**Learner Instructions**

**Patient's Name:** Thomas O'Brien
**Age:** 40 year-old male
**Setting:** Emergency Department
**Primary v Sign-Out**: primary

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

**Patient Information from initial H&P:**
40-year-old male with a PMH significant for kidney stones, who presented to the ED with 24 hours of abdominal pain. His symptoms have been ongoing since arriving in the ED and feel different from the pain associated with previous kidney stones. Upon arrival to the ED labs and urine were obtained for testing and results are pending.

His 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 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, **mild epigastric tenderness**, otherwise non-tender to palpation..
**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** | | |
|---|---|---|
| WBC | 7.4 | (3.5-10.5) |
| RBC | 5.01 | (4.2-5.8) |
| HEMOGLOBIN | 14.2 | (13.0-17.5) |
| HCT | 42.6 | (38.0-50) |
| MCV | 89 | (80-99) |
| MCH | 30 | (27-34) |
| MCHC | 34.2 | (33-35.5) |
| RDW | 14.8 | (11-15) |
| PLATELET | 187 | (140-390) |

| **CHEMISTRY** | | |
|---|---|---|
| SODIUM | 139 | (135-148) |
| POTASSIUM | 4.1 | (3.5-5) |
| CHLORIDE | 107 | (95-108) |
| BICARB | 24 | (24-32) |
| BUN | 15 | (0-20) |
| CREATININE | 0.7 | (0-1.7) |
| GLUCOSE | 98 | (65-110) |
| CALCIUM | 9.2 | (8.5-10.5) |
| | | |
| **HEPATIC PANEL** | | |
| TOTAL PROTEIN | 70 | (60-83 g/L) |
| ALBUMIN | 4 | (3.5-5.5 U/L) |
| TOTAL BILI | 0.4 | (0.1-1.3 mg/dL) |
| DIRECT BILI | 0.1 | (0-0.3 mg/dL) |
| ALT | 25 | (5-56 U/L) |
| AST | 28 | (8-40 U/L) |
| ALK PHOS | 63 | (53-128 U/L) |
| | | |
| LIPASE | 15 | (7-60 U/L) |

ECG: NORMAL SINUS RYHTHM. NORMAL ECG

He was given a 20mg of IV pepcid and a GI cocktail and had a RUQ US performed.

The RUQ US results are included on the following page.

Your initial plan was to discharge the patient if all of his labs and ultrasound imaging were normal.

RUQ US and laboratory testing were performed, and the results are included. The patient has not had a change to his 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 him that the nurse will be in shortly to give him his paperwork and take out his IV