Learner Instructions

Patient's Name: Paulina Southport
Age: 39 year-old female
Setting: Emergency Department
Primary vs Sign-Out: primary

Initial Chief Complaint on arrival to the ED: Back Pain

Patient Information from initial H&P:

39 year old female with history of DM, COPD, obesity presenting with atraumatic, acute left lower back pain that began upon getting out of bed this morning. The pain is non radiating, worse with changes in position, and has resolved after the pain received Tylenol and ibuprofen. She has experienced no fevers, urinary symptoms, vaginal bleeding or discharge, or numbness, tingling, or weakness. There is no chest pain, difficulty breathing, or abdominal pain. She has no history of STDs, and has no new sexual partners.

Her 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. No costovertebral angle tenderness. **Mild left paraspinous muscle tenderness**.

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 her diagnostic work-up are indicated here:

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

HCG: Negative.

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

The patient's pain has resolved and she 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 her that the nurse will be in shortly to give her paperwork and take out her IV