



Focused Cardiovascular Assessment

This course has been awarded 2.0 (two) contact hours

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Acknowledgements

RN.com acknowledges the valuable contributions of...

...Nadine Salmon, MSN, BSN, IBCLC, the Clinical Content Specialist for RN.com. Nadine is a South African trained Registered Nurse, Midwife and International Board Certified Lactation Consultant. Nadine obtained an MSN at Grand Canyon University, with an emphasis on Nursing Leadership. Her clinical background is in Labor & Delivery and Postpartum nursing, and she has also worked in Medical Surgical Nursing and Home Health. Nadine has work experience in three countries, including the United States, the United Kingdom and South Africa. She worked for the international nurse division of American Mobile Healthcare, prior to joining the Education Team at RN.com. Nadine is a nurse planner for RN.com and is responsible for all clinical aspects of course development. She updates course content to current standards, and develops new course materials for RN.com.

... Lori Constantine MSN, RN, C-FNP, the original author of this course.

Purpose & Objectives

This course discusses specific cardiovascular history questions and exam techniques for your adult patient. Physical exam techniques such as inspection, palpation, percussion, and auscultation will be highlighted. Additionally, throughout the course you will learn how alterations in your cardiovascular assessment findings could indicate potential cardiovascular problems.

After successful completion of this course, you will be able to:

1. Outline a systemic approach to cardiovascular assessment.
2. Discuss history questions that will help you focus your cardiovascular assessment.
3. Recognize abnormal cardiovascular assessment findings associated with inspection, auscultation, percussion, and palpation.

Introduction

Cardiovascular disease is the leading killer for both men and women among all racial and ethnic groups in the U.S. According to the Centers for Disease Control (CDC) studies among coronary heart disease patients, 90% of patients have had prior exposure to at least one heart disease risk factor that contributed to their disease.

A thorough cardiovascular assessment will help to identify significant factors that can influence cardiovascular health such as high blood cholesterol, cigarette use, diabetes, or hypertension (CDC, 2011). Therefore, a cardiovascular exam should be a part of every abbreviated and complete assessment.

A focused cardiovascular assessment is usually indicated after a comprehensive assessment indicates a potential cardiovascular problem. The focused cardiovascular assessment is also indicated when an interval or abbreviated assessment shows a change in status from your previous assessment or the report you received, when a new symptom emerges, or the patient develops any distress.

An advantage of the focused assessment is that it allows you to ask about symptoms and move quickly to conducting a focused physical exam. Based upon the results of your assessment, you may choose how often to perform interval assessments to monitor the patient's identified problem. Keep in mind that all assessments should consider patient's privacy and foster open, honest patient communication.

History

The purpose of the cardiovascular health history is to provide information about your patient's cardiovascular symptoms and how they developed. A complete cardiovascular history will give you indications to potential or underlying cardiovascular illnesses or disease states. Obtaining a cardiovascular history will guide you through your focused physical exam. In addition to obtaining data about the patient's cardiovascular status, you should obtain information about other factors that can impact physical status including spiritual needs, cultural idiosyncrasies, and functional living status.

Past Health History

It is important to ask questions about your patient's past health history. The past health history should elicit information about the following issues: hypertension, elevated blood cholesterol or triglycerides, heart murmurs, congenital heart disease, rheumatic fever or unexplained joint pains as a child or youth, recurrent tonsillitis and anemia. You will also want to ask about the patient's history of heart disease, when and how it was treated, last EKG, stress tests, and serum cholesterol levels. Ask the patient the reasons for any previous hospitalizations and the nature of the treatments received while in the hospital. Ask about cardiac catheterizations, echocardiograms, stress tests, and cardiac surgeries (Kaplow & Hardin, 2007).

Current Lifestyle and Psychosocial Status

Current lifestyle and psychosocial issues to explore when conducting your focused cardiovascular health history include:

- **Nutrition:** Have your patient describe their daily diet. Ask about their usual weight and any recent weight gain or weight loss.
- **Smoking:** Ask your patient if they smoke cigarettes or other tobacco. Ascertain the pack per year smoking history. This is done by multiplying the number of years your patient has smoked with the number of packs per day they have smoked (Cancer Treatment Centers of America, 2011).
- **Alcohol:** Ask how much alcohol the patient normally drinks per day or per week. Ask about when the last drink was and the usual number of drinks per episode.
- **Exercise:** Ask about your patient's activity level and usual amount of exercise done daily or weekly. Ask what type of exercise they participate in.
- **Drugs:** Ask your patient about all medication they take including anti-hypertensives, beta-blockers, calcium channel blockers, digoxin, diuretics, aspirin, anticoagulants, over-the-counter drugs, herbal supplements, or street drugs.

