Scenarios System Table

SCENARIO NAME	SPECIALTY
Normal Labor and Delivery	Obstetrics
Post Term Pregnancy with Meconium stain	Obstetrics
Gestational Diabetes / Vaginal Delivery with complicating diagnosis	Obstetrics/High Risk Pregnancy
Pregnancy Induced Hypertension / Vaginal delivery with complicating diagnosis	Obstetrics/High Risk Pregnancy
C-Section WT CC/MCC	Obstetrics
Full Term Pregnancy/Normal Newborn	Neonatology/OBGYN
Fetal distress During Labor and Delivery	Neonatology/Pediatrics
RDS(Respiratory Distress Syndrome) Pediatrics	Neonatology/Pediatrics
Neonatal Sepsis	Neonatology/Pediatrics
Neonatal Hypoglycemia	Neonatology/Pediatrics
Psychoses/Bipolar1 Mental Health	Psychiatry
ETOH Abuse	Psychiatry/Substance Abuse
Substance Abuse	Psychiatry/Substance Abuse
Depressive Neurosis/PTSD	Psychiatry/Substance Abuse
Respiratory Failure	Pulmonary/Internal Medicine
Severe Sepsis	Infectious Diseases/Internal Medicine
GERD	Gasteroenterology/Internal Medicine
Liver Cirrhosis/Liver Transplant	Gasteroenterology/Hepatolgy/ Transplant Medicine/Internal Medicine
Diabetic Ketoacidosis	Internal Medicine/Endocrinology
Acute Myocardial Infarction	Cardiology/Internal Medicine
Alcohol Withdrawal	Psychiatry/Substance Abuse
Subsequent MI & Viral Pneumonia	Cardiology/Infectious Diseases
Asymptomatic HIV	Infectious Diseases/Internal Medicine
HIV with LTBI	Infectious Diseases/Internal Medicine
Community Acquired Pneumonia	Infectious Diseases/Internal Medicine
Chronic Otitis Media	Pediatric Surgery/ENT
Down's Syndrome/PDA	Pediatric Cardiac Surgery
Insertion Of Pacemaker	Cardiology/Internal Medicine
Colles Fracture	Orthopedic/Surgery
Fracture of Hand	Orthopedic/Surgery
Breast Cancer	Surgery/Oncology
Hypertension Follow-up. Office Visit	Cardiology
Rheumatoid Arthritis Office -Visit	Rheumatology/Internal Medicine
Implantable Loop Recorder Follow-up office Visit	Cardiology/Internal Medicine
OCP prescription Office- Visit	Family planning
Type II DM (Uncomplicated) Follow -up Office Visit	Internal Medicine /Primary Care
Hypothyroidism Follow-up Office Visit	Internal Medicine/Primary Care
Hyperlipidemia Follow-up office visit	Internal Medicine/Primary Care
End Stage Renal Disease and Dialysis	Internal Medicine/Nephrology
Carpal Tunnel Syndrome	Internal Medicine/Primary Care
Streptococcal Throat Infection Office Visit	Internal Medicine/Infectious disease
Screening for Colorectal Cancer	GI/Internal Medicine
RT Hemicolectomy of Colorectal Cancer	Genral Surgery/GI
Spinal Cord injury	Neurosurgery
Asthma Office visit	Pulmonology/Internal Medicine
Insertion Of Intrauterine Contraceptive Device Office Visit	Family planning/OBGYN

Normal Labor and Delivery

CLINICAL SCENARIO	A 32 year old female admitted to the hospital with 39 weeks of gestation as per her 18 weeks ultrasound. She presented with uterine contractions coming every 4 min apart and increasing in intensity. She states that her pain started an hour ago with feeble intensity contractions which have increased in frequency and intensity in last half an hour. She is Gravid 2, Para 1 and her previous pregnancy was uncomplicated. On vaginal examination, cervix is 90% effaced and 8cm dilated. Patient went in normal labor and delivered a healthy single baby boy with 8 Apgar score at birth and 9 Apgar score at 5 min. she sustained a second degree perineal laceration which was repaired and sutures were applied. PT was discharged 2 days after delivery without any complications. She was scheduled for her postpartum visit with OBGYN. Her hospital LOS was 2 days.

