Learner Instructions

Patient's Name: Angela Christian
Age: 36 year-old female
Setting: Emergency Department
Primary vs. Sign-Out Patient: Sign-out

Initial Chief Complaint on arrival to the ED:
Chest Pain

Patient Information from Sign-out:
36-year-old female with a PMH significant for tobacco use, and family history notable for heart attack in her father and paternal grandfather (both in their 60s), who presented to the ED with intermittent aching chest pain that lasts for seconds at a time and occur without trigger. Her symptoms have been ongoing since arriving in the ED, and are not associated with painful breathing, or exertion. She has no PE risk factors. Upon arrival to the ED, an EKG, chest x-ray and labs were obtained and the results are pending.

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 female 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.

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 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)			
			Troponin	0.00	(<0.05)

ECG: NORMAL SINUS RYHTHM. NORMAL ECG

CXR: NO CARDIOPULMONARY ABNORMALITIES. NORMAL CXR.

The sign-out plan was to discharge the patient if all of her labs, chest x-ray, and EKG were normal.

A chest x-ray, EKG, and lab tests were performed, and the results are included above. The patient has not had a change to her pain and 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