Smokers Pack Per Day History

2 packs per day x 10 years = 20 pack-year history

1 pack per day x 20 years = 20 pack-year history

3 packs per day x 7 years = 21 pack-year history

Family History

Family history is an important factor used in identifying your patient's risk for certain cardiovascular diseases (Kaplow & Hardin, 2007).

Ask your patient about any cardiovascular family history such as hypertension, obesity, diabetes, coronary artery disease, or sudden death.

Test Yourself:

Which of the following diseases is associated with cardiovascular disease?

- A. Hypothyroidism
- B. Lung Cancer
- C. **Diabetes (correct)**
- D. Inflammatory Bowel Disease

Assessment of Chest Pain Using PQRST Mnemonic

When examining the cardiovascular system, the mnemonic PQRST, is very useful in assessing chest pain. It provides a methodology in which communication to other healthcare providers will be most efficient and informative.

Assess the following characteristics with each new report of pain and following any intervention:

(P) Provocative or Palliative: What makes the symptom(s) better or worse?

(Q) Quality: Describe the symptom(s).

(R) Region or Radiation: Where in the body does the symptom occur? Is there radiation or extension of the symptom(s) to another area of the body?

(S) Severity: On a scale of 1-10, (10 being the worst) how bad is the symptom(s)?

(T) Timing: Does it occur in association with something else (e.g. eating, exertion, movement)?

Provocative or Palliative Factors

Ask the patient about what starts or worsens the pain. Chest discomfort provoked by exertion is a classic symptom of angina, although esophageal pain can also result from exertion. Other factors that may provoke ischemic pain include:

- Cold
- Emotional stress
- Sexual intercourse
- Smoking
- Meals

However, discomfort that reliably occurs with eating is most likely related to an upper gastrointestinal disease. Pain made worse by swallowing is likely of esophageal origin.

Factors that influence pain should also be established. Pain that responds to sublingual nitroglycerin or cessation of activity strongly suggests a cardiac ischemic etiology, while pericarditis pain typically improves with sitting up and leaning forward.

Practice Pearl

Patients with a history of coronary heart disease tend to have the same quality of chest pain with recurrent episodes.

Quality of Pain

The patient with myocardial ischemia often denies feeling chest “pain” and may delay seeking treatment. Typical descriptions of chest pain from myocardial ischemia may include:

Squeezing - A band-like sensation is felt around the chest.

Tightness - There is a sensation of a knot being present in the center of the chest.

Pressure - A sensation of a lump in throat or a heavy weight on the chest.

Chest Constriction - The “Levine sign” is displayed by a patient suffering from chest pain caused by a myocardial infarction. The patient typically presses a clenched fist against the chest to illustrate the sensation of pressure and constriction in the chest.

Burning - Infarction pain is often mistaken for heartburn or indigestion, especially in women.

Region or Radiation of Pain

Pain that localizes to a small area of the chest is more likely to be related to a chest wall or pleural origin rather than the heart.

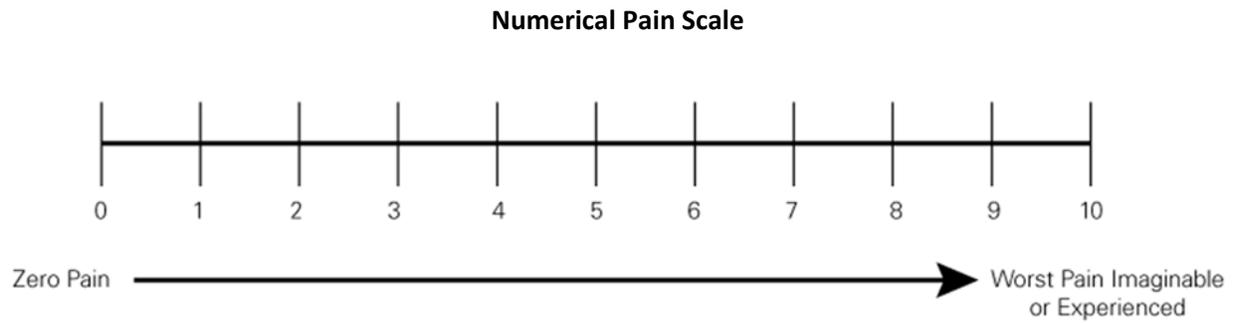
Ischemic cardiac pain is a diffuse type of nonlocalized pain.

