Certifying Exam
Case Materials

REASSESSMENT

CASE SAMPLE VIDEO
Use of the case materials in this document are demonstrated here.

CASE SUMMARY
Emergency physicians frequently address incomplete, changing, or conflicting information. These cases will present the candidate with clinical data or circumstances that require a reassessment of a patient's condition. The successful candidate will demonstrate the ability to evaluate new information, efficiently problem solve, and optimize patient management.

SCORING
Information on how this case will be scored can be found here.

REASSESSMENT SCENARIO TASK SHEET	ROOM #

CASE PARAMETERS

- This is a 10-minute case.
- You will interact with a patient.
- This patient was admitted for pneumonia during the last shift is awaiting a bed on the inpatient unit. She is being managed by the Internal Medicine team. The nurse has asked you to assess the patient because she is complaining of worsening dyspnea.
- You will explore the reasons why the patient is not improving and how to move forward with treatment.

TASK STATEMENT

Your tasks are as follows:

- Identify the reason for the patient's worsening condition
- Communicate your findings
- Manage the condition and articulate next steps

PATIENT CHART

Patient Name	Renee Marshall
Age	40-years-old
Gender	Female
Presenting Complaint	Fever and cough
History of Present Illness	A 40-year-old woman with a history of diabetes presents with seven days of cough productive of yellow phlegm. Fever and chills x 4 days. + fatigue and short of breath. Her blood sugar has been elevated on home testing. She quit smoking 5 years ago.
Past Medical History	Diabetes Type 2, hypertension, hyperlipidemia
Medication	Metformin, Enalapril, Simvastatin
Allergies	Penicillin

PHYSICAL EXAM FINDINGS

Vital Signs on ED Arrival	BP: 100/65 P: 118/min R: 24/min T: 38.8° C (101.8° F) O2 sat: 92% on room air
General Appearance	Alert and oriented, fatigued, coughing
Dermatologic	Normal, no rash
HEENT	Clear oropharynx, dry mucus membranes, no tonsillar exudate
Neck	Normal
Respiratory	Right-sided rhonchi with consolidation in the lower lung field, clear on the left
Cardiac	Tachycardic, regular rhythm
Abdominal	Soft, non-tender, non-distended
Extremities	No edema, pulses symmetrical and present
Neurologic	No focal findings

ASSESSMENT AND PLAN

Immunocompromised woman (history of DM) new dx/o bacterial community- acquired pneumonia. Work up below, sepsis protocol.

MEDICATIONS ORDERED

0.9% saline – 30ml/kg IV; acetaminophen – 1gm po; piperacillin and tazobactam. – 3.375 mg IV

RADIOLOGY RESULT

Chest x-ray	Right lower lobe infiltrate

LAB RESULTS (relevant and abnormal only listed)

CBC	Units	Normal Values
WBC	*17,500 /mm3	3,200-9,800/mm3
CBC - Differential	**Units**	**Normal Values**
Segs	85	%
Bands	*5	%
Lymphs	8	%
BMP	**Units**	**Normal Values**
CO2-	*19 mEq/L	23-28 mEq/L
Glucose	*162 mEq/L	70-105 mg/dL
BUN	*24 mg/dL	8-20 mg/dL
Creatinine	1.1 mg/dL	0.7-1.3 mg/dL
Lactate	**Units**	**Normal Values**
Initial Lactate	*4.5	0.4-2.3 mEq/L
Repeat Lactate	2.2	0.4-2.3 mEq/L

