Learner Instructions

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

Initial Chief Complaint on arrival to the ED:
Headache

Patient Information from sign-out:

36-year-old male with no PMH, presented to the Emergency Department after developing a headache several days prior. He has had headaches which were more severe but has never experienced a headache which has lasted for this long. The headache started gradually and progressively worsened and has not improved with Tylenol or ibuprofen. He has not had any fevers or chills, or neck stiffness. Upon arrival to the ED labs and a CT brain were ordered. Additionally he was given Reglan, Benadryl, and IVF for symptomatic relief.

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

Vital signs:

Initial Triage Vitals:	HR 92 BP 110/68 mmHg RR 16 Sat 100% RA T 98.6 F (oral)
Current Vitals:	HR 72 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)			
			URINE PREGNANCY	NEGATIVE	

ECG: NORMAL SINUS RYHTHM. NORMAL ECG

He was given a 20mg of IV Reglan, 25mg of IV Benadryl, and 1L of 0.9% NS IVF. A CT brain was performed

The CT brain are included on the following page.

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

CT brain and laboratory testing were performed, and the results are included. The patient still has some headache but is feeling better 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 the paperwork and take out his IV

CT Brain Report

Name of Patient: Marcus White
Age: 36
Physician: Dr. Jones

REASON FOR STUDY: Headache

COMPARISON: none

TECHNIQUE: Non-contrast helical images were acquired through the brain from the vertex to the foramen magnum. Coronal reformatted images were also generated.

FINDINGS:

The ventricles and cortical sulci are within normal limits. No acute intracranial hemorrhage or extra-axial collection is identified. There is no midline shift or mass effect. The basal cisterns are patent. There is no hydrocephalus.

There are no areas of abnormal parenchymal attenuation. The grey-white matter differentiation is maintained.

The calvarium is intact. The mastoid air cells are clear.

IMPRESSION:

No acute intracranial abnormality.