Learner Instructions

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

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