The pain of myocardial ischemia often radiates to the neck, throat, lower jaw, teeth, upper extremities, or shoulder.

If the chest pain is radiating to several areas, there is an increased chance that the patient is having a myocardial infarction (MI).

Severity and Associated Symptoms

Using a 10-point numeric pain rating scale or visual analog scale often helps patients describe the intensity of pain. The 10-point score grades pain in severity ranging from 0 (no pain) to 10 (most excruciating). The severity of pain does not necessarily correlate with the degree of ischemia. As many as 1/3 of myocardial infarctions may go undetected by the patient. Some patients have difficulty putting a number on the pain in which case an adjective rating scale may be most helpful. The Numeric Pain Scale below is a representation of one such numerical scale.



Modified from McCaffery, M. & Pasero, C. (1999). Pain: Clinical Manual, (2nd ed.). p. 63. St Louis: Mosby.

Severity and Associated Symptoms

Other symptoms that may be associated with myocardial ischemia may include:

- Nausea
- Vomiting
- Diaphoresis
- Syncope
- Palpitations
- Exertional dyspnea
- Fatigue
- Weakness
- Dizziness
- Light-headedness

Timing

Knowing the onset of chest pain is important to help to determine the cause and treatment of the pain. Ischemic pain is most often gradual with an increasing intensity over time. A crescendo pattern of pain can also be caused by esophageal disease. Pain associated with pneumothorax, aortic dissection, or acute pulmonary embolism typically has an abrupt onset with the initial sensation being the most intense.

Understanding the duration of pain and any patterns are also helpful. The pain from myocardial ischemia generally lasts for a few minutes whereas the pain from an MI may be more prolonged. Chest discomfort that only lasts for a few seconds or pain that is constant for days or weeks is not generally due to ischemia. Myocardial ischemia may have a circadian pattern. It is more likely to occur in the morning than in the afternoon, correlating with an increase in sympathetic tone. However, this pattern may not be exhibited in patients with diabetes or patients taking beta-blockers as the patient's sympathetic tone is altered.

If the patient is unable to qualify and quantify their pain, the following questions may be useful in getting needed information regarding their pain.

- “What gets the pain started?”
- “What helps the pain stop (rest, sitting up and leaning forward)?”
- “Would you describe it as more of a dull pressure or squeezing or more of a sharp, stabbing, or ripping feeling?”
- “Does this pain feel similar to when you had your previous heart attack?”
- “Is the pain mostly in one area or do you feel it up into your neck and arms?”
- “With ‘0’ being no pain and ‘10’ being the most excruciating pain ever, what number would you give the pain to describe the severity?”
- When applying a number is difficult: “Would you describe the pain as mild, moderate, or severe?”
- “Are you feeling nauseous, dizzy, lightheaded, short of breath, or tired?”
- “Does the pain start off gradually and get worse, or vice versa?”
- “How long does the pain last?”
- “When does the pain usually occur – morning, afternoon, or night?”

Chest Pain in the Elderly

It should be noted, however, that typical clinical manifestations such as chest pain occur in only 50% of elderly patients with coronary artery disease (CAD) (Milner, 2001). When pain is present in an older patient it is frequently vague and poorly localized or localized to the abdomen or epigastric area rather than the substernal area. Elderly patients experiencing angina or myocardial ischemia may describe their symptoms simply as: exertional dyspnea (most common), fatigue, syncope, nausea, anorexia, confusion, or dyspnea at rest.

Test Yourself:

Chest pain in the elderly is usually well-defined.

- A. True
- B. False (Correct)**

Other Symptoms: Dyspnea

Dyspnea (shortness of breath) that accompanies chest pain may also be due to a number of pulmonary disorders.

Ask your patient the following questions related to dyspnea:

- Do you ever get short of breath?
- What types of activity and how much activity brings on the shortness of breath?
- Does the shortness of breath come on suddenly or unexpectedly?
- Does the dyspnea come and go or is it constant?
- Is the shortness of breath associated with change in position?
- Does the shortness of breath wake you up at night?
- Does the shortness of breath interfere with activities of daily living?

Practice Pearl

Paroxysmal nocturnal dyspnea (PND) occurs at night with congestive heart failure. Laying down increases the volume of thoracic blood. The weakened heart cannot accommodate this greater volume. Your patient will complain of sleeping for about two hours and then arising suddenly needing “fresh air.”