Gestational DM

CLINICAL SCENARIO	A 32 year old multigravida, Hispanic origin woman came to clinic at 29 weeks of gestation for a routine prenatal visit. She has just undergone 1 hour, 50mg glucose load for screening of gestational diabetes. The glucose value came back 175mg/dl. She is 5'4" tall and weighs 180lbs. Her pregnancy weight gain is 25lbs so far. Her BMI before pregnancy was 26.5 which fall under overweight. Her previous baby was large for dates and weighed 4,200g. On Examination, her fundal height was 33cm. fetal heart sounds are 135/min in the left lower quadrant. 3 hour OGTT and fasting glucose was ordered. Her FBS were 106mg/dl and her 3 hr. OGT indicative of Gestational Diabetes. Patient was educated for diabetic diet and impact of higher blood glucose on the baby. Weekly prenatal visits were scheduled. U/S for fetal growth ordered and Home blood glucose monitoring education was provided. At 32 weeks prenatal visit she demonstrated high glycemic index and was put on insulin therapy. Her U/S revealed a male fetus in cephalic presentation with estimated fetal weight at 95th percentile. Six weeks later Patient presented in Maternity Unit at 38 weeks of gestation in active labor due to spontaneous rupture of membranes. Delivery was assisted by vacuum extraction and baby was born with severe shoulder dystocia that was relieved by McRoberts maneuver and suprapubic pressure. The infant weighed 4,600 gm and demonstrated decreased movement of the right upper extremity. Patient and neonate were discharged after 3 days and she was scheduled for postpartum visit at her OBGYN clinic.

Post-term preg+Meconium

CLINICAL SCENARIO	A 19 -year old African American primigravida woman at 43 weeks of Gestation came to ED for elective induction of labor and delivery due to post-term pregnancy. She was admitted to the Maternity Unit. She has a history of smoking during pregnancy. Prenatal ultrasounds were normal with no fetal/ placental anomalies. She was given Prostaglandin E2 gel for cervical ripening and induction of labor due to postdate pregnancy and unfavorable cervix. After induction of labor she progressed into active labor with 6 cm cervical dilation and 100% effacement. External fetal monitoring tracing showed fetal distress due to irregular deceleration with drops of 25 beats per minute. ARM was performed. Amniotic fluid was mildly stained with meconium. Amnio-infusion (with saline infused through intrauterine catheter) was done and assisted vaginal delivery was performed which resulted in birth of a single live born with no signs of respiratory distress and no MAS(Meconium Aspiration Syndrome). Neonate was observed for 12 hours for O2 saturation and for other signs of respiratory distress. Mother and child were discharged after 2 days with final diagnosis of Meconium stained Amniotic fluid during assisted vaginal delivery due to Post-term pregnancy.

pregnancy induced Hypertension

CLINICAL SCENARIO	A 35 year old African American female with systemic lupus erythematous develops moderate preeclampsia in the third trimester of her pregnancy. The fetus appears well developed so a Lower Uterine Segment Cesarean Section is performed to deliver the baby. The female neonate was delivered without incident and examination revealed a healthy, viable baby. Hospital LOS for mother and baby was 5 days.

C-sec WT CC

CLINICAL SCENARIO	A 30 year old Gravid 2 Para 1 at 36 weeks gestational age (by dates) came to the Emergency department with complaint of painless bleeding since this afternoon. Bleeding is moderate to severe and she denies passing any clots. She confirmed good fetal movement. She did not receive any prenatal care for this pregnancy. Her last pregnancy ended in Emergency C-section due to breech presentation. On physical examination she seems not in distress and vitals are WNL. Fundal height is 36cm, uterus is soft and non-tender. Fetal heart sounds by Doppler was 155 / min. CBC, biophysical Amniotic fluid index, blood type and cross match was ordered. OB Ultrasound confirmed single live fetus with 36 weeks gestation and Placenta Previa as a principal diagnosis. For fetal lung maturity, she was given Betamethasone intra muscular injection stat and at 24 hrs. Transverse C-section under spinal Anesthesia was performed. Patient delivered a healthy baby boy weighing 7.2 lbs. with no signs of respiratory distress. There were no post-operative complications. Her hospital Length of stay was 4 days.

FT pregnancy, Normal Newborn

CLINICAL SCENARIO	A 25 year old G0 P0 came to ED with presenting complaint of uterine contractions and spontaneous rupture of membrane. She has no comorbid condition and her course of pregnancy was normal. Her due date was yesterday. On Pelvic examination, cervix was soft and 8 cm dilated, shortly she went into labor and delivered a healthy live single newborn with no complications through vaginal delivery. She sustained a second degree perineal tear which was repaired. Her and baby's hospital LOS was 3 days.

