Case Scenario
Scenario 2

Dispatch: Difficulty breathing

Initial Impression: 64 y/o F presents CA&O though a bit lethargic sitting upright in a chair, tripoding, in respiratory distress.

Primary Assessment Findings: ∅ gurgling, stridor, or snoring. ⊕ frothy pink sputum noted around lips. RR = tachypenic with good TV, pt able to speak in 3-4 word sentences. ⊕ accessory muscle use. LS = rales in the mid and upper lobes ⊥, ∅ air movement to bases ⊥. Radial pulse = tachycardic, weak, and irregular. Skin = cool, diaphoretic, and peripherally cyanotic. RA SpO_2 = 76%.

Discussion:
With your group members, please discuss the following:

- Is the patient's airway patent? How do you know?
- How would you describe the patient's respiratory status?
- Are there any interventions you would like to perform right now?
- Is this patient stable or unstable, and what is your transport priority (rapid versus delayed)?
- Based on this initial impression, what does your differential diagnosis include?
- Based on the primary exam findings, is your patient in shock? I so, can you guess at the category and stage of shock?

History of Present Illness: Pt states she went to Easter lunch yesterday with family, started experiencing diff brth when she returned home in the afternoon, breathing has been getting worse since. She experienced orthopnea last night so was forced to sleep sitting up in her arm chair. Pt states that she then experienced an acute onset of nausea, and weakness about 30 minutes ago, and experiences dizziness and near-syncope when she attempts to stand. She denies CP, vomiting, syncope, abd or back pn, or headache.

PMH

- AMI x 2
- CABG x 2 '96
- HTN
- IDDM

Medications

- Metoprolol
- Procardia
- ASA
- NTG prn
- Insulin

Allergies

- NKDA

Discussion:

With your group members, please discuss the following:

- What does the patient's history tell you about her current problem?
- Based on this new information, how has your differential diagnosis changed? What does it now include?
- What is the physiologic basis for the patient's history findings? Explain your findings in pathophysiologic terms.
- Do you expect the patient's medications to effect her vital signs or ability to compensate for developing shock? If so, how?
- Based on the history findings, what clinical exam findings do you anticipate?
- Are there any interventions you would like to perform right now?

Vital Signs:

- HR = 88/min, weak, irregular
- BP = 160/106 mmHg
- RR = 24/min with adequate TV
- SpO_2 = 76% on room air
- GCS = 4/5/6

Clinical Exam:

- **HEENT/Neck**
  - PEARL, ∅ JVD
  - ∅ tracheal deviation
- **Chest/Back**
  - Lung sounds with rales in the mid and upper lobes ⊥, ∅ air mvmt to bases ⊥.
  - ⊕ accessory muscle use noted
  - Surgical scar noted over sternum
- **Abdomen/Pelvis**
  - ABD SNT, no masses, rigidity, distention, or guarding noted
  - ∅ sacral edema noted
- **Extremities**
  - Sensory, motor intact all extremities
  - ∅ peripheral edema noted

Discussion:

With your group members, please discuss the following:

- Based on the patient's vital signs, is she in shock? If so, what category and stage of shock?
- Have the clinical exam findings influenced your differential diagnosis? What is your best guess as to the problem?
- What is the physiologic basis for the patient's clinical exam findings? Explain your findings in pathophysiologic terms.
- Correlate all of the history and physical exam findings with your diagnosis.
- How would you manage this patient?