Other Symptoms: Orthopnea and Coughing

Orthopnea

Ask your patient how many pillows he or she sleeps on at night. Orthopnea is the inability to breathe when in a lying position.

Cough

Does your patient have a consistent cough? Have the patient describe the frequency, timing, severity of cough, and any sputum production. If the patient does have sputum production ask about the color of the sputum, if it has an odor, and if it is blood tinged.

Practice Pearl

Hemoptysis is often pulmonary in nature, but may occur with cardiogenic pulmonary edema.

Other Symptoms: Fatigue, Edema, Cyanosis and Pallor

Fatigue

Ask your patient if they tire easily. If so, ask about when the fatigue started. Was it sudden or gradual? Has there been any recent change in energy level? Also ask about the time of the day the fatigue is related to, e.g. all day, morning or evening to establish the presence of a circadian rhythm, which may indicate ischemia.

Practice Pearl

Cardiac related fatigue is worse in the evening. Fatigue to anxiety or depression occurs all day or is worse in the morning.

Edema, Cyanosis, and Pallor

Does your patient have any swelling or skin color changes? Cyanosis or pallor occurs with myocardial infarction or low cardiac output. If the patient has swelling, ask about its location. Is it in the feet and legs? If so, when was it first noticed? Ask about any recent change in the swelling, if it is unilateral or bilateral, and if the swelling subsides after sleeping or resting with feet up. Also ask about any associated symptoms with the swelling such as dyspnea.

Practice Pearl

Cardiac related edema is worse in the evening and better in the morning after resting with the feet up.

Other Symptoms: Nocturia

Does your patient get up at night to urinate? Ask how long this has been occurring and if there have been any recent changes in this pattern.

Practice Pearl

Recumbency promotes fluid re-absorption and excretion. Nocturia occurs with heart failure in the patient who is ambulatory during the day.

Pediatric, Pregnant, and Aging Patients

Additional history questions you may wish to ask regarding your infant, pediatric, pregnant, or aging patient are listed on the left side buttons.

Content adapted from Jarvis, 1996.

Additional History for Infants

- Mother's health during pregnancy? - Unexplained fever or rubella in the first trimester? Other infections, hypertension, drugs taken?
- Ever noticed any cyanosis while feeding, nursing or crying?
- Does the baby eat or play without tiring?
- Is the baby growing according to normal for age and gender?
- Were the baby's motor milestones achieved as expected
- How many naps per day and length of naps?

Additional History for Children

- Activity - Is the child able to keep up with same-aged playmates? Is the child willing or reluctant to play? Does the child prefer "quiet play"? Does the child ever have "blue spells"?
- Any unexpected joint pain or unexplained fever?
- Does the child have frequent headaches or nose bleeds?
- Does the child have frequent respiratory infections? Any proven to be strep infections?
- Any family history of congenital diseases?
- Anyone in the family with chromosomal abnormalities?

Additional History for Pregnant Patients

- Blood Pressure - Did you have high blood pressure in this or other pregnancies? What was your blood pressure before your pregnancy?
- Has your pressure been monitored in this pregnancy?
- Any protein in the urine?
- Any excessive weight gain?
- Have you had any swelling in the feet, legs or face?
- Have you experienced any faintness with this pregnancy?
- Have you experienced any dizziness with this pregnancy?

Additional History for Elderly Patients

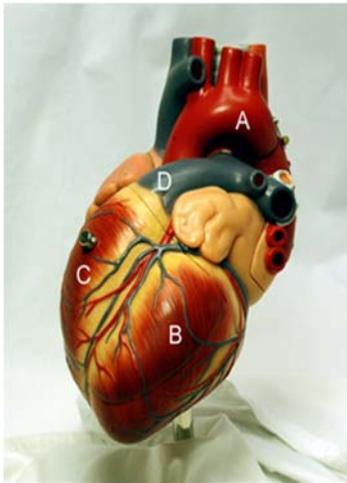
- Heart and Lung disease - Is there a history of heart disease, hypertension, coronary artery disease, emphysema, bronchitis?
- Do you take any medications for your illness?
- What are the side effects of the medication(s)?
- Have you recently stopped taking any of your medications? If so, which ones and why?

- Do your illnesses interfere with your activities of daily living?
- Does your home have any stairs? How often do you need to climb them?

