis (Non-Lactational)

History (Symptoms)	Painful, red, hot swelling in the breast. Often associated with smoking (periductal mastitis) or nipple piercing. Fever, malaise.
Examination (Signs)	Fluctuant, tender, erythematous breast mass. Nipple discharge/retraction may be present.
Bedside / GP	Vital signs (fever).
Investigations	Breast Ultrasound is essential to confirm an abscess collection. Fine Needle Aspiration (FNA) of pus for culture.
Management (NICE/BNF)	Antibiotics (Co-amoxiclav). Ultrasound-guided needle aspiration of the abscess (often needs repeating). Smoking cessation is vital to prevent recurrence.

BNF/BNFC Dosage Guide:


- Co-amoxiclav 625mg TDS PO or 1.2g IV TDS


 **Red Flags: Inflammatory breast cancer can perfectly mimic mastitis/abscess (red, swollen, hot breast). If symptoms do not completely resolve with antibiotics, urgent 2-week-wait referral is mandatory.**

 *Patient Explanation: "A painful collection of pus inside the breast tissue, usually linked to smoking or blocked ducts. It requires antibiotics and a needle to drain the pus. If it doesn't heal quickly, we must scan it to ensure it isn't something more serious."*

Bronchiolitis


History (Symptoms)	Infant (typically <1 year old). 1-3 days of coryza (runny nose) followed by a dry cough, rapid breathing, and difficulty feeding. Often caused by RSV in winter.
Examination (Signs)	Tachypnoea, subcostal/intercostal recession, tracheal tug, nasal flaring. Widespread fine crackles and wheeze on auscultation.
Bedside / GP	Check SpO2 (hypoxia). Observe a feed (assess for poor feeding/fatigue).
Investigations	Clinical diagnosis. Nasopharyngeal aspirate for RSV PCR if admitted. CXR rarely needed unless atypical.
Management (NICE/BNF)	Supportive: Nasal saline drops, small frequent feeds or NG tube feeding, Oxygen via high-flow nasal cannula (Optiflow) if SpO2 <92%. Bronchodilators/steroids DO NOT WORK.


 **Red Flags: Apnoeas (stopping breathing) in very young/premature babies. Severe respiratory distress or feeding <50% of normal requires hospital admission.**

 *Patient Explanation: "A very common winter virus causing inflammation in the tiniest airways of a baby's lungs. It causes fast breathing and coughing. Since it's viral, inhalers and antibiotics don't work; we just support their breathing and feeding until the virus passes."*

Cirrhosis

History (Symptoms)	Chronic liver scarring. Fatigue, weakness, easy bruising, jaundice, itchy skin, swollen abdomen (ascites), confusion (encephalopathy). Alcohol, Hep C, NAFLD.
Examination (Signs)	Jaundice, spider naevi, palmar erythema, gynaecomastia, hepatosplenomegaly, shifting dullness (ascites), asterixis (flapping tremor).
Bedside / GP	Calculate Child-Pugh or MELD score.
Investigations	Liver Ultrasound (coarse, nodular liver). Fibroscan. Bloods: Low albumin, prolonged PT/INR, low platelets.
Management (NICE/BNF)	Treat cause (stop alcohol). Diuretics (Spironolactone) for ascites. Lactulose for encephalopathy. Beta-blockers to prevent variceal bleeding. Liver transplant.


 **Red Flags: Massive upper GI bleed from ruptured oesophageal varices (emergency). Spontaneous bacterial peritonitis (fever in ascites).**

 *Patient Explanation: "Severe, irreversible scarring of the liver. The liver shrinks and stops filtering toxins or making clotting proteins. It causes fluid to leak into the tummy and can cause confusion or major bleeding. Sometimes a transplant is the only cure."*

Cushing's Syndrome


History (Symptoms)	Weight gain, easy bruising, muscle weakness, depression, irregular periods. Often taking oral steroids.
Examination (Signs)	Central obesity, moon face, buffalo hump, purple striae, thin skin, hypertension.
Bedside / GP	Check BP, BMI, medication history.
Investigations	Overnight Dexamethasone Suppression Test. 24h urinary free cortisol.
Management (NICE/BNF)	Reduce exogenous steroids slowly. Surgical removal of pituitary/adrenal tumour if endogenous.


