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Lymph nodes are also known as lymph nodes and these are small lumps of tissue that are part of the body's immune system. Lymph nodes consist of white blood cells that act as the active immune system of the body, by filtering harmful substances such as bacteria and cancer cells from the body. Lymph nodes are located throughout the body in places such as the neck, armpits, between the lungs, around the intestines, etc. Lymph nodes fight infections by filtering lymphatic fluids, which consist of fluids and waste products from the body's tissues. These nodes help to activate the immune system in case of infection. Lymph nodes play a very important role in the diagnosis of many diseases, such as tumors for simple infections. Examination of lymph nodes: This is done using techniques of control and palpation to examine the lymph nodes. The lymph nodes of the head and neck are variable, and the lymph nodes that are available for palpation in the head and neck area are occipital, trained, sub mandibular, retroauric, subchrobre lymph nodes. The Waldeyers Ring is a lymphatic ring around the neck. Detailed description of the Inner and Outer Ring of Waldeyers: Waldeyers Ring Principles of lymph node examination: 1. Inspection: Gross space magnification (approximate size) Number 2. Palpation test: Sensitivity- Sensitivity or not tendery number Discreet / Dull palpation of the lymph nodes of the head and neck: The epididym: They are palpable front to or before the back of the auche: Palpated in the process of mastoid or anterior to has lobe Occipitaloid: They are palpated at the base of the posterior tonsillar skull: Tonsillar lymph nodes are palpated at the angle of the mandible submanibular: These nodes are palpable at the lower end of the mandibular body an approximate angle. The patient is asked to partially bend the neck towards the side that is being studied Submental: Submental lymph nodes are palpable under the chin. The doctor is behind the sedentary patient. The patient is asked to partially bend the neck towards the side that is being examined. The fingers of both hands should be placed below the chin under the lower jaw boundary and submental lymph nodes should be cupped in the fingers both hands front superficial cervix: These lymph nodes lie superficial to sternocleidomastoid muscles deep lymph nodes of the cervix: Lies below the sternomastoid muscles and through the cervical fascination. Posterior cervix: Palpated in the posterior triangle of the neck near the posterior border of trapezius Supraclavicular: Examined just above the clavicle, lateral to fix the sternomastoid muscle: Supraclavicular nodes are palpable in supra clavicular fossa bilaterally standing behind the patient. The patient may be instructed to lift and foreboding his/her arms forward (suggesting chest or abdominal injury) types and features associated with lymph nodes: Acute infection: Chronic infection: Relentless Mobile Enlarged Tuberculosis: Squamous cell carcinoma: Lymphomas: Lymph nodes play an important role in the diagnosis of many cancers in many parts of the body. Because lymph nodes filter harmful substances and waste products, with the presence of immune cells inside the lymph nodes, it helps to destroy cancer cells and bacteria in the lymphatic fluid transferred to the lymph nodes by lymphatic vessels. Thus, in case of suspected cancer in the body, the associated lymph nodes are palpable and studied, and in some cases aspiration or biopsy is also performed to help with diagnosis. Lymphoma is a cancer of the lymph nodes, where the tumor begins in the lymph nodes and spreads to other parts of the body through lymphatic vessels. I am Varun, a dentist from Hyderabad, India trying my bit to help everyone understand dental problems and treatments and to make dental education simplified for dental students and the dental fraternity. If you have any doubts please contact us or comment in the post, thanks for visiting. This video clears the concept of lymph nodes present in the head and neck of the human body. The most commonly examined lymph nodes include submental, subdibular, before and after the uchochy lymph and acetic nodes. TAGSBasicsClinicalThree yearMBBSMedicineCho lymphatic films Ear Nose Sinuses Oro-throat Thyroid The main groups of lymph nodes are located along the anterior and posterior aspects of the neck and at the bottom of the jaw. If the nodes are quite large, you can see them bulging under the skin, especially if the magnification is asymmetric (i.e. it will be more obvious if one side is larger and the other). To sense, use the blocks of all four fingers, as these are the most sensitive parts of the hand. Examine both sides of the head at the same time, walking with your fingers on a given area, applying constant, gentle pressure. The main groups of lymph nodes, as well as the structures that drain, are listed below. The description of drainage paths is approximate