The Physical Exam

When assessing the cardiovascular system, other systems, such as the circulatory and respiratory systems, also need to be evaluated to provide a comprehensive and holistic picture.

In performing a cardiac assessment, a visual understanding of the heart may be useful:



A: Aorta

B: Left ventricle

C: Right ventricle

D: Pulmonary artery

The coronary artery Ramus interventricularis anterior can be seen in the groove (sulcus interventricularis) between the ventricles.

(wikimedia.org, 2007)

Assessment of The Neck Vessels: Inspection

When inspecting the neck vessels, look for any abnormalities you can observe with your eyes, ears, or nose.

The most important observation to be made in the neck region is the assessment of jugular venous pulse. From the jugular veins you can estimate central venous pressure (CVP) and estimate the heart's efficiency as a pump.

At a glance, if the patient is sitting in the supine position at 45 degrees or higher, you should not be able to see jugular venous pulsations unless there is underlying pathology.

Assessment of The Neck Vessels: Auscultation

When auscultating, ensure your room is quiet, auscultate over bare skin, and listen to one sound at a time. Your bell or diaphragm should be placed on your patient's skin firmly enough to leave a slight ring on their skin when removed. Be aware that your patient's hair may also interfere with true identification of certain sounds. The diaphragm is used to listen to high-pitched sounds and the bell is best used to identify low-pitched sounds (Kaplow & Hardin, 2007). Also, remember to clean your stethoscope between patients.

Auscultate the carotid arteries in persons middle aged or older, or those with a history of cardiovascular disease. You are listening for the presence of a bruit, which is a blowing or swishing sound, indicating turbulent blood flow. You may need to ask your patient to hold their breath for a short time so that you do not confuse tracheal breath sounds with a bruit. Typically, a bruit is absent.

Test Yourself:

A bruit is often confused with:

- A. Rales
- B. Crackles
- C. Wheezes
- D. Tracheal breath sounds (Correct)**

Assessment of The Neck Vessels: Palpation

Palpation, another commonly used physical exam technique, requires you to touch your patient with different parts of your hand using different strength pressures. During light palpation, you press the skin about ½ inch to ¾ inch with the pads of your fingers. When using deep palpation, use your finger pads and compress the skin about 1½ inches to 2 inches. Palpation allows you to assess the neck for tenderness, abnormal temperature, excessive moisture, pulsations, or masses.

Palpate the carotid arteries very gently and never at the same time. Feel the contour and amplitude of the pulse. Normally, the contour is smooth with a rapid upstroke and normal strength (+2). Findings should be similar bilaterally.

The right bundle branch spreads the wave of depolarization to the right ventricle. Likewise, the left bundle branch spreads the wave of depolarization to both the interventricular septum and the left ventricle. The left bundle further divides into three branches or fascicles. The bundle branches further divide into Purkinje fibers.

Circulatory Assessment: Inspection

Performing a visual assessment of the circulatory system is an important component of a comprehensive cardiovascular assessment. Areas for evaluation you may inspect include skin color, location of any lesions, bruises or rash, symmetry of motion, size of body parts, and any abnormal findings, sounds, and odors.

Begin by inspecting the patient's skin for color, warmth, and moisture. Cool, clammy skin results from vasoconstriction. Warm, moist skin results from vasodilation. Flushing of a patient's skin may be due to medications, excess heat, anxiety, or fear. Pallor can result from anemia or increased peripheral vascular resistance caused by atherosclerosis. Dependent rubor (redness) may be a sign of chronic arterial insufficiency. Peripheral cyanosis may cause a bluish discoloration to the lips and extremities. Inspect the oral mucous membranes for cyanosis that may not be readily apparent on the skin. Examine underneath the tongue, inside the cheeks, and the nail beds for signs of peripheral cyanosis.

There are two types of cyanosis that may occur in compromised patients: central and peripheral. Central cyanosis is consistent with reduced oxygen intake or transport from the lungs. Peripheral cyanosis suggests constriction of the peripheral arteries. This is usually from stress, cold, or anxiety. It may also be from hypovolemia, shock, or vasoconstrictive diseases.

Note the presence of any edema. Inspect your patient's hair distribution on their skin. Lack of hair may also indicate arterial insufficiency.

Next, assess arterial perfusion to the lower extremities. Have your patient lie supine on a flat surface and elevate one of his legs above his heart for about one minute. You may need to assist with this movement. Then ask him to sit up and dangle his legs over the bed and inspect the color of both legs. The leg that was elevated should show slight pallor in comparison to the other leg. The color of both legs should be about the same in about ten seconds, once the veins have had time to fill.

