Cover page

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Date of original case: 2015-12-03

Date of most recent revision: 2015-12-03

Name of patient: Laura Secord

Learner's level of expertise: MS1 to CC4

What kind of case is this? PE/Hx combination

Anticipated length of case in minutes: 10 minute Hx for MS1, 10 minute Hx/Px for CC4

Patient's problem(s): Abdominal pain, non-pregnant female

Case objectives: Correctly identify and consider abdominal and gynecological pathology

Key challenges: Patient writhing in pain on stretcher, giving short answers and continually asking for pain medications and if she's dying.

Special casting requirements: Young female SP

Most likely diagnosis: Appendicitis

Differential diagnosis:

- Abdominal: Appendicitis, Cholecystitis, Pancreatitis, Bowel obstruction, Bowel perforation, Kidney stone, Gastroenteritis

- Female-specific:

    (pregnant) Ectopic pregnancy, Abortion/miscarriage

    (non-pregnant) STIs/PID, Tubo-ovarian abscess, Ovarian Torsion

Examination room set-up: Patient lying on stretcher

Data collection and marking notes:

- Simulated patient gives feedback (if not OSCE scenario)

- Examiner does marking, PEPs

STEM ASCM1:

You are an Emergency Physician at a large community hospital. It is 8am. You are about to see Ms. Laura Secord, a 26 year-old female complaining of abdominal pain. Please perform a 10 minute history.

STEM ASCM2:

You are an Emergency Physician at a large community hospital. It is 8am. You are about to see Ms. Laura Secord, a 26 year-old female complaining of abdominal pain. Please perform a 10-minute history and focused physical exam.

STEM iOSCE:

You are an Emergency Physician at a large community hospital. It is 8am. You are about to see Ms. Laura Secord, a 26 year-old female complaining of abdominal pain. Please perform a 10-minute history and focused physical exam. Be prepared to answer post-exposure prompts regarding your differential diagnosis and management plan.

Instructions for actor

Current problem(s): Right-lower quadrant abdominal pain for 1 day

Communication challenge(s): You are in pain, writhing in the stretcher, and have to take deep relaxing breaths between sentences. You become annoyed at the numerous questions being asked. You continually ask for pain medications.

Age: 26

Setting: Emergency Department

Proximal biomedical perspective

- List of problems
    - RLQ Abdominal pain
    - Nausea
    - Vomiting
    - Decreased appetite / PO intake
    - Fever / Chills
- Sequence of events (OPQRST, triggers, associated symptoms, why now?)
    - Yesterday afternoon you were studying for an exam, lying on your bed, at approximately 1-2pm, then you noticed gradual onset, dull-achy/throbbing, 3/10, periumbilical pain There were no provoking or palliating factors, no radiation of the pain at that time. Over the course of the next 6h: the pain migrated to your RLQ, you experienced increased intensity to 8/10. Now the pain at baseline is dull/achy/throbbing, with episodes lasting minutes occurring every 1-2h of sharp 10/10 pain. Movement of your body increases the pain. Palpation in the RLQ increases your pain. Lying still feels better.
    - You've had nausea since the pain started, worse with pain and vomiting. You vomited: x 3 since yesterday but don't remember details of timing (there was no blood, your last meal was lunch yesterday, and the pain doesn't improve with vomiting). Your last bowel movement was this morning. You experienced subjective Fever/Chills since the pain began, no measured temperature.
    - You have come in now because you thought it was indigestion or pre-menstrual cramping yesterday, you were unable to sleep through the night
- Details of symptoms or problems
    - No chest pain, back pain, urinary symptoms
    - No diarrhea: normal stool, soft/formed, last BM was yesterday, no blood, or signs of UGIB/LGIB
    - No PO intake since pain began, decreased appetite, unable to keep food down
    - Never sexually active previously: no missed periods, LNMP 1 week ago, no vaginal bleeding or discharge, no Hx or concern for STIs/PID
- Pertinent risk factors or protective factors
    - No previous surgical history
    - No EtOH, drugs, IV drugs
    - Previously healthy, active

Distal biomedical perspective

Past Medical History

- No previous operations or hospitalizations. No previous illnesses or other problems with health

Medications including over the counter, herbal, oral contraceptive, etc.

- Mirena Intra-uterine device: you don't consider this a medication, do not volunteer unless asked specifically for birth control

Medical Family History: Mother recently diagnosed with colon cancer.