because there is often a lot of variability and overlap. Nodes are usually examined in the following order: Palpating the anterior cervical cervical lymph nodes (both superficial and deep): Nodes that lie both on top and under the sternocleidomastoid muscle (SCM) on both sides of the neck, from the angle of the jaw to the upper clavicle. This muscle allows the head to turn right and left. The right SCM turns its head to the left and vice versa. They can be easily identified by asking the patient to turn his head into his hand while provide resistance. Drainage: Internal structures of the throat, as well as part of the posterior throat, tonsils, and thyroid gland. posterior cervix: extend in the back line to the but before the quadrilateral, from the level of the bone to the clavicle. Drainage: Skin on the back of the head. Also often enlarged during upper respiratory tract infections (e.g. mononucleosis). Tonsillar: Located right at the angle of the mandibu. Drainage: Tonsilar and posterior throat regions. Sub-mandibuit: Along to the underside of the jaw on both sides. Drainage: Structures in the floor of the mouth. Sub-Mental: Right under your chin. Drainage: Teeth and intraoral cavity. Supra-clavicular: In the recess above the clavicle, the only lateral where the sternum connects. Drainage: Part of the thoracic cavity, abdomen. Lymph nodes of the head and neck There are many other groups of lymph nodes. However, palpation of these areas is limited to situations where a problem has been identified in this particular region (e.g. the pre-learning nodes in front of the ear may become inflamed during infection of the external ear canal). How do you feel? Lymph nodes are part of the immune system. As such, they are most easily palpable when fighting infections. Infections can either come from organs that drain or primarily within the lymph node itself, referred to as lymphadenitis. Infected lymph nodes appear to be: Firm, delicate, enlarged and warm. Inflammation can spread to the covering skin, causing it to appear red. If the infection remains untreated, the center of the node can become necrotic, which causes the accumulation of fluid and impurities in the structure. This is known as an abscess and feels a bit like a tensel filled with a balloon or grape (aka fluctuance). Knowing which nodes are emptying specific areas will help you search effectively. After infection, lymph nodes sometimes remain permanently enlarged, although they should be non-occasional, small (less 1 cm), have a rubbery consistency and none of the features described above or below. It is common, for example, to find small, tangible nodes in the subdibular/tonsil region of healthy individuals. This probably represents the aftermath of past pharyngitis or tooth infections. Malignant neoplasms may also include lymph nodes, mainly (e.g. lymphoma) or as a metastasis site. In both cases, these nodes are generally: firm, non-lead, dull (i.e. glued to each other), solid (i.e. not freely mobile, but rather glued to the underlying tissue) and increase in size over time. The location of the lymph node can help determine the site of a malignant tumor. Diffuse, bilateral involvement suggests systemic malignancy (e.g. myoma), while those limited to a specific anatomical region are more likely to be associated with a local problem. Enlargement of the nodes located only on the right side of the neck in the front cervical chain, for example, would be consistent with squamous cell carcinoma, often with intraocular primary cancer. Cervical adenopathy: The right cervical adenopathy secondary to metastatic cancer. Cervical adenopathy: Massive cervical adenopathy secondary to metastatic squamous cell carcinoma derived from this patient's oropharynx. Diffuse upper respiratory tract infections (e.g. mononucleosis), systemic infections (e.g. tuberculosis) and inflammatory processes (e.g. sarcoidosis) can cause enlarged lymph nodes (i.e. enlarged lymph nodes), HIV infection can also cause adenopathy in any region of the body, including the head/neck, armpits, epitrochlear, inch and other areas where lymph nodes are located. In these settings, the results can be symmetrical or asymmetric. Historical information, as well as results in other parts of the body are crucial for making these diagnoses. In addition, it can undertake serial testing within weeks to determine whether the node is really magnifying, suggestive of malignancy, or responding to treatment/time lapse and retreating in size as can occur with other inflammatory processes. External structures of the ear: Briefly examine the external structures, paying special attention to any skin lesions suggestive of cancer (e.g. basal cell, melanoma, squamous cell), common asymptomatic abnormalities affecting this sun-exposed area. If the patient has pain, try to identify its exact location. Infection in the external canal (inflammation of the outer ear), can cause discharge, and pain when the ear lobe and tragus are