**Learner Instructions**

**Patient's Name:** Matthew Parks
**Age:** 37 year-old male
**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 male 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. Testicular exam was negative for torsion, varicocele, or hernia. The remainder of the exam was unremarkable. He was given Tylenol, which did not affect his pain. The plan is to discharge the patient if his urinalysis is normal, he 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 male. 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 male genitalia. No penile discharge.
**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 his 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 |

The patient's symptoms have not changed during her ED stay 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

**Scrotal Ultrasound Report:**

**Name of Patient**: Matthew Parks
**Age**: 37
**Physician**: Dr. Smith

**Type of exam**: Scrotal ultrasound

**Clinical history**: 37-year-old male with new onset of suprapubic abdominal pain. Concern for testicular torsion.

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

**Results**: The left testicle is normal in size and attenuation, it measures 3.2 x 1.7 x 2.3 cm. The right testicle is normal in size and attenuation, it measures 3.9 x 2.1 x 2.6 cm. There is normal blood flow bilaterally. Both the left and right epididymis measures 9 mm. There are no hydroceles visualized.

**Impression:** No abnormality demonstrated. Normal scrotal ultrasound.