Learner Instructions

Patient's Name: Edward Watson
Age: 42 year-old male
Setting: ED
Primary vs Sign-Out: sign-out

Initial Chief Complaint on arrival to the ED: Abdominal pain

Vital Signs over Course of Evaluation:
HR 64 bpm; BP 135/78 mmHg; RR 18; 100% RA; 98.8 F (oral).
VS stable during ED course.

Patient Information Presented at Sign-Out:
42-year-old male with no PMH, who presented to the ED with 1-day Hx of LLQ pain. Patient arrived to the ED with normal vital signs, afebrile, with reproducible tenderness in the LLQ. The remainder of the remainder of exam was unremarkable. Initial plan was to check labs, obtain a CT to evaluate for possible diverticulitis versus any other occult intra-abdominal pathology. He was given Tylenol, which improved his pain, as well as 1 liter of normal saline. The plan from the initial team is that if the CT is normal, can tolerate PO, and repeat re-examination is reassuring than the patient can go home.

Labs and UA were unremarkable. At the time of sign-out, the CT results are still pending.

ED Course
Initial Vital Signs: HR 68 bpm; BP 130/74 mmHg; RR 16; 100% RA; 98.8 F (oral).
Current Vital Signs: HR 67 bpm; BP 128/73 mmHg; RR 15; 100% RA; 98.8 F (oral)

Exam (abnormal findings bolded):
General: Well-developed, well-nourished female **resting anxiously**. 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.
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	3.4		(3.5-5)
HEMOGLOBIN	13.4	(13.0-17.5)	CHLORIDE	108		(95-108)
HCT	40.2	(38.0-50)	BICARB	24		(24-32)
MCV	88	(80-99)	BUN	18		(0-20)
MCH	30	(27-34)	CREATININE	0.8		(0-1.7)
MCHC	34.2	(33-35.5)	GLUCOSE	89		(65-110)
RDW	14.8	(11-15)	CALCIUM	9.2		(8.5-10.5)
PLATELET	192	(140-390)				
			TROPONIN	0.01		(0.00-0.03)
			BILIRUBIN		10	(5-17)
			ALKALINE PHOSPHATASE (ALP)		42	(35-130)
			ASPARTATE TRANSAMINASE (AST)		25	(5-40)
			ALANINE TRANSAMINASE (ALT)		35	(5-40)
			ALBUMIN		45	(35-50)

ECG: NORMAL SINUS RHYTHM. NORMAL ECG
The CT results are included on the following page.

The sign-out plan from the initial team was to discharge the patient if there were no noted abnormalities on the CT and if he continued to be abdominal pain free

CT test has been performed, and the results are included. The patient had no new issues during his ED stay, continues to be pain free and is waiting for an update.

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

CT Abd/pelvis Report:

Name of Patient: Edward Watson
Age: 42
Physician: Dr. Brown

Type of exam: Computed tomography (CT) of the abdomen and pelvis with intravenous and oral contrast.

Clinical history: 42-year-old male with new onset of left lower quadrant pain. Concern for diverticulitis.

Comparison: No previous imaging for comparison.

Technique: 5-mm axial images from the lung bases through the pubic symphysis were acquired following the administration of intravenous and oral contrast. Coronal and sagittal reformatted images were constructed from source data.

Findings:
Lung bases: No pulmonary nodules or evidence of pneumonia.
Cardiac: Base of heart is within normal limits. No pericardial effusion.
Liver: Normal size and contour.
Gallbladder: Normal appearance, no gallstones.
Biliary: No intra or extrahepatic biliary dilation.
Spleen: No splenomegaly.
Pancreas: No mass or ductal dilation.
Kidneys and Adrenals: No masses, stones or hydronephrosis. No adrenal nodules.
Lymph nodes: No lymphadenopathy.
Bowel: No dilation or wall thickening.
Bladder and prostate: Within normal limits.
Testes: Within normal limits.
Bones and soft tissue: There are no osseous or soft tissue abnormalities.
Other: No free fluid within the pelvis.

Impression:
Normal CT of the abdomen and pelvis. No findings on the current CT to explain the patient's clinical presentation of abdominal pain.