ED COURSE / MEDICAL DECISION-MAKING

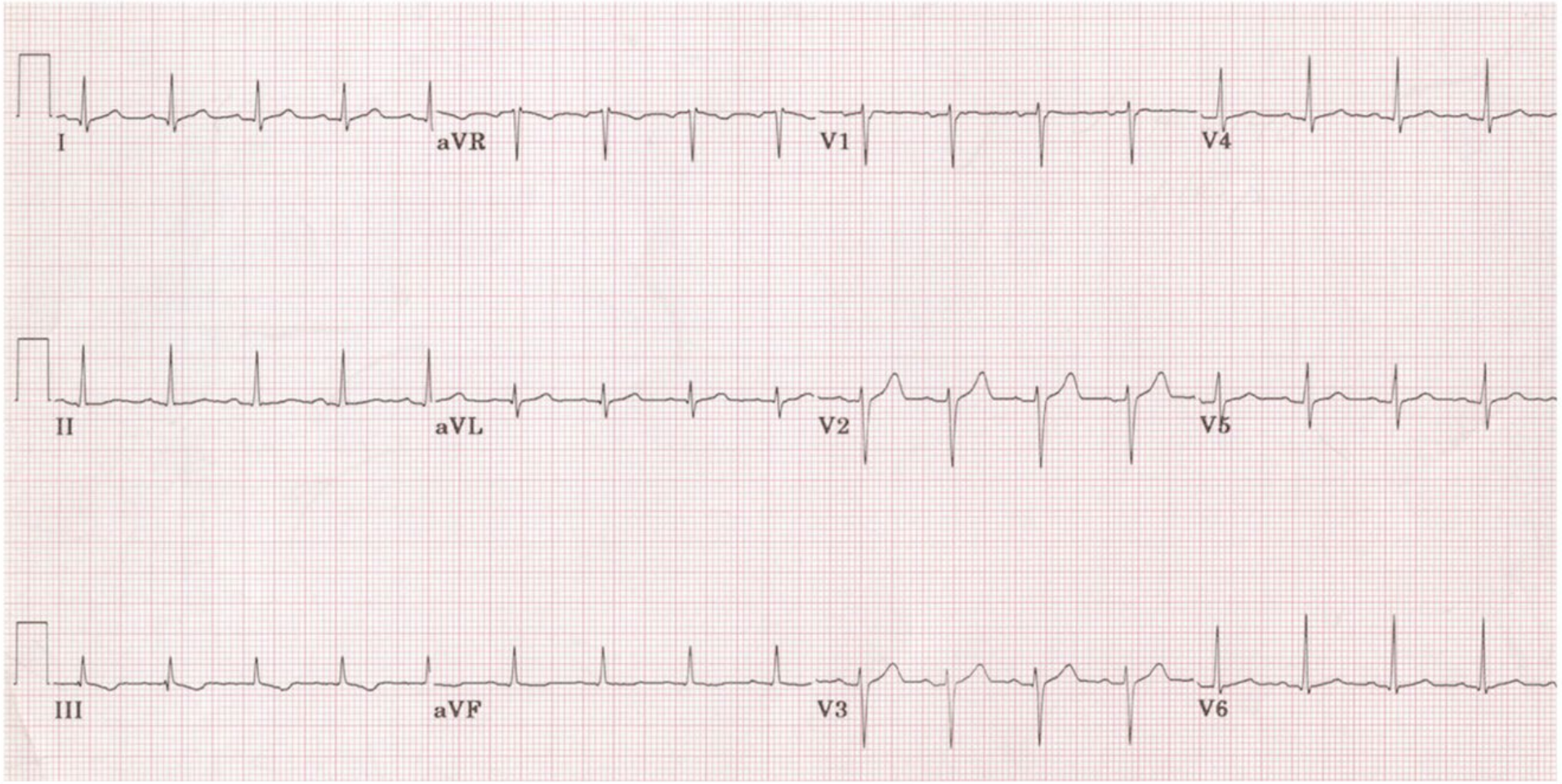
Repeat Vital Signs	BP: 116/68 P: 95/min R: 18/min T: 37.5° C (99.5° F) O2 sat: 95% on room air

The patient's symptoms improved after IV fluids and acetaminophen. CXR shows R-sided pneumonia. Given her presentation, the patient has evidence of sepsis. Requires IV antibiotics and monitoring as an inpatient. Discussed with her physician, Dr. Smith, who agrees with the plan. Admission placed to the floor and report given to the inpatient team.

While boarding in the ED, she is being managed by the Internal Medicine team. The nurse has asked you to assess the patient because she is complaining of worsening dyspnea

PHYSICAL EXAM FINDINGS	ROOM #
REPEAT VITAL SIGNS	BP: 110/62 P: 104/min R: 20/min T: 37.5° C (99.5° F) O2 sat: 97% on room air
GENERAL APPEARANCE	Alert and oriented, moderately dyspneic
DERMATOLOGIC	Diffuse, well-demarcated, mildly raised, confluent rash with wheals on the trunk, upper arms and thighs
HEENT	Clear oropharynx, normal airway, moist mucous membranes, no swelling
NECK	Normal
RESPIRATORY	Tachypnea but otherwise clear with rhonchi in the right lower lung field
CARDIAC	Tachycardic, regular rhythm
ABDOMINAL	Soft, non-tender, non-distended
EXTREMITIES	No edema, pulses symmetrical and present
NEUROLOGIC	Normal exam without focal findings

STIMULUS 1. ECG

ROOM #

Ventricular rate: 104 bpm
PR interval: 158 ms
QRS duration: 84 ms
QTc: 408 ms