duct obstruction from stone or by a carcinoma of the head of the pancreas. Murphy's sign is acute pain in this area on inspiration and suggests cholecystitis, even if the gallbladder is not palpable. It is easiest to elicit by hooking bent fingers under the ribs while pressing the liver forward with the other hand on the back. Pancreatitis may enlarge the pancreas in the epigastrium, and cysts are common with chronic disease.

The abdominal aorta lies just anterior to the spine and above the umbilicus. The aorta-iliac bifurcation is at about the level of the umbilicus and 6–8 cm above the top of the sacrum. Pulsation can be palpated. If it is enlarged, suspect an aneurysm. There may be a bruit distally unless the lumen is normal size due to a clot. Bruits can also be heard due to mesenteric or renal arterial stenoses. Pulsatile masses laterally and below the umbilicus may be iliac aneurysms, which commonly accompany aortic ones. Arteriovenous malformations produce both systolic and diastolic murmurs and can occur in any organ; these may rupture.

A suprapubic mass may be a distended bladder (inquire when the patient voided), and pressure usually produces an urge to void. A pregnant uterus, or one enlarged with fibroids or tumour, is found in the same region. If in doubt, a vaginal examination with pressure on the cervix will move the uterus but not the bladder.

The small bowel is not palpable unless distended or inflamed, but tinkling high-pitched sounds due to air-fluid motion are readily audible with disease. Tenderness may suggest Crohn's disease. The descending and sigmoid colons contain solid stool and are often palpable. There may be left lower quadrant tenderness with diverticulitis but not with diverticulosis. The stomach is not normally palpable except within 3 hours of a meal. A *succussion splash* that is palpable and audible after 3 hours suggests obstruction usually around the pylorus. Increased bowel sounds over the cecum also suggest obstruction – although these can be heard at any level of the colon.

The ovaries can be felt with combined vaginal and rectal examinations but rarely on the abdominal wall unless enlarged. Large cysts may be either benign or malignant and are readily palpable and often associated with ascites.

Auscultation is then repeated for the character and location of the bowel sounds, and for bruits. Remember that small tubes produce high-pitched sounds and large tubes produce low-pitched ones. Usually the sounds are intensified after the palpation, but bruits may be harder to hear as they are masked by bowel sounds.

Rectal examination is important to detect tenderness of fissures, a rectal tumour, an enlarged prostate (benign or malignant), and the presence or absence of a rectal shelf. The stool on the glove should be tested for occult blood. Only a few internists regularly do pelvic or scrotal examinations; these are usually the domain of the family doctor, gynecologist, or urologist.

After this survey examination, it is important to go back and re-examine the patient to see if other signs are present to support your diagnosis. For example, cirrhosis is often associated with a hard liver, a big spleen, ascites, spider nevi, and muscle wasting. Thorough auscultation may help determine the presence of an irritable bowel, inflammatory bowel disease, a volvulus, or a partial obstruction. The scratch test may show that apparent hepatomegaly is really due to a flattened diaphragm from pulmonary hyperinflation, and the liver is normal in size.

Abdominal examination tends to be done quickly and poorly by many physicians, who rely mainly on palpation. Hopefully, internists will not fall into this trap as many subtle, but useful, clues can be revealed with careful examination.

Dans la pratique de la médecine interne générale en français

Votre infarctus : « *steamé* » ou « *toasté* »?

Donald Echenberg, MD, Éric Deland, MD

Au sujet des auteurs

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La médecine avance. Nous travaillons avec de nouveaux concepts. Est-ce que notre langue évolue aussi rapidement?

Prenez par exemple le cas des syndromes coronariens aigus. On les classifie maintenant en trois catégories :

1. Infarctus du myocarde avec élévation du segment ST
2. Infarctus du myocarde sans élévation du segment ST
3. Angine instable

Après quelques jours d'observation on peut constater une évolution de l'ÉCG vers un infarctus avec ou sans onde Q.