manipulated. Otoscope Otoscopy: Otoscope allows you to explore the outer canal, a structure that connects to the outside world to the middle ear, as well as the auditory eardrum and several structures of the inner ear. Proceed as follows: Put the otoscopic head on the oto-ophthalmologist. It should easily turn into a position. Turn on the light source. Place one of the disposable specules at the end of the range. Grip the range so that the handle is pointing directly down or tilted upwards and towards the patient's forehead. Each of these techniques is acceptable. The range should be in the right hand if you are examining the right upper hand. Place the tip of the speculi in the hole of the outer channel. Whether it's as part of a direct vision (i.e. not when looking through a range). Gently grip the upper part of the left ear with your left hand and pull back and forth. This will straighten the channel, allowing you to move the range more easily. Otoscopic examination Look through the lookout window with your eye. Slowly move the range, pointing slightly towards the patient's nose, but without any angle up or down. Move in small steps. Try not to move the range too much, because the external channel is quite sensitive. I find it helpful to lengthen the pinky and fourth fingers of my right hand and place them on the side of the patient's head, which is Stabilizing. As you progress, pay attention to the appearance of the external channel. Under the conditions of infection, called ot ot ot externa, the walls become red, swollen and may not accommodate a speculator. In a normal state, there should be a lot of space. If wax, which seems brownish, irregular and mushy, is blocking your view, stop and go to the other side. Don't try to extract it to/unless you've had specific training in this area! There are pharmacological wax softeners, which can then be easily irrigated from the canal. Externa otitis: Swelling caused by infection in the outer canal of the left ear (pictured right) limits the space around the Q-Tip. The image on the left is a normal uche for comparison. After moving forward a few centimeters, you should see the eardrum (aka eardrum). Pay special attention to: Color: When healthy, it has a grayish, translucent appearance. Structures behind it: Plastic, one of the bones of the middle ear, touches the drum. The drum is applied to this bone, which is visible through the upper half, at an angle down and backwards. The part closest to the top of the drum is called the side process and is generally the most visible. The tip at the bottom of the facet is umbo. Light Reflex: Light coming from your range will be reflected from the drum surface, making a triangle that is visible under the plastic. In the setting of infection in the middle ear (known as otitis media, the most common pathological process affecting this area), the drum becomes diffuse red and the reflex of light is lost. Plastic also seems less visible and may be able to see the line caused by the accumulation of fluid behind the drum. This is called middle ear exudation and can cause the drum to bulge outwards. On your range there is a valve that allows you to attach a small, compressive bulb. Place the bulb in your hand, which does not hold the bezel. With this device, you can squirt small withers of air (known as a pneumatic otoscopy) on the tympanic membrane. The normal membrane moves, which can be appreciated by the examiner. Outsdue prevent its occurrence. Ask an experienced examiner to demonstrate that at first it is quite awkward and difficult to appreciate the movement. Go to the other side of the body and examine the left eye. The position of the hand is reversed. Auditory acuities: If the patient does not complain of hearing loss, this part of the exam is omitted. A strict assessment can be carried out by asking the patient to close his eyes when placing his fingers a few centimeters from the ear. Rub the tips of the fingers first hand, and then the second. Note any obvious differences in hearing. Alternatively, you can stand behind the patient and whisper a few words in the first chu, and then in the second. Are they able to repeat the returns back correctly? Does it seem that it's equal on both sides? These of course they are not very objective. Precise quantification requires sensitive equipment and is usually performed by a trained audiologist. Conduction detection v. Nervous deficits: As with focus, these tests will only be performed if the patient has complained of hearing loss. The transmission of sound can be divided into two elements: Conduction: the transition of sound from the outside to level 8 of the crater nerve. This includes the transmission of sound through the external channel and the middle ears. Sensory-phonic: Transmission of sound through 8 nerves to the brain. Hearing loss can occur at any level. To determine which impact this has, the following tests are performed: Weber: Grip the 512 Hz tuning fork behind the