

## Learner Instructions

**Patient's Name:** Samantha Peterson

**Age:** 41 year-old female

**Setting:** ED

**Primary vs. Sign-Out Patient:** Primary

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

Headache

**Vital Signs over Course of Evaluation:**

HR 85 bpm; BP 135/78 mmHg; RR 18; 100% RA; 98.8 F (oral)

VS stable throughout ED course.

**Patient Information:**

41 year-old-female with PMH significant for hypothyroidism, who presents to the ED for a 2-day history of a gradual-onset headache. She takes Synthroid daily. Patient arrived to the ED with normal vital signs, without fever, and with reproducible occipital and frontal tenderness on palpation. Her comprehensive neurologic, HEENT, Eyes (including visual acuity, fundoscopy, afferent pupillary defect) were unremarkable. She had no meningismus, Kernig or Brudzinski signs. The remainder of her exam was unremarkable. She was given Tylenol, Motrin, and 1 liter of normal saline. This improved her pain.

**ED Course**

Initial vitals: HR 85 bpm; BP 130/74 mmHg; RR 16; 100% RA; 98.8 F (oral).

Current vitals: HR 80 bpm; BP 120/65 mmHg; RR 14; 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.

**Eyes:** Visual acuity 20/20 (both eyes), normal visual field, normal fundoscopic exam, no afferent pupillary defect

**Neck:** No cervical lymphadenopathy, no thyromegaly, or mass. No meningismus

**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 all 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. **Patient still has persistent but improved headache. Pain 3 out of 10.**

**Psych:** Affect full range. Speech is fluent, no SI or HI.

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)	TSH	1.5	(0.5-5.0)
			URINE PREGNANCY	Negative	
			(Negative)		

The bloodwork have resulted and were unremarkable. The patient reported improved headache after her treatment 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 her that the nurse will be in shortly to give her paperwork and take out her IV