Fetal Distress during L&D

CLINICAL SCENARIO	A 31 year old primigravida woman is in the maternity unit in active labor at term. Her prenatal course was unremarkable, and she came in with spontaneous uterine contractions. She was 4 cm dilated, 100% effaced, 0 stations with fetus in Cephalic presentation. She was put on Ringer's lactate solution at 125ml/hr. Intravenous Oxytocin for augmentation of labor was administered because of arrest of cervical dilation at 5cm. Fetal membranes are intact. An External fetal heart rate monitor reading which was initially normal progressed into repetitive late deceleration. Base line fetal heart rate was 170/m. Her oxytocin was stopped and she went under emergency C-section due to fetal distress during labor and gave a single live birth of a male infant. Infant was healthy 8lbs with 8 and 9 Apgar, went for normal circumcision on first day of birth. Mother and child recovered normally. She was scheduled for her postpartum appointment in next 6 weeks with her OBGYN. Her hospital LOS was 3 days.

RDS Pediatrics

CLINICAL SCENARIO	A 21 year old African Female who is Gravid 1 Para 0 came to emergency department with 29 weeks of gestation complaining of uterine contractions every five minutes. After assessment, she was found to be in an active labor with fetal distress and was underwent for emergency C-section. Prior to C-section she was administered with Betamethasone for fetal lung maturity. She delivers a single live born female infant with 7 and 8 Apgar score at 1 min and 5 min respectively. Infant weighs 1350 grams and was cyanosed with expiratory grunting and was diagnosed with Respiratory distress Syndrome. Patient was transferred to NICU where umbilical vein catheterization was done. Shortly Infectious Diseases went into distress and CPR was performed which proceeded to intubation of ETT and she was put on Mechanical Ventilator. Patient stayed on MV for 8 days. Further work up on patient's condition was done to evaluate presence of other congenital disorder and was diagnosed with PDA along with Anemia of prematurity. I/V Ibuprofen was given for closure of PDA. Patient's Hospital LOS was 57 days.

Neonatal Sepsis

CLINICAL SCENARIO	A 25 year old female, full term, Gravid 2, Para 2 was admitted to the hospital in OBGYN due to active labor uterine contractions every 5 min with increasing in intensity. She has a history of Group B Streptococcus infection during this pregnancy which was treated with antibiotics. Her labor progressed normal and she delivered vaginally a single live born male who developed a high grade fever shortly after birth. He looked irritable and was not feeding well. Spinal tap indicated Neonatal Sepsis (streptococcal) complicating into Streptococcal Meningitis. Newborn was admitted to NICU with principal diagnosis of neonatal sepsis and was started on antimicrobial therapy. Arterial catheterization and umbilical vein catheterization was done. His CBC was indicative of Thrombocytopenia and ABG's indicated Acidosis. His condition got worse and Patient developed difficulty in breathing and went into Respiratory failure and was put on Mechanical Ventilation. Patient stayed on Ventilator for more than 96hrs. Hospital LOS was 28 days.

Neonatal Hypoglycemia

CLINICAL SCENARIO	A term male infant was born after an uneventful pregnancy to a 28-year-old gravida 1 woman via C-section. She had no evidence of hyperglycemia and no chronic diseases. The infant had Apgar scores of 7 and 9 at 1 and 5 minutes, respectively. His growth parameters were in the normal range, with weight at the 60th percentile, head circumference at the 50th percentile, and length at the 50th percentile. The baby was taken to the well-baby nursery, examined and bathed, and then taken to the mother for nursing at about 2 hours of age. He appeared slightly jittery at that time and was not very interested in nursing or very aware. A blood glucose concentration of 1.39 mmol/L (25 mg/dL) was obtained using a One Touch® instrument. The baby was fed 25 mL of 5% dextrose in water. The blood glucose concentration obtained 1 hour later was 2.22 mmol/L (40 mg/dL), and the baby nursed for about 5 minutes at each breast with apparent satisfaction. Jitteriness and somnolence were improved. Circumcision on 2nd day of birth was performed and HEP B vaccination was given. Mother and infant were discharged from the hospital after 4 days.

Psychoses

CLINICAL SCENARIO	A 23 year old female was brought to the emergency department by local police officer because of her strange behavior complaint by her neighbors. They told police authority that she was playing loud music and bright lights for the last 10 days. Patient had symptoms of hallucination, insomnia and delusions. Her speech was disorganized with homicidal ideation. Her past history is indicative of such episode for which she was hospitalized 6 months ago and was treated with SSRI's. After her initial assessment she was admitted to the hospital with Principal diagnosis of Psychoses/ Bipolar 1 Disorder with Homicidal thoughts. Her secondary diagnosis was Naltrexone affecting ETOH, GERD, developmental disorder and conduct disorder. Her hospital LOS was 23 days.