stem and keep it vibrating, hitting your teeth in the hand or slamming the ends between your thumb and middle finger. Then place the stem towards the back of the patient's head, on an imaginary line at an equal distance from both sides of the neck. The bones of the skull will pass this sound to 8 nerves, which should then be appreciated in both ears equally. Remind the patient that they are trying to detect a sound, not a vibrating feeling buzzing from a fork. If there is a conductive deficit (e.g. wax in the external channel), the sound will be better heard in this ear. This is because conduction disorders have prevented any competitive sounds from entering your ear on a normal route. Transient hearing loss can be transient by inserting your finger into one ear. The sound transmitted from the tuning fork will then be heard louder on this side. In the setting of sensory-nervous abnormalities (e.g. acoustic neuroma, tumor formed from 8 CN), the sound will be best heard in a normal heart. If the sound is heard better in one of the hands, it is described as lateral to this page. Otherwise, Weber's test is reportedly halfway through the line. Weber Test Rinne: Strike the same tuning fork and place the stem on the pumper bone, the bony prominent is located just behind and below the ear. Bone conduction will allow you to transmit and appreciate the sound. Instruct the patient to inform you as soon as they no longer hear the sound. Then place the teeth of the still vibrating fork right next to it, but without touching the outer channel. They should again be able to hear the sound. This is because when everything is functioning normally, the transmission of sound in the air is always better than through the bone. This will not be the case with conductive hearing loss (e.g. fluid associated with infection in the middle ear), which causes bone conduction to be greater or equal to air. If there are sensory and nervous abnormalities (e.g. drug toxicity up to 8 CN), air conduction should be even better than bone, as both will be equally affected by the deficit. Rinne Nose Test In the absence of symptoms, this one is Skipped. First check whether the patient is able to breathe through or nostrils effectively. Press on one nostril until it is obscured and do not inhale. Then repeat on the other side. The air should move equally well through each nares. To look into the nose, let the patient tilt his head back. Slightly push on the tip of the nose with the thumb of your left hand. Place the end of the sightpiece (it's OK to use the same with the ear exam) to nares under direct sight. Now look out the observation window, noting: The color of the mucous membrane. It can become quite red in the infection setting. The presence of any secretions, as well as its color (bright with allergic reactions; yellowish with infection). Middle and inferior mussels, which are projections resembling a shelf along the side wall. Any polypoid growths that may be associated with allergies and obstructive symptoms? The second nostril is studied in a similar way. Loss of sense of sense of chaught (anosmia) is a relatively common problem, although often undiagnosed. In patients who mention this problem, the sense of sense of mouth can be severely assessed using the alcohol pad-induction test as follows: Ask the patient to close his eyes so that he does not receive any visual guidance. Enveid each nostril sequentially, making sure that they can move the air appropriately through both. Enveid one nostril, then present an unknown element with a characteristic aroma, asking the patient to inform when they are able to detect its smell. The patient should be able to detect the smell of substances with characteristic aromas at a distance of 10 cm. Coffee, mint or winter green oil are usually used. Using coffee grounds to assess the must. Evaluation of the frontal and maxillary maxillary sinuses and frontal sinuses Head and face contain a number of sinuses, open cavities that communicate with the upper respiratory tract. They work to warm up and clean the air before it moves into the lungs. They can also help to reduce the total weight of the skull. In normal health, these sinuses can not be appreciated for examination and cause any symptoms. Inflammation, especially those caused by an allergy or infection, provokes symptoms and results that can be detected during the test. Symptoms associated with sinusitis include: nasal congestion, nasal discharge, facial pain, fever and pain during palpation of the maxillary teeth. The frontal and maxillary sinuses are two that can be indirectly studied. The examination for sinusitis should include the following: Examination of the nasal mucosa for colored secretions, as described above. This is due to the fact that the maxillary sinuses flow into the nose through the passage located under the middle aurile. Directly palpate and percuss the skin overlying the frontal and maxillary sinuses. Pain suggests inflammation. Lights