**Learner Instructions**

**Patient's Name:** Christopher Jackson
**Age:** 36 year old male
**Setting:** Emergency Department
**Primary vs. Sign-Out Patient:** Sign-out

**Initial Chief Complaint on arrival to the ED:**
Shortness of Breath

**Patient Information from sign-out:**
36-year-old male with no prior medical history, presented to the Emergency Department after developing shortness of breath the day before. He has not had any prior shortness of breath like this before. The shortness of breath gradually worsened over the course of the day and he feels as if it is limiting his activity. He has not recently been ill, no recent coughs or colds, and does not have a fever. He described a sensation of not feeling as if he could get enough air when he breathes. He has not had any recent long overseas travel, does not smoke or use illicit medications. There is no one in his family with problems related to blood clots in the lungs or the legs. He has not tried anything for the shortness of and does not have a history of asthma or any other lung problems.

Upon arrival to the ED labs including a D-dimer and a CXR were ordered. Additionally he was given an albuterol nebulizer and toradol for symptomatic relief.

His vital signs and physical exam over the course of the evaluation are as follows:

Vital signs:
Initial Triage Vitals: HR 106 BP 112/70 mmHg RR 18 Sat 100% RA T 98.6 F (oral)
Current Vitals: HR 86 BP 108/66 mmHg RR 14 Sat 100% RA T 98.6 F (oral)

Exam (abnormal findings bolded):

**General:** Well-developed, well-nourished male 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 his initial diagnostic work-up are indicated here (results outside reference range are bolded):

| **CBC** | | | **CHEMISTRY** | | |
|---|---|---|---|---|---|
| WBC | 8.2 | (3.5-10.5) | SODIUM | 138 | (135-148) |
| RBC | 4.9 | (4.2-5.8) | POTASSIUM | 4.0 | (3.5-5) |
| HEMOGLOBIN | 13.5 | (13.0-17.5) | CHLORIDE | 104 | (95-108) |
| HCT | 40.5 | (38.0-50) | BICARB | 24 | (24-32) |
| MCV | 81 | (80-99) | BUN | 12 | (0-20) |
| MCH | 28 | (27-34) | CREATININE | 0.6 | (0-1.7) |
| MCHC | 34.2 | (33-35.5) | GLUCOSE | 89 | (65-110) |
| RDW | 14.8 | (11-15) | CALCIUM | 9.1 | (8.5-10.5) |
| PLATELET | 157 | (140-390) | | | |
| | | | TROPONIN | 0.01 | |
| | | | D-DIMER | <243 | |
| | | | *(In the appropriate clinical context, a result of less than 243 may be sufficient to rule out a pulmonary embolism)* | | |

ECG: NORMAL SINUS RYHTHM. NORMAL ECG

He was given an albuterol nebulizer treatment, 15mg of IV toradol, and 1L of 0.9% NS IVF. A Chest X-ray was performed

The Chest X-ray results are included on the following page.

The sign-out plan is to discharge the patient if all of his labs and CXR imaging were normal.

CXR and laboratory testing were performed, and the results are included. The patient still has persistent shortness of breath 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.
4. * When you are finished, you can tell him that the nurse will be in shortly to give him the paperwork and take out his IV

## Chest X-Ray Report

**Name of Patient**: Christopher Jackson
**Age**: 36
**Physician**: Dr. Jones

**TECHNIQUE:** 2 views (PA and Lateral) of the chest were performed.

**HISTORY:** Shortness of Breath

**COMPARISON:** None

**FINDINGS:**

Support Devices: None.
Cardiac Silhouette/Mediastinum/Hila: The cardiac, mediastinal, and hilar contours are within normal limits for age.
Lungs/Pleural Spaces: The lungs and pleural spaces are clear.
Chest Wall/Diaphragm/Upper Abdomen: The thoracic musculoskeletal structures and the upper abdomen are age-appropriate in appearance.

**CONCLUSION(S):**

1. There is no acute cardiopulmonary process.

**FINAL REPORT**