ETOH Abuse

CLINICAL SCENARIO	A 35 year old male was hospitalized with principal diagnosis of Alcohol abuse and drug abuse for 1 year. He admits that he is suffering from excessive use of alcohol and alcohol dependency which is affecting his social life. He said, he is getting into violent behavior at work due to which he lost his job and unable to pay his bills. He admits that he has been doing binge drinking and consuming more than 5 glasses of hard liquor. He has a history of Attention Deficit Disorder for which he is seeing a doctor. Patient does not seem compliant with his medicines and said "he does not want to take them as they are no good to him". He has no significant surgical history. ROS was unremarkable other than mild constipation. His Mental Status examination reveals that he cannot perform serial 7 and demonstrate difficulty on recall of information. His Neurological examination is positive for intermittent carpal spasm of both extremities. On Abdominal examination liver was palpable. He was admitted in the hospital with principal diagnosis of Alcohol abuse and dependency. Patient denied any rehabilitation therapy. His hospital LOS was 10 days.

Substance Abuse

CLINICAL SCENARIO	A 35 year old male was brought to ED by his friends as he was found alone and irritable in his apartment. Patient complained of muscle cramps, diarrhea for one day and is feeling nauseated. He denied any vomiting. Patient acknowledged occasional use of heroin but denied that he is "hooked on it". His past medical and surgical history is insignificant. His temperature is 100.2 F; pulse is 90/min and BP is 150/90 mmHg. On CNS examination, his Pupils were dilated but are equal and reactive to light. He was restless and irritable but coherent in speech and showed no psychotic symptoms. His blood toxicology report came positive for Opiates and was admitted to the hospital with principal diagnosis of Opioid withdrawal/ Substance abuse without any major medical or surgical illness. He was started on detox therapy with Clonidine and other supportive medications for his GI symptoms. His hospital LOS was 30 days.

Depressive Neurosis

CLINICAL SCENARIO	A mother of an 18 year old girl brought her daughter to the Emergency department with the presenting complaint of severe nightmare and screaming in the middle of the night that woke her up. She said that this is the third time her daughter is having this incident in a row. Mother stated that her daughter was found in her room drenched in sweat and was shaking with tears. According to the patient she has been having nightmares more than a month and are getting worse since she had a bad subway incident 3 months ago. Patient stated that she found herself almost unconscious on a subway station after she was attacked by a man who physically assaulted her badly. Since then she is avoiding going through Subway even though it is a shorter route. Patient also admits that she is been feeling low in mood and not enjoying normal activities of daily life which she used to enjoy before like hanging out with her friends. She also said that she is having difficulty in concentrating in class and her grades in school have gone down. She admits that she feel worthless about herself and does not want to live and have suicidal ideation. Her mother also mentioned that her daughter does not follow her advice and their mother daughter relationship was never been good for several years. She was admitted in the hospital with the Primary diagnosis of Depressive Disorder/ Depressive Neuroses along with PTSD and Suicidal ideation. Her blood and urine test did not show any evidence of substance abuse. She was started on Anti-depressant, psychotherapy and Crisis intervention. Her hospital LOS was 7 days.

Respiratory Failure

CLINICAL SCENARIO	A 65 year old male walks into an emergency department with chief complaint of high grade fever with chills for 3 days, productive cough worsening since last night, and difficulty in breathing for 2 hours and recent development of state of confusion and agitation. He also complains that he is having difficulty in swallowing which started with solid food a month ago but recently it has been difficult for him to swallow liquids as well. His social history with CAGE questions is positive for Alcoholism. Past medical and surgical history is insignificant. On physical examination, his vitals were, RR was 35 breaths per minute, PO2 58mm Hg, O2 saturation was 92%, and pulse was 130 beats / min rapid and regular. His Chest X- Ray showed localized infiltrates. Spiral Chest CT was done and was indicative of bacterial Pneumonia. Sputum for gram staining and blood culture test was sent. Patient was admitted with Primary diagnosis of Pneumonia and was started on Ceftriaxone and Azithromycin. For dysphagia, Upper GI Endoscopy was performed which revealed Esophageal hemorrhage, Esophagitis and Esophageal stricture for which Esophageal dilation was performed during Endoscopy. After Endoscopy his condition got worse and he went into Respiratory failure and developed Encephalopathy. ETT was passed and Patient went onto Mechanical ventilation for 5 days. His Hospital LOS was 15 days.

