Texas Tech University Health Sciences Center SON
Faculty Training Notes
Abdominal Pain OSCE

Case Name	Mr(s). John/Joan Roberts
Presenting Situation	You are a 62 y/o (fe)male who presents to the ER with a chief complaint of abdominal pain Your vital signs are: VS BP 149/96 Pulse 110 RR 22 Temp 100.9 Pulse ox 97% on Room air You have been taking 2 Tums three times a day for the past 3 days without relief Your daughter has brought you to the ER for further evaluation
Opening Statement	"My stomach keeps hurting and the pain just won't go away"
Psychosocial Profile	You are appropriately dressed and appear to be in a moderate amount of pain.
History of Present Illness	• The pain started 2 weeks and has gradually worsened • The pain has become "unbearable" over the past 3 hours • You have had nausea after you eat for the past 2 weeks • Sharp, stabbing type of pain to the middle and upper right side of the abdomen • Pain radiates to between your shoulder blades • The pain is worse about 30 minutes after eating • The pain is rated as a 9 on a scale of 1-10 • Tums have not made the pain better • Lying on your back makes the pain worse • Sitting and leaning forward seems to lessen the pain
Past Medical History	• High blood pressure for 8 years • High cholesterol for 8 years • You had your tonsils taken out as a child • You are allergic to penicillin (which if asked causes a rash) • For females: You reached menopause at age 50 • Last tetanus was 5 years ago. • You had the flu shot this year. • You have not had a pneumonia vaccine.

<table>
<tr><td></td><td>Give the following card (Roberts Medication Card) to student when asked about medications:

<table>
<tr><td>Medication</td><td>Dose</td></tr>
<tr><td>• Zestoretic</td><td>• 10/12.5 mg po daily</td></tr>
<tr><td>• Pravachol</td><td>• 20 mg po daily at bedtime</td></tr>
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<tr><td>Social History</td><td>.
• Married 35 years
• You have 2 daughters who are married
• Work as an elementary school principal
• Drink one glass of wine 3-4 evenings per week
• No tobacco, illicit or IV drug use</td></tr>
<tr><td>Family Medical History</td><td>• Father deceased age 81 of stroke
• Mother alive age 83: High blood pressure
• Brother age 60: High blood pressure, heart attack age 59
• Sister age 64: High blood pressure
• Daughters: Ages 32 and 34: Healthy</td></tr>
<tr><td>Review of systems (things the student should ask you)* you should answer only when asked about the specific area</td><td>*Constitutional
Appears appropriately dressed.
Reports no weight loss/gain or chills.
Low-grade fever for past 3 days.
Generally in good health.

Head
You have no history of injury, headache, lightheadedness or seizures.

Eyes
You wear glasses when reading. No eye pain, visual changes, drainage, redness, or sensitivity to light.

Nose
No drainage or bleeding

Mouth
No difficulty swallowing or dental pain.

Sinuses
You have seasonal allergy symptoms.

Neck
No swelling.

Cardiovascular</td></tr>
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	No prior episodes of chest pain or dizziness. **Respiratory** No prior episodes of shortness of breath, wheezing or increased sputum production. ***Gastrointestinal** Abdominal pain for the last 2 weeks with occasional nausea. No vomiting, diarrhea or blood in stools. Formed bowel movement daily. **Genitourinary** No pain with urination, frequency, urgency, problems starting your urine stream or flank pain. **Musculoskeletal** Stiff back in the morning that is worse with cold weather. No joint swelling **Neurological** No loss of consciousness, headaches, vision changes, walking problems or falling. **Psychiatric** No psychiatric disorders, anxiety or depression. **Skin:** No acne or skin rash. **Endocrine** No frequent urination, excessive thirst or excessive hunger. **Hematologic/Lymphatic** No history of bleeding problems, excessive bruising, anemia, skin spots, lymph node swelling or tenderness. **Allergic/Immunologic** No frequent infections, problems healing or recurrent infections.
Physical Exam Findings	**Constitutional** Patient is appropriately dressed and pleasant. Appears uncomfortable due to abdominal pain. You are alert and know person, place and time. Height 5'9" Weight 225 **Head** No bumps or bruises

Eyes
Eyes are normal to inspection. Pupils equal, round and reactive to light. No discharge from eyes. Extraocular muscles intact. Sclera are normal. Conjunctiva are normal.