in the room. Place the illuminated otoscope directly on the (bones just below the eye). Ask the patient to open his mouth and look for light shining through the mucous membrane of the upper part of the mouth. In the setting of inflammation, the maxillary sinus becomes filled with fluid and will not allow this transillumination. There are specially designed transilluminators that can work better for this task but are not readily available. Transillumination of the right maxillary sinus With the help of a tongue dismotive, touch the teeth that sit in the floor of the maxillary sinus. This can cause discomfort if the sinus is inflamed. Oro-pharynx exposure and good lighting are critical. Head and neck specialists have head lamps that provide excellent lighting and allow them to use both hands to explore the mouth. Most other doctors, however, use an otoscope or flashlight for lighting. Language depressor helps with exploration. The exam should be performed in an orderly manner as follows: Let the patient protrude from the tongue so that the posterior throat (i.e. the back of the throat) can be examined. Ask the patient to tell Ach what lifts the soft palate, giving a better view. If you're still unable to see, put the blade of your tongue back on your tongue and press down while the patient says Ach again, hopefully improving your view. This causes some people to gag, especially when the blade is pushed into more close aspects of the language. Sometimes it may be important to determine whether the emetic reflex is functional (e.g. after a stroke that impairs PN 9 or 10; or to determine whether a patient with reduced levels of consciousness is able to protect the airways from aspiration). This is done by touching the q-tip in front of the posterior throat, uvula or tongue. It is not necessary to do this during a routine exam, as it can be quite harmful! It should be remembered that uvula hangs from the roof of the mouth, directly in the middle of the line. With Ah, uvula rises. Deviation on the one hand can be caused by paralysis cn 9 (the lye deviates from the affected side), tumor or infection. Cra cravage nerve disorder 9: The patient suffered a stroke, causing loss of function of the left CN 9. As a result, uvula is pulled in the direction of the normally functioning (i.e. right) side. The normal throat has a matte red color. Under conditions of infection, it can become quite red, often covered with yellow or white exuding (e.g. from Strep. throat or other types of pharyngitis). The tonsils lie in a cavation created by arches on both sides of the mouth. The apex of these arches is located laterally to and on the line of uvula. Normal tonsils range from barely visible to quite visible. After infection they become red, they are often covered with whitish / yellow discharge. In the alignment of the peritoneal abscess, the tonsils appear asymmetric, and uvula can be pushed away from the affected side. When this Tonsils can actually threaten the size of the mouth, making breathing quite difficult. Left peritoneal abscess abscess. Note the deviation of uvula to the right. Look carefully along the upper and lower gum lines and on the mucous membrane in general, which can appear quite dry if the patient is dehydrated. Examine your teeth to get a sense of general teething, as oral health has broad implications, including: Nutrition (ability to eat) Appearance Self-esteem Social acceptance Systemic disease (endocarditis, ? other) Local problems: A profound lack of access to dental care has resulted in MDs taking responsibility for basic Dx and Rx multiple dental conditions. Dental Anatomy & Exam 16 top teeth, 16 bottom teeth Examine all the teeth and gums, using gloved hands, gauh, tongue depressor &am; lighting if abnormal Note: General appearance, any absent teeth, broken teeth or obvious cavities; Areas of pain, swelling, or infection If abnormal areas are noted, try to accurately determine the tooth/teeth involved as well as the extent of the problem. For example, the pain produced by touching the tooth is often caused by an abscess of the root. NIH Tooth Site Tooth Abscess: A tooth abscess involving the left molar region. Associated with inflammation of the left face can be seen clearly. Let the patient glue the tongue outside the mouth, which allows the cn 12 to be evaluated. If there is a nerve impairment, the tongue will deviate towards the affected side. Any obvious increases or irregularities? Invite them to turn their tongue so that you can look to the bottom. If you see something abnormal, catch your tongue with gauze to get a better look. Left CN 12 Dysfunction: Stroke caused L CN 12 Paralysis: The language therefore deviates from the left. Note any growths along the cheeks, hard palate (the roof of the mouth between the teeth), soft palate or anywhere else. In particular, patients who smoke or chew tobacco are at risk of oral squamous cell carcinoma. Any areas that are painful or appear abnormal should also