Sepsis

CLINICAL SCENARIO	A 52 year old Native American man came to ED with chief complaint of increasing swelling and erythema of left leg from knee down, for 2 weeks. Patient stated that his leg swelling is getting worse. He denies shortness of breath and chest pain. His Past Medical HX is indicative of MRSA infection of skin a year back which was treated with Vancomycin. His Surgical HX was insignificant. On examination, his temperature was 101.1F. Local examination of his left leg showed swelling and erythema. Skin was warm to touch and moderately tender. There was a localized area of fluid collection. Duplex Ultrasound scan of the venous system of the leg was ordered which indicated no signs of deep vein thrombi. Patient was admitted to the hospital with diagnosis of cellulitis/ Leg Abscess. Incision and drainage of abscess was done and fluid was sent for culture and sensitivity. Patient was started on I/V Vancomycin. Culture report indicated MRSA cellulitis. During the course of stay in the hospital, Patient developed UTI with significantly decreased urinary output, abrupt change in mental status and shortness of breath. BUN and Creatinine were high and indicated Acute Renal failure. Patient was transferred to ICU where he developed severe sepsis. I/V crystalloid solution was infused immediately and EDGT was followed later. Patient hospital LOS was 3 days.

GERD

CLINICAL SCENARIO	A 55 year old Caucasian American female came to ED with chief complaint of chest pain for an hour. Patient states that pain started 2 hours after eating spicy food. She said pain is sharp in nature, 6 to 8 in intensity, localized non radiating sub -sternal in location which is relieved by sitting upright. Patient vomited 1/4th the size of cup vomitus which was mixed with blood and fluid 30 min before coming to ED. She denies having such pain episode in the past or bloody vomiting. She denies shortness of breath, difficulty in breathing, diarrhea or constipation. No evidence of other GI or cardiac symptoms. She also complaints of hoarseness of voice, sore throat and cough. Her past Medical/ Surgical History is indicative of HTN, hyperlipidemias for 8 years, CAD for 6 years; PTCA was performed 2 years ago. She has a history of CVA happened 4 year back which caused neurological deficit of right side of her mouth resulted into drooping of the corner of Right side of the mouth. She is been non-compliance with her medications lately. She denies drinking ETOH and drug abuse. She smokes ½ pack of cigarette per day. She has a family Hx of MI. On physical examination vitals were WNL. Cardiovascular exam showed S1 and S2 WNL, Regular rate and rhythm. No murmurs/rub/gallop sitting or supine. No JVD, PMI not displaced. No clubbing, edema. Carotid, Radial, DP and PT pulse NL and equal B/L. No Carotid Bruit. Abdomen was soft and non-tender on palpation. No hepatosplenomegaly found. ECG was done in the hospital which was normal with no signs of ischemia. CBC, CMP and cardiac enzyme Trop I were sent and result returned normal. Troponin I was ordered to be repeated at 6 hours. She was admitted in the hospital with primary diagnosis of GERD and observation for worsening symptoms leading to possible gastritis. Patient was discharged from the hospital with final diagnosis of GERD. She was started on PPI Omeprazole and life style changes were explained to her including quitting smoking. She was scheduled for follow up appointment in three weeks with her primary care. Her hospital LOS was 1 day.

Liver Transplant

CLINICAL SCENARIO	A 52 year old male came to ED with chief complaint of generalize malaise, fatigue and 4 episodes of bloody vomiting in last one hour. Patient is confused and lethargic. AUDIT (Alcohol Use Disorder Identification Test) done by his primary care is indicative of Alcohol abuse. He has low grade fever, tachycardia, yellow sclera, Ascites, flapping tremors, hepatosplenomegaly. His urine is dark in color and LFT'S revealed Liver failure. He was admitted to ICU with primary diagnosis of Alcoholic Liver Cirrhosis and Hepatic Encephalopathy/ Liver Failure. He was started on Glucocorticoids therapy and LFT's were repeated to evaluate his Liver status. He was considered for Liver transplant once his LFT's returned to normal and his status of being abstinence from ETOH was confirmed. Patient underwent Liver transplant and developed post-transplant peripheral edema and hematuria leading to post-operative Respiratory failure. Tracheostomy was done and Patient was put on Mechanical Ventilator. Patient's hospital LOS was 221 days.