ENT
Ears normal to inspection. Nose examination normal. Posterior pharynx normal. Mouth normal to inspection.

Neck
Normal painless movement. No jugular venous distention. Carotid pulses normal. No bruit.

Cardiovascular
Rate and rhythm regular. Normal S1, S2. No murmur, rub or gallop. Normal to palpation.

Respiratory
Chest is nontender. Breath sounds normal in all lobes. No respiratory distress.

Abdomen
Abdomen is tender when the student presses down over your stomach or the upper right portion of the abdomen. (Give student Roberts abdomen card: Positive guarding and pain to palpation over the upper abdomen/epigastric area. Abdomen is distended with hypoactive bowel sounds). No masses. No bruit.

Musculoskeletal:
Upper extremity:
Inspection normal. No clubbing, cyanosis or edema. Normal range of motion.
Lower extremity:
Inspection normal. No clubbing, cyanosis or edema. Normal range of motion. No palpable cords. No edema. Negative Homan's. Distal pulses are 2+ bilaterally.

Integumentary
Skin hot to touch, increased sweating. Skin is pale. (Give student Roberts skin card: Skin hot to touch, increased diaphoresis throughout. Pallor noted).

Neurological
Awake, alert, oriented. Follows all commands. Walking is normal. Reflexes are normal.

Labs & Diagnostics

CBC

WBC	15.5	H	(4.5-11.0 k/µL)
RBC	5.25		(4.40-6.00 m/µL)
Hgb	14.2		(14.0-18.0 g/dL)
Hct	42.9		(41.0-51.0 %)
MCV	85.2		(82.0-100.0 fL)
MCH	29.3		(27.0-34.0 pg)
MCHC	33.1		(31.0-37.0 g/dL)
RDW-CV	15.1		(11.0-15.3 %)
MPV	8.3		(6.9-11.0 fL)
Platelets	249		(150-400 K/µL)
Neutrophils	92	H	(44-88 %)
Lymphocytes	3	L	(12-43 %)
Monocytes	5		(2-11 %)

Complete Metabolic Panel

Sodium	139		(135-145 mEq/L)
Potassium	3.6		(3.5-5.0 mEq/L)
Chloride	101		(99-109 mEq/L)
CO_2	29		(24-31 mEq/L)
BUN	30	H	(8-24 mg/dL)
Creatinine	1.2		(0.5-1.5 mg/dL)
Glucose	146	H	(65-110 mg/dL)
Protein	7.3		(6.3-8.2 g/dL)
Albumin	4.5		(3.5-5.0 g/dL)
Total bilirubin	1.2		(0.2-1.2 mg/dL)
Alk phosphatase	112		(30-115 U/L)
AST (SGOT)	45		(15-46 U/L)
ALT (SGPT)	32		(10-55 U/L)

Coagulation Studies

PT	14.1	(12.0-15.0 seconds)
PTT	35.2	(23.0-36.0 seconds)
INR	1.1	

Amylase

Amylase	281	H	(23-85 U/L)

Lipase

Lipase	768	H	(4-24 U/L)

	<u>Plain Abdominal Film</u> NO EVIDENCE OF FREE AIR NOTED. MILD CONSTIPATION NOTED IN THE DESCENDING COLON. OTHERWISE UNREMARKABLE ABDOMEN. <u>Abdominal Ultrasound</u> SLIGHT THICKENING OF GALLBLADDER WALL. NO GALLSTONES OR BILIARY SLUDGE NOTED. PANCREAS ARE UNABLE TO BE ADEQUATELY VISUALIZED SECONDARY TO OVERLYING BOWEL GAS. <u>Abdominal CT scan</u> SLIGHT THICKENING OF GALLBLADDER WALL. NO GALLSTONES OR BILIARY SLUDGE NOTED. DIFFUSE ENLARGEMENT OF THE PANCREAS WITH OVERLYING HAZINESS CONSISTENT WITH ACUTE PANCREATITIS. OTHERWISE UNREMARKABLE ABDOMEN.