be palpable. Put on your gloves to better explore these regions. How do they feel? Are they difficult? To what extent does growth require deeper structures? If the patient feels something that is not visible, try to get someone else to have a light source, releasing both hands to examine the mouth with two tongue depressors. The at-anal glands are located in both cheeks. Infection will cause pain and swelling in this area, which can be confirmed during palpation. The channels that drain the ate cups enter the mouth according to the lower molars and are easily visible. After infection, you may be able to express pus from the channels of gently palpating the gland. Right obedient mass. Notice the magnification on the right compared to the left. Examination of the thyroid gland before the test look at the thyroid region. If the gland is quite enlarged, you can notice that it protrudes under the skin. To find the thyroid gland, first locate the thyroid cartilage (aka Adams Apple), which is bulging in the middle of the line towards the upper part of the front surface of the neck. It is especially visible in thin males, sits on the trachea rings and is best seen when the patient tilts his head backwards. Deviation on one side or the other is usually associated with pathology inside the chest. For example, air trapped in one pleus space (known as pneumothorax) can generate enough pressure to collapse the lung on this side, causing mediastinal structures, along with the trachea, to be pushed towards the opposite chest. This deviation can be seen during the inspection and can be emphasized by gently placing the finger at the top of the thyroid cartilage and from the quotation of its position relative to the midline. The thyroid gland lies about 2-3 cm below the thyroid cartilage, on both sides of the trachea rings, which may or may not be visible for visual inspection. If you are not sure, give the patient a glass of water and swallow when you look at this region. Thyroid tissue, along with all adjacent structures, will move up and down with swallowing. The normal thyroid gland is not visible, so it is not worth going through this swallowing exercise if you do not see anything on glaring control. Palpation: The thyroid gland can be examined when you are standing in front of or behind a patient. The patient's exam is described below: Stand behind the patient and place the middle three fingers of both hands along the middle line of the neck, just below the chin. Gently go with them until you reach the upper part of the thyroid cartilage, the first hard structure with which you come into contact. Use gentle pressure, otherwise it can be uncomfortable. Make sure you tell your patients what you're doing so they know you're not trying to choke them! Cartilage has a small notch in the upper part and is about 1.5-2 cm long. Since you don't see the area you're exploring, it can be helpful to exercise in front of a mirror. You can also try to identify and feel the structures in front by looking at the area before taking the exam from behind. Go down with your fingers to the cartilage of the thyroid gland until you reach the horizontal groove that separates it from the cartilage cricoid (the first ring of the trachea). You should be able to feel a small indent (barely accepts the tip of your finger) between these 2 structures, directly in the middle line. It is a crico-thyroid membrane, a place for emerging tracheal access in case of obstruction of the upper respiratory tract. Continue walking down until you reach the next well-defined trachea ring. Now move three fingers of both hands to both sides of the rings. The thyroid gland extends from this point down for about cm along each side. The two main lobes are connected by a small isthth outcoming that reaches through the midline and is almost never perceptible. Apply very gentle pressure when you touch, because the normal tissue of the thyroid gland is not very visible and easily compressed. If you are not sure or want to confirm, let the patient drink water, like palpate. The gland should slide under the fingers as it moves upwards along with the cartilaginous rings. It takes a very soft, experienced touch to feel this structure, so don't be disappointed if you can't identify anything. A thyroid examination should pay attention to a few things as you try to identify your thyroid gland: If you get enlarged (and it's a subjective feeling that you will develop after many exams), is it symmetrically so? One-sided and two-sided? Are there discrete nodules in both lobes? If the gland feels tight, is attached to adjacent structures (i.e. attached to the underlying tissue... compatible with the tumor) or freely mobile (i.e. moves up and down from swallowing)? If there is a fear again: malignant neoplasm, a careful examination of the lymph nodes (described above) is important, because it is the most common place of spread. Spread.

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