Diabetic Ketoacidosis

CLINICAL SCENARIO	A 17 year old girl came to Emergency department with presenting complain of lower abdominal pain, dysuria, weakness and lethargy for 2 days. Her mother has noticed that her daughter's appetite has significantly reduced and is accompanied with nausea and vomiting. Patient's mother also states that she has noticed that her daughter is being very thirsty and using bathroom to urinate more frequently since 3 weeks. Her vitals show 100.0 F temperatures, BP 100/70 mmHg, pulse is 130/min, RR 32 breaths/min. On physical examination Patient seems ill appearing and lethargic. MSE shows that she is able to answer question with difficulty but appropriately. Her mouth shows dry oral mucosa, JVD not raised neck supple, PERLA and she has tachycardia. Her abdomen is tender on deep palpation with no organomegaly. Other systems examination was unremarkable. CBC, BMP, RBS. BUN and Creatinine, LP and toxicology was ordered. Results showed Electrolyte imbalance with acidosis and hyperkalemia. Her Blood glucose came 580mg/dl. All other test results were normal. Patient was admitted in Intensive Care unit with primary diagnosis of Diabetic Ketoacidosis. Treatment plan included I/V Insulin first then subcutaneous. Aggressive intravenous hydration with 0.9% normal Saline was started. Blood and Urine cultures were sent and antibiotics started for presumed sepsis. After 3 hours Patient is feeling much better with stable mental status. Her RBS went down and is now 220mg/dl. She was put on subcutaneous insulin and was switched to dextrose and half normal saline solution. Her feeding was started and labs for BMP were sent again which came normal. Patient was discharged from the hospital next day with final diagnosis of Diabetic Ketoacidosis and her follow up appointment was scheduled. Her hospital LOS was 2 days.

Acute MI (STEMI)

CLINICAL SCENARIO	A 68- year old male came to the ED with a chief complain of 1 hour severe, dull, sub sternal non radiating chest pain which is associated with shortness of breath. He denies diaphoresis, nausea and vomiting. Pain was not aggravated or relieved by changing posture. Patient states that pain started when he was helping his son moving some furniture in his apartment. ROS was unremarkable. He is hypertensive since 10 years and is on beta- blocker and is compliant with his medication. He denies any episode of chest pain like this one in the past. He does not drink alcohol or smokes nicotine. His father died at age 67 due to heart trouble. Vitals were WNL. Chest was clear to auscultation bilaterally with normal vesicular breathing. CVS examination shows Tachycardia, S1 and S2 WNL with no murmurs or gallop. No evidence of peripheral edema and no hepatomegaly. EKG was done and showed sinus tachycardia with 2 mm of ST elevation in leads V2 Patient Trop I and CK-MB was not elevated. Chest x-ray was normal and Pulse oximetry showed 99% O2 saturation. Patient was admitted to the CCU department with primary diagnosis of Acute MI and treatment with Aspirin, Morphine (if pain persists) Sublingual Nitroglycerin was started. Troponin I and CK-MB levels were ordered to be repeated and came elevated at 8 hr. Primary Angioplasty was performed with in 90 min of admission. Patient was sent home with ACE inhibitors after 5 days and scheduled for follow up appointment with Cardiologist.

Alcohol Withdrawal

CLINICAL SCENARIO	A 64 year old male with history of chronic alcoholism was brought to the emergency by the police, who found him agitated, combative and shouting at imaginary monsters. His past medical history is indicative of Bipolar 1 disorder for which he takes anti-psychotic. On examination his vitals were with in normal limits except temperature was 102.2F. Patient appeared agitated and sweating profusely with altered mental status and hallucinating. HEENT was normal except poor dentition and malnourishment was evident. Neck was supple and cranial nerves were intact. CVS examination was unremarkable except tachycardia. Neurological examination was non focal and no signs of external injury. Patient was admitted with initial impression of altered mental status. CMP, UA, blood cultures, toxicology screen, ABG's, vitamin B12 levels, Chest X-ray, LP and CT head were sent and all came normal except serum magnesium levels were low along with electrolyte imbalance indicative of dehydration. Patient was diagnosed with primary diagnosis of Alcohol withdrawal and was started on Chlordiazepoxide 50 to 100mg I/V X 4 to 6 hourly, I/V Thiamine and B 12, Clonidine and I/V D5N5 solution until hemodynamic status is stable. Patient was discharged to home after 11 days of hospital stay.

Subsequent MI &Viral Pneumonia

CLINICAL SCENARIO	A 58 year old male was brought to the emergency department following a Sub-endocardial Myocardial Infarction two weeks ago with chief complaint of persistent cough for 1 week, difficulty in breathing, chest pain during inspiration and fever with chills for one week. His past medical history indicates that he was hospitalized two weeks back due to MI and was treated with medications with no surgical intervention. On general physical examination, Patient shows signs of acute respiratory distress and chest auscultation revealed bilateral basal rales. Patient was admitted to the hospital and chest X-ray and Chest CT and CMP were sent which were indicative of Viral Pneumonia as primary diagnosis. Patient was started on supportive treatment. His hospital LOS was 4 days.