Edema can result from many disease processes including heart failure, liver failure, or by venous insufficiency, varicosities, and thrombophlebitis.

Circulatory Assessment: Auscultation

Auscultate your patient's blood pressure. The systolic reading reflects the pressure exerted by the left ventricle during contraction. The diastolic reading reflects the pressure in the arteries when the heart is at rest.

Blood pressure is lowest in the newborn, and rises with age, weight gain, stress, anxiety, and during exercise.

Circulatory Assessment: Auscultation

When auscultating blood pressure, be sure to choose an appropriate size cuff to avoid false readings. Some helpful hints when assessing blood pressure include:

- Never take a blood pressure in an arm on the same side as a mastectomy.
- Never take a blood pressure in an arm with an arteriovenous fistula or shunt, or in an arm with a peripherally inserted central catheter.
- If either the systolic BP is over 140 or the diastolic pressure is over 90 on repeated measurements, the patient is considered to have Stage 1 Hypertension (high blood pressure).
- Hypertension is risk factor for heart disease, stroke, and kidney disease.
- Diet, exercise, and, when necessary, medications can control blood pressure.

Blood Pressure Classification in Adults

Category	Systolic	Diastolic
Normal	<120	And <80
Pre-Hypertension	120-139	Or 80-89
Stage I Hypertension	140-159	Or 90-99
Stage II Hypertension	> 160	Or > 100

Classification and Management of Blood Pressure in Adults. National Institute of Health (2003).

Circulatory Assessment: Palpation

The next part of the circulatory system examination is palpation.

Begin by palpating the peripheral arteries. These include the brachial, radial, femoral, popliteal, dorsalis pedis, and posterior tibial.

Note the contour and amplitude of each pulsation. These should feel similar bilaterally.

As you move away from the core of the body, you may notice that the contour or upstroke of the pulsation is less rapid. This is normal, but it is important to assess that the arteries have similar strength bilaterally.

Test Yourself:

When assessing normal circulation in the extremities, you anticipate finding that:

- A. **Blood flow is similar bilaterally. (Correct)**
- B. The contour and amplitude of pulsations are greater on the left side of the body.
- C. The contour and amplitude of pulsations are great on the right side of the body.
- D. As you move further away from the core of the body, the contour pulsations are more rapid.

The Precordium: Inspection and Auscultation

Inspection

Inspect the anterior chest for pulsations. You may or may not see the apical pulse. If it is visible, you will see it in the fourth or fifth intercostals space.

Auscultation

Before you begin your auscultation of the precordium, preface your exam by telling the patient you will be listening in many different places for what might be a while. Then, you must identify the areas you need to auscultate. You may want to inch your stethoscope in a “Z-pattern” across the precordium, from the base of the heart to the apex. Concentrate to the sound of the “lub” and the “dub.” The “lub” or first heart sound is known as S1. The “dub” or the second heart sound is known as S2.

Heart Sounds: S1

S1, the “lub” of the “lub-dub,” is produced by the closure of tricuspid and mitral valves.

Alterations you may auscultate that involve S1 are as follows:

- S1 is accentuated in exercise, anemia, hyperthyroidism, and mitral stenosis.
- S1 is diminished in first degree heart block.
- S1 split is most audible in tricuspid area (T-lub-dub)

(Kaplow & Hardin, 2007)

Heart Sounds: S2

S2, the “dub” of the “lub-dub,” is produced by the closure of aortic & pulmonic valves.

Alterations you may auscultate that involve S2 are as follows:

- Normal physiological splitting of S2 is best heard at pulmonic area. It occurs on inspiration (“lub-T-dub, lub-dub”).
- Splitting of S2 sound can occur when the aortic and pulmonary valves do not close at the same time (Kaplow & Hardin, 2007). This can indicate pulmonic stenosis, atrial septal defect, right ventricular failure, or left bundle branch block.

Heart Sounds

Listen to actual heart sounds using the Auscultation Assistant

<http://www.wilkes.med.ucla.edu/intro.html>

This great tool will expose you to many different normal and abnormal heart sounds.

Heart Sounds: S3

The third heart sound is produced by the rapid filling of the ventricle (that is not completely empty) during early diastole (Kaplow & Hardin, 2007). S3 is also known as a ventricular gallop (“lub-DUB-ta” or “Ken-tuc’-ky”).

