Learner Instructions

Patient's Name: William Tiller
Age: 40 year-old male
Setting: ED
Primary vs. Sign-Out Patient: Primary

Initial Chief Complaint on arrival to the ED:
Chest pain

Patient Information:

40-year-old male without significant PMH or Fhx presents to the ED for an episode of chest pain while climbing-up a flight of stairs. His symptoms resolved upon arrival to the ED.

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

Vital signs:

Initial Triage Vitals:	HR 70 BP 120/70 mmHg RR 18 Sat 100% RA T 98.8 F (oral)
Current Vitals:	HR 68 BP 116/68 mmHg RR 16 Sat 100% RA T 98.6 F (oral)

Exam (abnormal findings bolded):

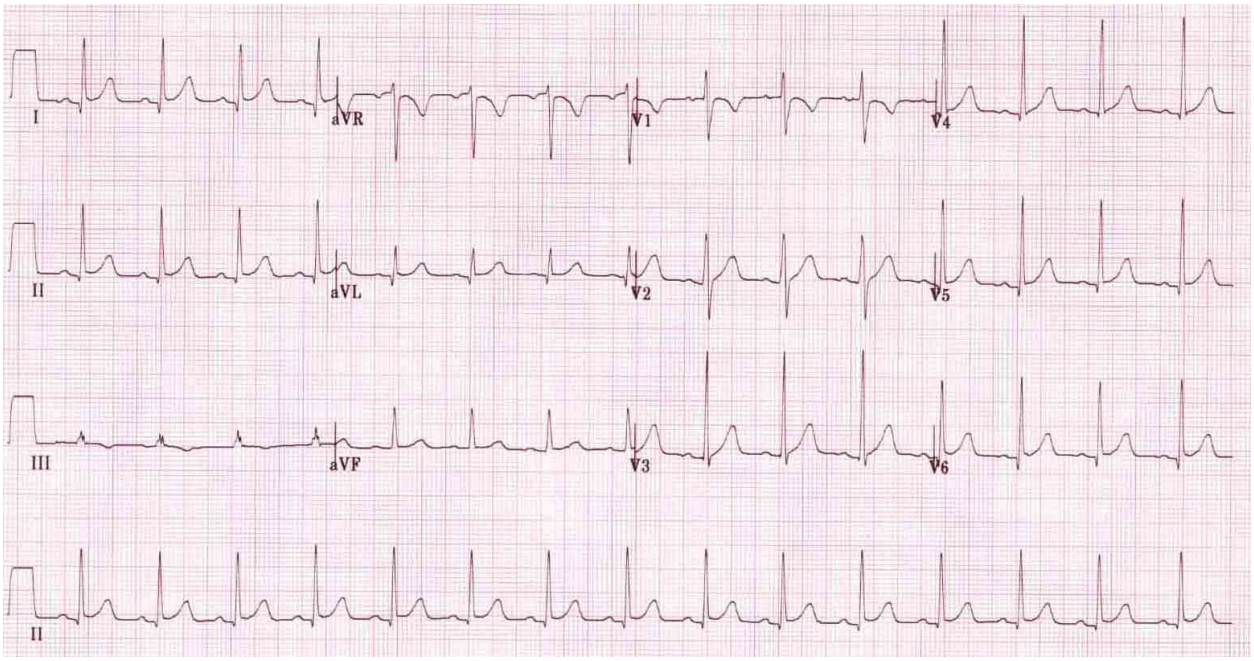
General: Well-developed, well-nourished male resting comfortably in no acute distress.
HEENT: Normocephalic, atraumatic, no conjunctival injection or pallor, sclera non-icteric, PERRLA, nasal mucosa pink, moist mucous membranes, oropharynx without evidence of erythema, tonsillar enlargement or exudates.
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, 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	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)			
			TROPONIN	0.01	(0.00-0.03)
			*TROPONIN (X2)	0.01	(0.00-0.03)
			D-DIMER	<150	(0-243)

***Troponin (X2)** represents the second troponin result two hours after the initial lab draw

ECG: NORMAL SINUS RHYTHM. NORMAL ECG:



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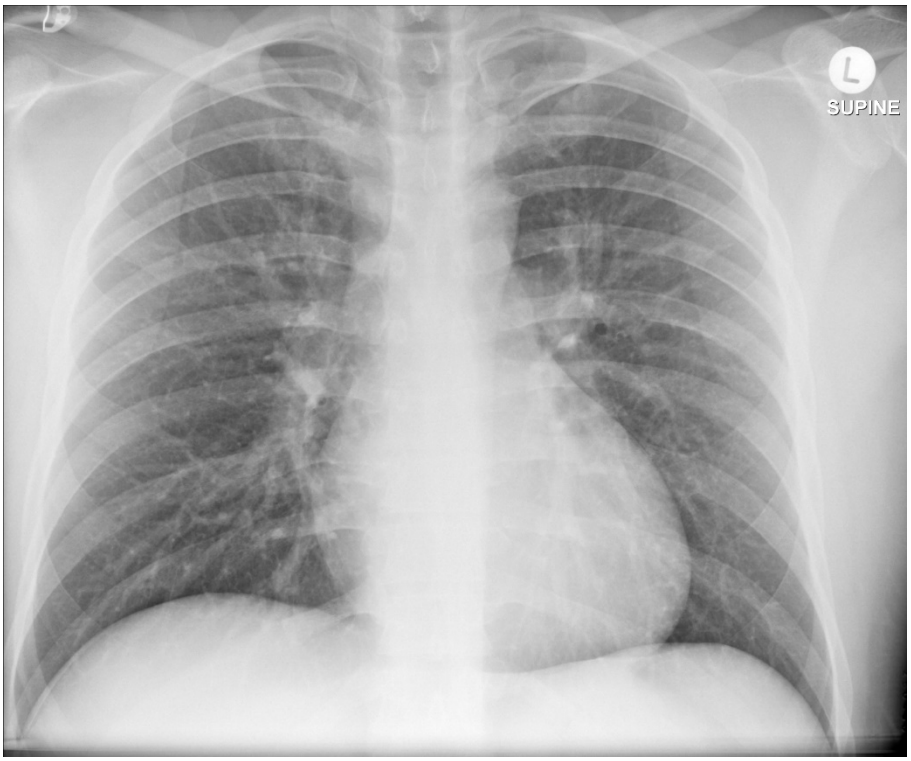
CXR: THERE ARE NO CARDIOPULMONARY ABNORMALITIES. NORMAL CXR



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The plan was to discharge the patient if there were no noted abnormalities on the repeat troponin and if he continued to be chest pain free.

Repeat troponins were performed, and the results are included. The patient had no outstanding issues and is waiting to talk to you regarding his results.

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 his paperwork and take out his IV