Asymptomatic HIV

CLINICAL SCENARIO	A 47 year old female who is recently been diagnosed with HIV Positive status came to the clinic for initial evaluation. She has no medical problem and currently is not on any medication. Her initial tests and their results showed CD4 count 700 cells/µL PCR –RNA viral load was 50 copies/ml and PPD skin test with 4mm in duration. She has no significant symptoms indicative of HIV manifestation. Her vitals and examination including pelvic examination was normal with no evidence of opportunistic infections. Initial diagnostic test panel including VDRL, Toxoplasmosis antibody, Pap smear and HEP A, B, and C serology were ordered and results were normal. She was diagnosed with Asymptomatic HIV positive status and was scheduled for a follow up visit.

HIV with LTBI

CLINICAL SCENARIO	A 42 year old male who is been diagnosed with HIV positive a year ago came to clinic for his follow up appointment. His past medical HX is devoid of any HIV related manifestation. He does not have any major chronic illness and currently he is not on ART. He is a chronic I/V drug user and recently visited India. His recent labs done prior to this visit indicated remarkable CD4+cell count dropped from 600 to 200cell/µl, PCR-Viral load has increased and is now 150,000. PPD skin test came positive with 8mm induration. Patient does not have any signs and symptoms of active TB. Chest X-ray was done which did not show any signs of active TB. Patient was diagnosed with LTBI (Latent Tuberculosis Infection) with stage 2 HIV infection. Base line LFT before the start of NPH was ordered which came normal. He was started on INH 300mg/d for 9 months with pyridoxine along with ART. Educational materials and side effects with ART were discussed with patient. LFT was ordered and patient was scheduled for follow up visit with labs.

Community Acquired Pneumonia

CLINICAL SCENARIO	A 77 year old male presented in ED with an episode of shaking chills last night. Since then, he has developed high grade fever, profuse sweating, malaise, and pleuritic chest pain moderate in intensity. He also had moderate productive cough with purulent sputum and one episode of hemoptysis. His past Medical history is unremarkable except that he has Osteoarthritis since 5 years for which he takes NSAIDS. He took Tylenol for fever 4 hours back. His social history reveals that he is been smoking for 30 years ½ pack per day. His Vitals showed temperature 103.3F, BP 90/60, pulse 106/min and respiratory rate 32 breaths/ min. The patient is diaphoretic but alert, his lung auscultation reveals right lower basilar rales. His skin is moist and neck is supple with no lymph adenopathy. Examinations of other systems were unremarkable. Patient was admitted to the hospital and Labs including Chest-x ray PA view and Decubitus view were sent along with CBS, blood culture, Sputum Gram staining and Culture. Chest x-ray showed right lower lobe infiltrates with blunting of costophrenic angle and decubitus X-ray of chest showed pleural effusion. Patient was diagnosed with community acquired pneumonia, drainage of paraneumonic effusion was done via placing a chest tube and patient was started on intravenous antibiotics. Patient hospital Los was 5days.

Chronic Otitis Media

CLINICAL SCENARIO	A 4 year old girl with history of chronic Otitis Media of both ears with bilateral hearing loss was admitted to the hospital for bilateral Myringotomy and drainage tubes placement in both ears. Patient has a history of recurrent Otitis Media which has caused a significant hearing loss, slowed speech development and decreased school performance. Review of systems is unremarkable. Patient's immunization is up to date. She does not have any developmental problems. Under general anesthesia both ears are prepped and the tubes are inserted into the opening of the tympanum in each ear. Patient recovered fully with no post-operative complication. Hospital LOS was 2 days.

Down's Syndrome

CLINICAL SCENARIO	A 1 year old female infant with Down's syndrome with Translocation trisomy 18 was admitted to the hospital for a surgical closure of severe persistent patent ductus arteriosus (PDA). Patient was diagnosed with PDA at the time of birth and was put on medication until surgery. Patient's symptoms have not shown significant improvement and recent Echocardiogram revealed large size PDA running between Aorta and Pulmonary Artery with biventricular hypertrophy. A Surgical ligation of the ductus arteriosus by a right thoracotomy was performed under general anesthesia. A chest tube was inserted and remained for 24 hours post operatively. There were no post-operative complications and patient recovered fully from surgery. Hospital LOS was 4 days.

Insertion of Pacemaker

CLINICAL SCENARIO	A 65 year old male was admitted to outpatient surgical department with primary diagnosis of Mobitz II advanced second degree AV block with wide QRS complex (as per most recent ECG) for insertion of Pacemaker. Patient has a history of bradycardia and 2 episode of syncope in last 4 months. He had a transvenous insertion of the permanent dual chamber pacemaker, which was performed successfully. Patient recovered completely without any complications from surgery. He was given post-surgical care advice and his follow up appointment with cardiologist was scheduled.