S3 is normal in pregnancy, children, adults less than thirty years old, during exercise, anxiety, or anemia. It is heard best at the apex in the left lateral decubitus position, using the bell.

Pathologic S3 occurs in people over the age of 40, usually due to myocardial failure.

Heart Sounds: S4

The fourth heart sound is typically heard in late diastole before S1, as a result of increased ventricular resistance to atrial filling, due to either decreased ventricular compliance or increased ventricular volume. It is low pitched and best heard with the bell. S4 is also known as an atrial gallop (“ta-lub-DUB” or “Tenn-es-see”).

S4 is often normal in older adults and is heard best at the apex in the left lateral decubitus position.

Pathological S4 may be caused by coronary artery disease, hypertension, cardiomyopathy, or aortic stenosis.

Test Yourself:

Which heart sound is known as the atrial gallop?

- A. S1
- B. S2
- C. S3
- D. **S4 (Correct)**

Abnormal Heart Sounds Summation Gallop & Opening Snap

Summation Gallop

A summation gallop is produced when S3 & S4 merge into one sound. It often occurs at rates greater than 100 beats per minute. It may occur in heart failure and pericarditis. Summation gallops occur in 15% of all myocardial infarctions and are common following cardiac surgery. They are best heard with patient leaning forward, holding breath after full expiration.

Opening Snap

At the end of ventricular systole, when the aortic and pulmonic valves close, S2 is produced. Immediately after S2, the heart relaxes, and ventricular pressure falls below that of atrial pressure. This allows the atrioventricular valves to open. This is the start of diastole. Normally, you cannot hear these valves open. However, if the mitral valve becomes stenotic or abnormally narrowed they will create an opening snap. This sound usually precedes the development of a diastolic murmur associated with mitral stenosis. Once the valve becomes seriously impaired and inflexible, the opening snap disappears (Kowalak, Johnson & Sussman, 2002).

An “Opening Snap” is an abnormal heart sound due to a stenotic valve opening. When a normal cardiac valve opens, there is no sound created.

Abnormal Heart Sounds: Ejection Click & Mid-Systolic Click

Ejection Click

Similar to an opening snap, an ejection click is caused by stenotic valve leaflets. This sound is produced when the aortic or pulmonic valves open at the beginning of systole. It is a brief high frequency sound best heard with the diaphragm over the aortic or pulmonary artery or Erb’s point, or near the apex over the mitral area (Kowalak, Johnson & Sussman, 2002).

Mid-Systolic Click

A mid-systolic click occurs when the mitral valve’s leaflets and cordae tendinae tense. The anterior or posterior or both leaflets can prolapse. Every once in a while multiple clicks occur. They are heard in mid to late systole. They are best heard over the tricuspid area and towards the mitral area. They are crisp, high frequency sounds (Kowalak, Johnson & Sussman, 2002).

Abnormal Heart Sounds: Pericardial Friction Rub & Mediastinal Crunch

Pericardial Friction Rub

A pericardial friction rub is usually heard best and is sometimes palpable over the tricuspid and xyphoid areas. It occurs when inflamed pericardial surfaces rub together. The rubbing of these surfaces produce the characteristic, high-pitched, grating noises. To differentiate a pericardial friction rub from a pleural friction rub, have the patient hold his or her breath. When they do this, a pericardial friction rub will continue, a pleural friction rub will cease (Kowalak, Johnson & Sussman, 2002).

Mediastinal Crunch

A mediastinal crunch is produced due to displaced air under the surface of the skin near the mediastinum. Patients with mediastinal crunch often have subcutaneous emphysema. You can assess for this by palpating crepitation in the neck. The noise has a crunching quality and is heard best along the left sternal border. It may be louder on inspiration (Kowalak, Johnson & Sussman, 2002).

Abnormal Heart Sounds: Murmurs

A murmur is an abnormal heart sound caused by turbulent blood flow. The sound may indicate that blood is flowing through a damaged or overworked heart valve, that there may be a hole in one of the heart's walls, or that there is a narrowing in one of the heart's vessels.

Some heart murmurs are a harmless type called innocent heart murmurs which are common in children and usually do not require treatment.

Auscultation of Murmurs

If you auscultate a murmur, it is important to assess and document the following qualities of the murmur:

Timing: Are they systolic or diastolic?

Anatomical location of maximum intensity: Where is the murmur best heard?

Frequency: What is the pitch of the murmur?

