Looking back over the last 30 or 40 years, many of the tests we assiduously carried out on our patients have been declared unreliable. Many of the findings on cardiac auscultation were shown to be erroneous by electrical and imaging tests, yet we continue to listen to the various heart sounds. A pathway to celebrity was to describe a new physical sign that became eponymous. Professor Niels Rosling of Copenhagen, in 1907, showed that in patients with acute appendicitis, pressure in the left iliac fossa produced sharp pain in the right iliac fossa, attributed to compression of the left colon driving round bowel gas to distend the cecum. We later learned that it is unusual for a significant amount of gas to accumulate in the descending and sigmoid colon. The sign is unreliable, yet many senior clinicians continue to test for it, and teach their students to use it.

I was astonished when reviewing the literature at the number of reports demonstrating that palpation and percussion provide poor evaluation of the liver. The paper by Joshi and colleagues is a valuable addition to the long list. Apart from being a well conducted study, the added value is that it comes from India. I have visited many parts of India over many years – not only the famous institutions in big cities but also small rural hospitals where facilities for advanced investigations and treatment are in short supply. As a result, reliance on clinical judgement and sedulous pursuit of physical findings must be as good anywhere in the world. This gives added weight to the finding that liver enlargement cannot be reliably diagnosed by abdominal palpation and percussion.

We should not be surprised. The anterior surface of the liver in contact with the anterior abdominal wall, moving up and down by about 10 cm during full inspiration and expiration, has an upper surface receding from us below, the organ normally becomes progressively thinner and more flexible. How can we accurately detect a thin soft liver edge through a variably thick, variably flexible and variably tensed abdominal wall? Unless there is air-containing bowel below, how can we define the edge by percussion? If there is a thick chest wall it may be equally difficult to define the upper edge in the same manner.

The question we should ask is, "Should we try?" I have the privilege of working in a hospital alongside one of the most distinguished hepatologists in the world, Dame Professor Sheila Sherlock. Although she had available the latest diagnostic equipment, and used it liberally, she never failed to carry out a routine clinical examination and to relish demonstrating the resulting physical signs. Woe betide an assistant who ordered a test without first examining the patient and applying the findings to justify the selection of an appropriate investigation.

There is far more to abdominal examination than determining the vertical length of the anterior surface of the liver in the mid-clavicular line. The authors make it plain that they are well aware of this. The more carefully one looks, feels, listens, smells, gently moves, percusses, ballots, watches as the patient moves, the deeper our knowledge of the person becomes and we develop what we call a 'sixth' sense.

There are two types of knowledge, explicit and tacit. Explicit (L. ex = out + plicare = to fold; hence, unfold) encompasses scientific knowledge; when Watson and Crick described the double helix mechanism of the DNA molecule it could be explained in words, numbers, diagrams. In contrast, tacit (L. tacere = to be silent) knowledge cannot be transmitted in words. It must be passed from one person to another by demonstration and example. In palpating the liver, in placing a hand over it and asking the patient to breathe so that it passes beneath the 'watching,' still hard; in percussing it gently and firmly, information that is difficult to put into words is gathered by the examiner. Indeed, just watching a consummate expert examining an abdomen is educational in a verbally indefinable way.

This 'personal' knowledge is described by Michael Polanyi. Although he was a doctor, he used as an example the genius of Antonio Stradivari, the violin-maker of Cremona. He had learned as an apprentice to the famous Amati family and brought violin making to the pinnacle of perfection. Polanyi points out that in spite of subsequent meticulous measurements of his instruments, sophisticated physical and chemical examination of the wood, varnish, and other components, no one has duplicated a Stradivari violin. One can imagine the intimate, tacit, personal knowledge of Stradivari as he held a piece of wood and felt it in the making of a wonderful instrument.

It is this tacit familiarity and 'feel' that makes me adjure trainees to take every opportunity to examine patients by every means. They may not be able to make certain accurate measurements but in a subtle way they accumulate a knowledge of what is the range of normality. Without knowing this, how can we look patients in the eye and say, firmly, and reassuringly, 'All is well'? It is for this reason that I sent my children who studied medicine to the Indian subcontinent, where they learned superb clinical medicine by examining patients under the supervision of outstanding clinicians. Physical examination is more than the laying on of hands, although in some...
called 'complementary medicine', many patients derive comfort and reassurance from this.

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References

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