Although in many cases inspection of the abdomen may have less to offer than palpation and percussion, a good visual scan is still essential to obtain the most from the subsequent examination. For example, the question of whether an abdomen is protuberant because of obesity and/or ascites may be difficult to resolve, without first scanning the patient both in the standing and lying positions.

In simple obesity, fat is laid down over many years and it tends to gravitate in the suprainguinal and suprapubic folds (8.1). This chronic fixed dependence can be better appreciated by looking at the side view of the patient (8.2) which also reveals fat-laden skin folds at the back.

In contrast, the patient with ascites shows mobile dependence of the ascitic fluid, which, on standing, protrudes in the middle and overhangs the pubis (8.3). The suprainguinal areas on either side show a furrow instead of a fold and the umbilicus looks stretched, sometimes everted, under the pressure of the fluid (8.4). These points are reinforced by looking at the side view of this patient with ascites (8.5) compared with Figure 8.2. The ascitic fluid...
fluid has gravitated to the suprapubic region, leaving a furrow in the left supranguinal region where a redundant fold of fat is seen in the obese patient (8.2). In addition, *gynaecomastia* and *dilated veins* can be seen in Figure 8.5, which are helpful clues about this patient’s underlying **portal cirrhosis**. The lateral furrow is also seen when the abdominal swelling is caused by a retroperitoneal cyst or hydronephrosis (8.6, 8.7).

Only after attention to these details can a clinician proceed to further examination with ample confidence. Sadly, many postgraduate students let themselves down in higher examinations by proceeding with palpation and percussion of the abdomen without first looking at it. This is the chief reason why they miss polycystic kidneys in an obese subject.

The abdomen and the chest provide a large area for looking for the various stigmata of **liver disease** such as **jaundice**, **gynaecomastia**, **telangiectasia** and **scratch marks** (8.8). In bright natural light, jaundice can be detected easily by looking at the skin, as in this patient with a **cholangiocarcinoma** (8.8).

Looking at a standing patient with suspected intra-abdominal pathology should not be omitted in those with no ascites, since a fullness caused by an enlarged liver (8.9) or spleen, or both (8.10), may be made obvious by this procedure. A lateral view will also reveal the scar of a previous operation and a surface impression of a transplanted kidney (8.11).

Dilatation of the abdominal wall veins (8.12) occurs in **portal hypertension** and in **inferior vena caval obstruction**. The flow of blood within the veins can be determined by blanching the dilated vein (8.13) and then by releasing the pressure at each end to see the refilling in the direction of the flow (8.14). In **intrahepatic** portal hypertension,
paraumbilical veins are enlarged and the flow is away from the umbilicus towards the caval system (8.5, 8.15, 8.16). In inferior vena caval (IVC) obstruction, the collateral venous channels carry blood upwards to reach the superior vena caval system (8.17). The interpretation regarding the flow should be made with caution in tense ascites, which may cause functional obstruction of the inferior vena cava (8.18). Rarely, a number of prominent collateral veins may
be seen radiating from the umbilicus (caput medusae) (8.19). Attention should be directed to the other clinical features associated with chronic liver disease (8.20).

The umbilicus should be inspected for the presence of umbilical and periumbilical herniae (8.21, 8.22), which usually occur in obese subjects particularly after abdominal surgery. Nickel dermatitis (8.22) may be seen around the umbilicus in sensitive subjects wearing nickel buckles next to the skin.

The umbilicus is also a site of predilection for the dark red papules of angiokeratoma corporis diffusum (Fabry’s disease; 8.23), which is an X-linked recessive disease. This is an inborn error of metabolism in which there is a deficiency of alpha-galactosidase A, leading to an accumulation of glycosphingolipid ceramide in endothelial cells, and fibrocytes in the dermis, heart, kidneys and autonomic nervous system. Progressive renal failure occurs in adult life. Most patients have attacks of excruciating, unexplained pain in their hands.

A valuable but rare sign of acute haemorrhagic pancreatitis is a bruise or pigmentation near the umbilicus termed Cullen’s sign (8.24). This occurs when retroperitoneal blood dissects its way anteriorly towards the umbilicus, where the colour of the overlying skin depends on the age.

8.18 Portal hypertension with tense ascites: the dilated veins are draining towards the superior vena cava

8.19 Caput medusae

8.20 Clinical features of chronic liver disease

8.21 Umbilical hernia

8.22 Periumbilical hernia. Note maculopapular eruption caused by nickel buckles

8.23 Fabry’s disease: periumbilical rosette of dark red papules
of the resulting bruise. The blood may also dissect into the flanks where a similar discolouration may be seen called the *Grey Turner’s sign* (8.25).

As for the axillae, the groins should be inspected for increased or decreased pigmentation, glandular swellings, intertriginous infections, and for herniae. Small glands may be palpable in normal subjects but visible large glandular masses (8.26) are mostly pathological (e.g. suggestive of infection, lymphoma or secondaries). Tuberculous adenitis may involve the inguinal glands and form a **cold abscess** (8.27). **Lymphogranuloma venereum** (8.28) is a sexually transmitted disease caused by *Chlamydia trachomatis*. Among heterosexuals, primary infection produces a rarely observed genital ulcer 2–3 weeks after exposure, followed later (2–4 weeks) by painful inguinal lymphadenopathy, often associated with signs of systemic infection. It heals spontaneously. It must be distinguished from a tumour, chancroid, syphilis and other granulomatous diseases.

An **inguinal hernia** (8.29) is not difficult to recognize in a standing patient but it may regress in a recumbent position.
It would seem logical to extend the examination of the groins to that of the genitalia as part of the overall clinical assessment. However, most clinicians limit this practice to those occasions when they expect to find an abnormality. Thus, testicular bulk would be assessed in chronic liver disease and myotonia dystrophica, whereas underdeveloped and infantile genitalia would be looked for in Klinefelter’s syndrome (8.30) and in the growth hormone deficiency syndrome (8.31).

A dermatologist may look routinely for genital lesions when he or she has already diagnosed scabies (8.32) or lichen planus (8.33).