**Learner Instructions**

**Patient's Name:** Jennifer Taylor
**Age:** 37 year-old female
**Setting:** ED
**Primary vs Sign-Out:** primary

**Initial Chief Complaint on arrival to the ED:** Abdominal pain

**Vital Signs over Course of Evaluation:**
HR 84 bpm; BP 135/78 mmHg; RR 18; 100% RA; 98.8 F (oral).
VS stable during ED course.

**Patient Information:**
37-year-old female with no PMH who presented to the ED with 4-days hx of intermittent suprapubic abdominal pain. Patient arrived to the ED with normal vital signs, afebrile, with reproducible tenderness in the suprapubic region. Supervised pelvic exam was negative for cervical motion tenderness, abnormal discharge, or cervical discoloration. The remainder of the exam was unremarkable. She was given Tylenol, which did not affect her pain. The plan is to discharge the patient if her wet mount and urinalysis are normal, she can tolerate PO, and repeat vital signs are normal.

**ED Course**

Initial Vital Signs: HR 84 bpm; BP 135/78 mmHg; RR 18; 100% RA; 98.8 F (oral).
Current Vital Signs: HR 80 bpm; BP 130/74 mmHg; RR 16; 100% RA; 98.8 F (oral).

Exam (abnormal findings bolded):

**General:** Well-developed, well-nourished female. No acute distress. Pain 3 out of 10
**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, **mildly tender over the suprapubic region**, no distended bladder. No CVA tenderness
**Genitourinary**: Normal external female genitalia. Normal vaginal mucosa, pink cervix. No discharge. No cervical motion tenderness. Bimanual exam: uterus is anterior, midline, smooth, not enlarged. Adnexa not felt.
**Lymph**: No palpable abnormal lymphadenopathy
**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 her initial diagnostic work-up are below (results outside reference range are bolded):

| **Urinalysis** | **Result** | **Reference Standard/Range** |
|---|---|---|
| Color | Yellow | Yellow |
| SpBloodecific gravity | 1.01 | 1.005-1.030 |
| pH | 7.0 | 5.0-8.0 |
| Protein | Negative | Negative |
| Glucose | Negative | Negative |
| Leukocyte esterase | Negative | Negative |
| Nitrate | Negative | Negative |
| Beta-HCG (pregnancy) | Negative | Negative |

**Cervical wet mount:**
Normal appearance. pH 4.5 (normal). No clue cells, pseudohyphae, budding yeast cell or mobile mobile trichamonads. Negative whiff test.

The patient's symptoms have resolved during her ED stay and she 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 her that the nurse will be in shortly to give her paperwork

**Transvaginal Pelvic Ultrasound Report:**

**Name of Patient**: Jennifer Taylor
**Age**: 37
**Physician**: Dr. Smith

**Type of exam**: Transvaginal pelvic ultrasound.

**Clinical history**: 37-year-old female with new onset of suprapubic abdominal pain. Concern for ovarian pathology.

**Comparison**: No previous imaging for comparison.

**Results**: The uterus and both ovaries were well visualized and were normal. No free fluid noted. The bladder was normal as were both kidneys. Normal appearances of anteverted uterus and both ovaries. No masses or free fluid seen. The uterus and both ovaries appear normal. No adnexal mass or cyst identified. No free fluid.

**Impression:** The uterus and both ovaries were clearly identified. No abnormality demonstrated.