Smoking: None

EtOH: None

Proximal context (paragraph)

You are a single 26 year old female who is currently a culinary student in college. You work part-time in a chocolate store and dream of one day owning your own. You live in a house with your parents (mother and father) both 50 years old and a younger sister (Emily, 24 years old). Your mother is a home-maker and your father is a recently laid off accountant. You do not have any children or dependents. You live within walking distance of the hospital. Though your main modes of transportation are public transit and rides from your parents. You have a good support network of friends and family in the city. You have no social or educational concerns. Financially, your family is coping, but resources are stretched thin. You are worried as to how you will fund further years of education. Your mother has recently been diagnosed with colon cancer, you don't know the details but are worried you have colon cancer as well. You feel it must be worse than your mother's cancer since you feel worse than she does.

Distal context

Community, culture, power relationships, discrimination, media, geography, socioeconomic, and historic factors of your history are not your main concern today. If asked these questions, appear agitated, question the importance of these factors at the present time, and redirect the examinee towards your pain experience.

Patient's perspective

- Ideas and thoughts
    - Am I dying?
    - Will I need surgery?
    - Do I have colon cancer like my mother?
- Concerns
    - Am I dying from cancer? – how will my sister cope without me if I die
    - Will the surgery leave a scar?
    - What wiill this cost my family? (you have OHIP)
- Expectations
    - Make my pain go away
- Feelings
    - Terrible, why is this happening to me?
    - It hurts, can't you make the pain go away?

For information-gathering station

How to present the symptom(s) or problem(s)

How to start the consultation:

- "I have terrible, terrible pain in my belly that's been going on since yesterday. Now I can't even walk or move without it hurting."

- What to divulge to screening questions
    - You are also having nausea, vomiting, fever/chills, and no appetite
- How to respond to specific types of questions or approaches:
    - Do not divulge sexual history, details about menstruation/birth control without specifically being asked closed questions
- What patient says when asked subsequent open questions

    - 'Tell me what has been going on from the time this all first started to the present': redirect to focus on one symptom at a time
    - 'Tell me more about the pain/symptom': what would you like to know about it?
- How to respond to emotional subjects and questions
    - Appear anxious and worried when speaking about your family's financial situation and your mother's recent cancer diagnosis
- How to respond to questions about patient ideas, concerns and expectations about the problems
    - Divulge your concerns regarding financial struggles and your worry that you may have colon cancer

Actor instructions (please be detailed)

- dress, mood, mannerisms, affect, attitude, temperament and behaviour
    - Patient gown
    - Agitated, in pain, constantly asking for pain medications, moaning and groaning
    - Speaking slowly, trying to remain still
    - Cooperative with questioning but visibly in pain
- how to respond to emotional subjects and questions
    - Show apprehension and hesitation, but give straightforward answers
- how to respond to questions about patient fears, concerns and beliefs about the problems
    - Say: "You're the doctor, shouldn't you be telling me?" If asked further, divulge information freely
- physical symptoms that need to be acted out (e.g. cough, hand tremor)
    - Acute distress and pain
    - You are worried you are dying

Physical findings e.g. character can only bend knee to 45-degree angle, raise arms past shoulder level, cannot feel vibrations from tuning on toes, etc.

Physical Exam

Vitals (given when examinee states will perform): 110HR, 110/60BP, Temp 37.9, 99% RA, 18RR

CVS: unremarkable

Resp: unremarkable

Pelvis exam: not required to perform, findings within normal limits

Abdo: grimacing and saying it hurts to any manipulation or movement of your abdomen, pain gets much worse with the following maneuver's

- "point with one finger towards your pain": McBurney's point
- Bowel sounds present in all 4 quadrants – patient is tender, guarding to stethoscope
- Palpation: positive rebound tenderness, positive guarding
- Rovsing's positive: press in LLQ, tender in RLQ
- Peritoneal signs: pain with shaking abdomen or stretcher
- Positive: psoas sign, obturator sign
- Negative Murphy's sign

Laboratory findings

U/A: negative

B-HCG: negative

CBC/lytes/BUN/Cr, Coags: 16 WBC, otherwise within normal limits

LFTs/lipase: normal

Props

None

Post Encounter Probe

ASCM1

What is your differential? What is your most likely diagnosis? Why?

ASCM2

What is your differential? What is your most likely diagnosis? Why?

iOSCE

What is the most likely diagnosis?

What investigations?

- Bloodwork as above: students may not include full abdominal panel (i.e. LFTs, lipase, coags)
- Imaging: Abdominal ultrasound r/o Ovarian torsion, CT A/P r/o Appendicitis. Students may go straight to CT.

What treatment?

- Pain management: Morphine, Hydromorphone
- Nausea: Ondansetron, Gravol
- Dehydration: Normal Saline
- Consult: General Surgery

1. Kurtz S, Silverman J, Draper J. *Teaching and Learning Communications Skills in Medicine*. Vol Second Edi. London: Radcliffe Publishing; 2014.