Radiation: Can you hear the murmur in other locations such as the neck or upper chest?

Quality: Is the murmur harsh, soft, or blowing?

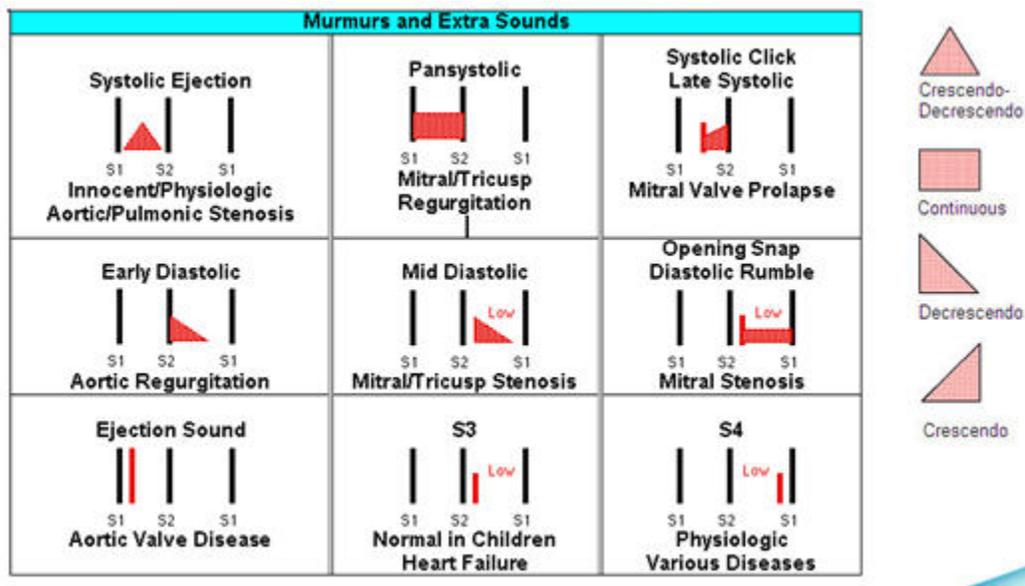
Intensity: Describe the loudness of the murmur on a scale of 1 to 6, as indicated by Levine's 6 point grading scale:

Grade	Intensity
1	Very Faint - Easily Missed
2	Quiet – Barely Audible
3	Moderately loud – but easily heard – same intensity as S ₁ or S ₂
4	Loud, but usually no thrill present
5	Very loud, thrill present
6	Heard with stethoscope off chest – Thrill present

(Lippincott, Williams & Wilkins, 2005)

Timing and Quality of Common Murmurs

The following table depicts the timing and quality of common murmurs.



The Precordium: Palpation and Percussion

Palpation

Palpate the apical pulse, normally in the fourth or fifth intercostal space, mid-clavicular line. It should be felt as a short, gentle tap. It can be palpated in about half of people. It is more difficult to palpate in obese patients or those with thick chest walls. Stress, fever, anxiety, hyperthyroidism, and anemia may increase the amplitude and duration of the apical pulse. When the apical pulse is palpated lower in the thoracic cage and has a greater amplitude than expected, it is often due to cardiac pathology.

Percussion

You may use percussion to outline the cardiac border. Typically, however, a chest x-ray can reveal the same results. There are times, however, that chest x-rays are not available and percussion may be one of your only tools to assess cardiac size.

To perform effective percussion, press the distal part of the middle finger of your non-dominant hand firmly on the body part, keeping the rest of the hand off the body surface. Using the middle finger of the dominant hand, tap quickly and directly over the point where the other middle finger makes contact with the patient's skin. Dullness should be heard over the area where the heart is located.

Recording Findings

It is important to accurately and thoroughly record and document your findings from the cardiovascular exam.

Standard documentation ensures that all members of the healthcare team interpret the findings accurately. In documenting murmurs, Levine's six point grading scale is the most accurate way to record findings, as is the use of a standard 4 point scale to assess and document edema.

Remember that your recordings are part of the medical record, and should be as objective and accurate as possible.

Conclusion

Integrating the cardiovascular health history and physical exam takes practice. It is not enough to simply ask the right questions and perform the physical exam. As the patient's nurse, you must critically analyze all of the data you are obtaining, synthesize the data into relevant problem focus, and identify a plan of care for your patient based upon this synthesis. As the plan of care is being carried out, reassessments must occur on a periodic basis. How often these reassessments occur is unique to each patient, based upon their physical disorder.

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