 **Red Flags: Abrupt steroid withdrawal causes a fatal adrenal crisis.**

 *Patient Explanation: "Too much stress hormone (cortisol) in the body, causing weight gain and thin skin. Usually from taking steroid tablets, but sometimes from a small tumour. We treat the root cause."*

Depression

History (Symptoms)	Pervasive low mood, lack of enjoyment (anhedonia), poor sleep (early morning waking), low energy, weight changes, feelings of worthlessness, suicidal thoughts.
Examination (Signs)	Psychomotor retardation, flat affect, poor eye contact.
Bedside / GP	PHQ-9 score. Suicide risk assessment.
Investigations	Bloods (TFTs, B12, Calcium) to rule out organic causes.
Management (NICE/BNF)	CBT, SSRIs (Sertraline, Citalopram). Safety planning.


 **Red Flags: Active suicidal planning, psychosis (delusions of guilt), severe self-neglect.**

 *Patient Explanation: "A medical illness affecting brain chemistry, causing persistent sadness and lack of energy. Highly treatable with talking therapies and antidepressants."*

Irritable Bowel Syndrome (IBS)

History (Symptoms)	Abdominal pain relieved by defecation. Altered bowel habit (diarrhoea/constipation/mixed). Bloating, mucus in stool.
Examination (Signs)	Normal exam, mild general tenderness.
Bedside / GP	Weight check.
Investigations	Diagnosis of exclusion. Normal FBC, CRP, Coeliac screen, and Faecal Calprotectin.
Management (NICE/BNF)	Low FODMAP diet, Mebeverine (spasms), Laxatives or Loperamide. Low-dose Amitriptyline.


 **Red Flags: Weight loss, rectal bleeding, onset >60 years old (requires cancer rule-out).**

 *Patient Explanation: "A sensitive gut causing cramps, bloating, and unpredictable bowels. Not dangerous, managed with diet and symptom-relieving tablets."*

Leukaemia (General)

History (Symptoms)	Fatigue (anaemia), severe infections (neutropenia), easy bruising/bleeding (thrombocytopenia), bone pain, night sweats.
Examination (Signs)	Pallor, petechiae, lymphadenopathy, hepatosplenomegaly.
Bedside / GP	Examine lymph nodes/bruising.
Investigations	FBC (pancytopenia or very high abnormal white cells). Blood film. Bone marrow biopsy.
Management (NICE/BNF)	Intensive chemotherapy, blood transfusions, stem cell transplant.


 **Red Flags: Neutropenic sepsis (fever requires immediate IV antibiotics).**

 *Patient Explanation: "A blood cancer where the bone marrow makes millions of useless white blood cells, crowding out the good cells. Treated with chemotherapy."*

Lower Respiratory Tract Infection (LRTI)


History (Symptoms)	Acute cough, purulent sputum, fever, breathlessness, chest discomfort.
Examination (Signs)	Wheeze or crackles on chest auscultation. Fever, tachypnoea.
Bedside / GP	SpO ₂ , Respiratory Rate, CRB-65 score.
Investigations	Chest X-ray if pneumonia suspected. Point-of-Care CRP (if >100, antibiotics indicated).
Management (NICE/BNF)	Amoxicillin or Doxycycline if bacterial/pneumonia suspected. Self-care if acute bronchitis. BNF/BNFC Dosage Guide: <ul style="list-style-type: none">• Amoxicillin 500mg TDS (Adult) 250mg TDS (Child 1-5y) PO• Doxycycline 100mg OD/BD PO (Avoid in pregnancy/children)


 **Red Flags: Sepsis, severe hypoxia (SpO₂ <92%).**

 *Patient Explanation: "An infection deep in the lungs. It can be a simple chest infection (bronchitis) or pneumonia. Treated with antibiotics if bacterial."*

Metastatic Disease (General)

History (Symptoms)	Known history of cancer. New severe bone pain (bone mets), headaches/seizures (brain mets), jaundice/RUQ pain (liver mets), breathlessness (lung mets), severe weight loss.
Examination (Signs)	Cachexia, hard enlarged lymph nodes, hepatomegaly, focal neurological signs.
Bedside / GP	Assess overall performance status.
Investigations	CT staging scans, MRI brain, bone scan. Bloods: LFTs, Calcium (hypercalcaemia).
Management (NICE/BNF)	Palliative chemotherapy, radiotherapy (for bone pain/brain mets), bisphosphonates for bones, adequate analgesia (opioids).

