Learner Instructions

Patient's Name: Foster Davis
Age: 39 year-old male
Setting: Emergency Department
P**rimary vs Sign-Out:** primary

Initial Chief Complaint on arrival to the ED:
Back Pain

Patient Information from initial H&P:
39 year old male patient with a PMHx of kidney stones, prostate cancer, and herniated discs, who presented to the ED with atraumatic lower back aching that began yesterday while laying on the cough, and has resolved after receiving Tylenol and ibuprofen in the ED. He has not had fevers, weight loss, urinary or bowel symptoms, radicular pain, or neurologic symptoms associated with the pain. His ED evaluation included a bedside ultrasound demonstrating a normal abdominal aorta, and he has had bloodwork, urinalysis and an XR lumbar spine ordered.

His vital signs and physical exam over the course of the evaluation are as follows:

Vital signs:

Initial Triage Vitals:	HR 86 BP 134/76 mmHg RR 18 Sat 100% RA T 98.6 F (oral)
Current Vitals:	HR 72 BP 128/70 mmHg RR 16 Sat 100% RA T 98.6 F (oral)

Exam (abnormal findings bolded):

General: Well-developed, well-nourished male resting comfortably in no acute distress.
HEENT: Normocephalic, atraumatic, no conjunctival injection or pallor, sclera non-icteric, PERRLA, nasal mucosa pink, moist mucous membranes, oropharynx without evidence of erythema, tonsillar enlargement or exudates.
Neck: No cervical lymphadenopathy, no thyromegaly, or mass.
Cardiovascular: No jugular venous distension, regular rhythm, normal S1 and S2, no murmurs, rubs, or gallops. Radial and DP pulses 2+ bilaterally. No edema.
Pulmonary: Thorax is symmetric without increase in anteroposterior diameter. Lungs clear to auscultation, no rales, wheezes, rhonchi, or rubs.
Abdomen: Flat, no hepatosplenomegaly, soft, non-tender to palpation in all quadrants.

Musculoskeletal: full range of motion in al joints, no evidence of swelling or deformity. **Mild tenderness to bilateral lower paraspinous muscles.**
Neuro: Alert and oriented x 3. CNs II – XII symmetric, sensation to light touch grossly intact, 5/5 strength in all extremities. Gait steady without evidence of ataxia.
Psych: Affect full range. Speech is fluent, no SI or HI.

The results of his initial diagnostic work-up are indicated here (results outside reference range are bolded):

CBC			**CHEMISTRY**		
WBC	7.4	(3.5-10.5)	SODIUM	139	(135-148)
RBC	5.01	(4.2-5.8)	POTASSIUM	4.1	(3.5-5)
HEMOGLOBIN	14.2	(13.0-17.5)	CHLORIDE	107	(95-108)
HCT	42.6	(38.0-50)	BICARB	24	(24-32)
MCV	89	(80-99)	BUN	15	(0-20)
MCH	30	(27-34)	CREATININE	0.7	(0-1.7)
MCHC	34.2	(33-35.5)	GLUCOSE	98	(65-110)
RDW	14.8	(11-15)	CALCIUM	9.2	(8.5-10.5)
PLATELET	187	(140-390)			
			ESR	0.00	(0 - 22)

UA: No RBCs or blood. No WBCs, leukocyte esterase, or nitrites.

Lumbar Spine XR: Mild degenerative disc disease, unchanged from prior. No fracture.

Bedside Ultrasound: Normal caliber aorta.

Your initial plan was to discharge the patient if his workup was normal.

A lumbar xray, UA, and lab tests were performed, and the results are included above. The patient's pain has resolved and he is awaiting the results of testing done in the ED.

Your Task:

1. Reassess and the update
2. Discharge the patient from the Emergency Department.

3. This simulation is focused on communication. This case is not an assessment of your medical decision making. You do not need to order additional emergency department tests or admit this patient.

   * When you are finished, you can tell him that the nurse will be in shortly to give him his paperwork and take out his IV