Ça va bien jusque là …

Cependant les acronymes anglais créés pour désigner ces entités n'ont pas encore d'équivalents en français, et dans les hôpitaux francophones, on entend souvent la désignation des infarctus comme « STEMI » et « NON-STEMI », ce qui nous rappelle les hot-dogs « *steamés* » et « *toastés* » de notre enfance : ces acronymes ont le mérite d'être courts, mais ce n'est pas du très bon français …

Nous sommes donc partis à la recherche d'une désignation adéquate en français. Nous avons également consulté un expert dans le domaine, le Pr Serge Quérin, de l'Université de Montréal, auteur du *Dictionnaire des difficultés du français médical* (2e édition, 2006, Edisem ISBN : 978-2-89130-210-4). Après avoir obtenu son avis, et avoir consulté divers articles provenant de revues médicales francophones, voici ce que nous suggérons :

Pour le français écrit :

Deux acronymes pourraient convenir :

1. SCA pour *syndrome coronarien aigu*

   SCA ST + et SCA ST – (ou encore SCA ↑ et SCA ST↓)

2. IDM pour *infarctus du myocarde*

   IDM ST + et IDM ST – (ou encore IDM ST ↑ et IDM ST↓)

L'emploi des symboles ↑ et ↓ n'est pas conventionnel, mais pour les notes au dossier médical, il nous semble acceptable. Dans un article en bonne et due forme, la première occurrence de l'un ou l'autre de ces acronymes devrait être entre parenthèses après l'expression complète, afin qu'il soit clair entre autres choses que le symbole – (et plus encore↓) signifie que le segment ST n'est pas surélevé, sans pour autant être *abaissé*. Quant aux termes *syndrome coronarien aigu* et *infarctus du myocarde*, le choix se fera, bien entendu, en fonction de la période d'évolution (aiguë, sub-aiguë ou chronique), et des caractéristiques cliniques du syndrome.

Pour le français parlé :

Nous suggérons :

1. *Infarctus avec ST élevé* et *infarctus sans ST élevé*
2. *Syndrome coronarien avec ST élevé* et *syndrome coronarien sans ST* élevé, en abrégé *: SCA avec ST élevé* et *SCA sans ST élevé*

Bien sûr, c'est un peu plus long, comme endoprothèse est plus long que « stent » : mais quel niveau de français voulons-nous avoir?

Maintenant, quelqu'un veut-il nous aider à traduire : *PICC (peripherally inserted central catheter) line* et *Bladder scan* pour notre prochaine chronique?

Case Review

Subacute Progressive Paraneoplastic Necrotizing Myelopathy: A Rare Presentation of Lymphoma

Michaël Mayette, MD, Jean Rivest, MD, Bassem Sawan, MD

About the Authors

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Case Report

An 84-year-old right-handed man presented to our hospital with complaints of recurrent falls. He was known to have longstanding seronegative rheumatoid arthritis (RA), well controlled on hydroxychloroquine therapy, and a recent inferior wall myocardial infarction. His falls were associated with recent-onset distal right leg weakness and bilateral symmetrical lower extremity hypoesthesia. He had no other neurological complaints, no recent febrile illness, and no symptoms suggestive of collagen-vascular disease. His arthritis was not active. He had not travelled outside of Quebec. Upon examination, his mentation was normal, his visual fields were intact, and his cranial nerves were normal. Upper extremity sensory and motor examination was unremarkable. However, lower extremity examination revealed asymmetrical distal paresis, particularly in dorsiflexion of the ankle and hallux, and to a lesser extent in the knee and foot flexors. These findings were initially limited to the right leg. Flaccidity was apparent, without fasciculation. On sensory examination, there was loss of proprioception and severely diminished vibratory sense to the mid-thigh in both legs. Pain sensation was initially normal.

Results of a routine blood workup were unremarkable, with a normal complete blood count, B_{12}, and folic acid levels, thyroid function tests, and stable renal function. Initial findings on head computed tomography (CT) and magnetic resonance imaging (MRI) were normal. Full-spine MRI (Figure 1A) revealed three foci of an intramedullary hypersignal in T2 and STIR (lower cervical, lower thoracic, and conus medullaris). There was no medullary edema, evidence of extrinsic compression, or contrast-induced enhancement. Lumbar puncture revealed mild pleocytosis, normal glucose, elevated