 **Red Flags: Spinal cord compression (back pain + leg weakness) and hypercalcaemia are oncological emergencies.**

 *Patient Explanation: "Cancer that has spread from its original site to other organs. We use scans to find it and treat it with therapies aimed at controlling symptoms and slowing the spread."*


Pneumonia

History (Symptoms)	High fever, productive cough (rusty/green sputum), pleuritic chest pain, breathlessness, confusion in the elderly.
Examination (Signs)	Focal coarse crackles, bronchial breathing, dullness to percussion over the infected lobe.
Bedside / GP	CRB-65 score to decide admission.
Investigations	Chest X-ray shows focal consolidation. Sputum cultures. Blood cultures if severe.
Management (NICE/BNF)	Amoxicillin (mild community). Co-amoxiclav + Clarithromycin IV (severe hospital). Oxygen.

BNF/BNFC Dosage Guide:


- Amoxicillin 500mg TDS (Adult) | 250mg TDS (Child 1-5y) PO
- Co-amoxiclav 625mg TDS PO or 1.2g IV TDS
- Clarithromycin 500mg BD PO


 **Red Flags: CRB-65 > 2 requires urgent hospital admission. Hypoxia, sepsis.**

 *Patient Explanation: "A serious bacterial lung infection where air sacs fill with fluid. Causes severe cough and fever. Needs strong antibiotics to clear."*

Thyrotoxicosis

History (Symptoms)	Weight loss, increased appetite, heat intolerance, palpitations, anxiety, tremor, loose stools.
Examination (Signs)	Tachycardia, fine tremor, warm sweaty skin, goitre. Exophthalmos if Graves'.
Bedside / GP	ECG (check for AF).
Investigations	TFTs (Low TSH, High T4/T3). TSH receptor antibodies.
Management (NICE/BNF)	Propranolol for symptoms. Carbimazole. Radioactive iodine.


 **Red Flags: Thyroid storm (severe fever, tachycardia, delirium) is a fatal emergency.**

 *Patient Explanation: "The thyroid gland is in overdrive, speeding up your heart and metabolism. We treat it with tablets that block the hormone production."*

Vasa Praevia


History (Symptoms)	Painless vaginal bleeding immediately after the waters break in labour, followed by catastrophic fetal distress.
Examination (Signs)	Severe fetal bradycardia on CTG.
Bedside / GP	Continuous CTG.
Investigations	Antenatal ultrasound with Doppler identifies it early.
Management (NICE/BNF)	Emergency category 1 Caesarean section.

 **Red Flags: The blood lost belongs to the baby, leading to rapid fetal death.**

 *Patient Explanation: "The baby's blood vessels are exposed across the cervix. If the waters break, the vessels tear. Requires emergency C-section to save the baby."*

Vitamin B12 and/or Folate Deficiency

History (Symptoms)	Profound fatigue, breathlessness, 'pins and needles' in hands/feet, sore red tongue.
Examination (Signs)	Lemon-yellow pallor, loss of vibration sense in feet.
Bedside / GP	Neurological exam.
Investigations	FBC (Macrocytic anaemia), Low B12/Folate. Intrinsic factor antibodies.
Management (NICE/BNF)	B12 injections BEFORE Folate tablets to prevent nerve damage.

 **Red Flags: Subacute combined degeneration of the spinal cord (irreversible nerve damage if missed).**

 *Patient Explanation: "Lack of vitamins needed for blood and nerves, causing extreme tiredness and tingling. Treated easily with injections or tablets."*