Urgent Care cases that fall out of the “norm”

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ATSU graduate 2006

Identifying unusual presentations
Evaluating the history of the patient
Conducting a physical exam
Recognize that these presentations may be subtle but important facts.

These are real cases seen in family practice/urgent care and if not treated and evaluated correctly may have been catastrophic to the health of the patient. Other cases may be considered zebras but, need to be on the differential despite the remote and unlikely possibility.

Objectives

- Identifying unusual presentations
- Evaluating the history of the patient
- Conducting a physical exam
- Recognize that these presentations may be subtle but important facts.

Program Description
Didactics have taught us to listen to our patients and if we listen long enough they will tell us what is wrong with them. Personally, this has been a key to examining patients. Instinct has no quantifiable value but, it is that gut sense that may be something that needs to be pursued if there is any doubt.

A 20 year old patient (and his mother) come in complaining of left ear pain x 2 days. Denies hearing loss or drainage, fever/chills/nausea or vomiting.

- Vitals stable: blood pressure 118/82; pulse 82; temp 98; respirations 22 and weight 155.
What is wrong with this picture?

Physical examination:
- All normal: left ear normal; TM pink/not retracted; no drainage; ear canal normal; no cerumen; pinna neg for pain; hearing grossly normal
- The rest of the physical examination was normal.

History, history, history and on occasion more history
- The case was not about the presenting complaints although it may have been a referred pain.
- After the examination was done and the history was obtained from the patient, I explained to the patient and his mom that the examination was negative.
His mom proceeded to inform me that the patient had had a GSW (gun shot wound to the chest/upper abdomen) about 1 week prior to the visit. Furthermore, she said that the patient was treated and released.

Listen to all the clues that may seem irrelevant at the time but, may be the keys to solving the pieces to the puzzle in making a correct diagnosis. The patient was referred to the ER for thoracentesis and further treatment.

A 27 year old male reports that he is having a severe headache. Patient stated that he has had a history of headaches in the past and had a history of meningitis. He stated the headache felt like it did when he had had meningitis.
PHYSICAL EXAMINATION

- GENERAL APPEARANCE: The patient is alert, oriented, no acute distress.
- VITAL SIGNS: T currently 97.5, blood pressure 110/60, respirations 22, and heart rate 88.
- NECK: Supple without lymphadenopathy, no meningismus.
- HEART: Regular rate and rhythm.
- LUNGS: NORMAL breath sounds at the bases. No crackles or wheezes are heard.
- NEUROLOGICAL: Gross nonfocal. Skin: Warm and dry without any rash.

Typical signs of meningitis

- Symptom of Meningitis
  - General
    - Headache
    - Altered mental status
  - Gait
    - Paraparesis
  - Neck
    - Stiffness
  - Systemic
    - High fever
  - Trunk
    - Spinal hyperesthesia, paresthesia of meningeal
    - Mental
    - Drowsiness

Brudzinski and Kernig’s
This patient was sent to the ER even though all the tests for meningitis were normal and the cbc was normal. The ER examined him and he was sent home. However, the patient returned about 12 hours later with a severe headache and a Lumbar puncture was performed confirming the diagnosis of meningitis. Bottom line: Listen to your patients!!!
A 50 y/o female presenting for blood pressure medication refill. States she was seen by her primary care doctor the day before but one of the medications was not refilled. She reported she had mentioned to her primary care provider that she had vomited “green stuff” twice in the last 2 weeks but, nothing further was followed up.

Physical examination was normal (including the vitals) except for the abdominal examination. The patient was exquisitely tender in the RUQ and was sent to the ER for further examination. of 30,000 and was being admitted.

A high number of WBCs is called leukocytosis. It may be due to:
- Aplastic anemia
- Certain drugs or medicines (see list below)
- Cigarette smoking
- Not having a spleen, due to spleen removal
- Infections, most often those caused by bacteria
- Inflammatory disease (such as rheumatoid arthritis or allergy)
- Leukemia
- Severe mental or physical stress
- Tissue damage (for example, burns)
Case 4 medication refill

- This is a 30 year old male presenting for a refill of his albuterol inhaler around 9 am in the morning. He reported he had been short of breath but it was due to his need for his inhaler.

Physical examination

- At first glance, this male presented with a mostly normal examination and his oxygen saturation rate was 98% except he had some alcohol on his breath at that time in the morning.

A chest xray was ordered
Another physical examination was conducted and the patient had JVD and lower extremity edema noted.

In addition, a BNP was ordered and the levels were over 3000. Significantly higher than the norm.

The BNP level helps to determine if you have heart failure.
- BNP levels below 100 pg/mL indicate no heart failure.
- BNP levels of 100–300 pg/mL suggest heart failure is present.
- BNP levels above 300 pg/mL indicate mild heart failure.
- BNP levels above 600 pg/mL indicate moderate heart failure.
- BNP levels above 900 pg/mL indicate severe heart failure.

This is a 45 year old female presenting with dysuria and frequency. Past medical history is history of UTI's in past and as an infant the patient had glioblastoma of the liver. Also, patient reported she had severe pain with her menses monthly. Additionally, positive history of scoliosis and had a Harrington’s rod in her back.
Mostly normal examination but, the patient was exquisitely tender to palpation in her lower pelvis and abdomen during the examination.

Tumors noted in bilateral kidneys, liver, uterus. Essentially, the patient was in stage 4 cancer. One note: A ct scan of the head was not performed – suspect lesions in the brain.

Researched the glioblastoma of the liver—normally located in the brain and spinal cord—in the article it stated glioblastomas were the most common liver tumor.
This is a 50 year old patient coming in for something for pain. She reported she had been discharged from the hospital 2 months prior to the visit and she had been in a coma for most of that time. Prior to the hospitalization, the patient stated she had been an IVDA and was homeless, sleeping near dumpsters.

Further, she reported that after she was “rescued,” she had been on many antidepressants/anxiolytics and in addition had been given lithium. She stated she had overdosed on the lithium and that was the reason she had been hospitalized. The patient reported she had to be resuscitated twice and had been to hell during that time.

Speech impediment—sounded like she was speaking with a mouth full of marbles
Parkinson-like movements—cogwheel and shuffle gait
Mood—anxious and constantly repeating the same statement
Otherwise normal exam
The American Psychological Association concurs. It defines near-death experiences as “profound psychological events with transcendental and mystical elements, typically occurring to individuals close to death or in situations of intense physical or emotional danger.”

Example 1: An elderly woman had been blind since childhood. But, during her NDE, the woman had regained her sight and she was able to accurately describe the instruments and techniques used during the resuscitation her body. After the woman was revived, she reported the details to her doctor. She was able to tell her doctor who came in and out, what they said, what they wore, what they did, all of which was true. Her doctor then referred the woman to Moody who he knew was doing research at the time on NDEs.
In conclusion

Courage is what it takes to stand up and speak; courage is also what it takes to sit down and listen.

Winston Churchill