Colles Fracture

CLINICAL SCENARIO	A 65 year old woman was brought to the emergency department with injury to her left wrist with an excruciating pain. According to patient she was coming down the stairs in her house when she tipped over and lost her balance which resulted in a fall from the last step. She fell with her left arm in outstretched position. Her left wrist looks deformed, red in color with moderate to severe swelling and painful to touch. Pain intensity is 8/9 on a scale of 10. She has restricted movement at her left wrist. Patient is oriented in time, place and person. There is no evidence of any other site of injury. X ray of left forearm including elbow joint and left hand with both views at $90^{o}$to one another were ordered. X- Ray revealed main lesion dorsally displaced dorsally angulated fracture of the left distal radius. Patient was given pain medication and her arm was stabilized. Close reduction and long arm cast was applied to her left forearm. An instruction for the care for her cast was given and follow up appointment was scheduled.

Fracture of Hand

CLINICAL SCENARIO	A 22 year old male came to ER with severe pain and swelling over his right hand. He had a fist fight an hour ago at a local Bar and sustained an injury to his right hand. There are no open wounds, his right hand knuckles showed moderate to severe swelling, redness and pain on palpation. ROM at 4th and 5th right metacarpal bone was restricted and tender. X –Ray of right hand, distal end of right arm including right wrist joint was ordered which revealed 4th and 5th right metacarpal neck fracture with angulation of 30^{o}. Fracture was reduced by closed reduction at 4th and 5th right metacarpal bone and Ulnar Gutter Splint was applied for immobilization. Patient was given Ibuprofen for pain and follow up visit was scheduled.

CLINICAL SCENARIO	A 52 year old Caucasian American female admitted to the hospital for CA breast surgery. She is diagnosed with stage II invasive ductal carcinoma in retro alveolar region of the left breast which is estrogen positive as per Excisional biopsy report. Her Sentinel Lymph node biopsy showed three out of twenty lymph nodes positive for cancer. Her FNAC and mammogram reports were also persistent with the diagnosis. Modified radical mastectomy of left breast with left axillary lymph node dissection was performed. Patient recovered fully without any postoperative complication. Her hospital LOS was 2 days.

Hypertension Followup Office Vi

CLINICAL SCENARIO	A 54 year old Caucasian American male came for an outpatient office visit with complaint of dry cough for six months. His cough is affecting his sleep and performance at work. There were no aggravating or relieving factors related to cough. He was diagnosed with hypertension six months ago for which he takes Lotensin (ACE Inhibitor). He has a history of type II Diabetes without any complications for one year for which he takes Metformin. Patient's family history is significant as his father had a heart attack at age 55. He is a social drinker and occasionally smokes cigar. His ROS was unremarkable. His vitals are WNL with BP 120/65 mmHg. PT has normal vesicular breathing on chest auscultation with no added sounds. CVS- S1, S2 WNL regular rate and rhythm, no murmurs sitting and supine. No raised JVD and no signs of peripheral edema. The patient was diagnosed with dry cough resulting from ACE inhibitor as a drug side effect. Lotensin was discontinued and he was started on Diovan (ARB).

Rheumatoid Arthritis

CLINICAL SCENARIO	A 35 year old female came to the physician's office with a chief complaint of pain in both of her hands for the past one year. She takes OTC NSAIDS and Acetaminophen for pain relief. The pain began in several metacarpophalangeal (MCP) joints of hands with thumbs especially affected. The pain is getting worse and is now affecting metatarsophalangeal (MTP) joints of both feet. She has difficulty moving the joints when getting out of the bed in the morning or after staying in one position for too long. The pain is worse in the morning and gets better over the course of time during the day. Past medical and surgical history is insignificant. Her OBGYN HX is normal, she is P0G0 with regular flow 28 day cycle and normal Pap test result. Physical Examination of Musculoskeletal System showed swelling of several small joints in each hand and foot symmetrically, palpation over the swollen joints felt boggy and indicative of overgrowth of the synovial lining, decreased in grip strength in both hands. The skin did not show any nodules. Chest auscultation revealed dullness and decreased breath sounds on left base of the lung. Her lab results showed ESR 68mm/h, CRP elevated, Anti CCP positive. X-ray of right and left hand showed normal joints. Pleural effusion on left base of the chest was evident on Chest X-ray. The patient was diagnosed with Rheumatoid Arthritis and started on a low dose of prednisone and Methotrexate. The patient was advised not to become pregnant while on Methotrexate as it is teratogenic and continue on NSAIDS for pain. She was scheduled for a follow up visit.

Implantable Loop Recorder Follo

CLINICAL SCENARIO	A 58 year old Caucasian American male presented to the cardiology clinic for his six month follow-up visit regarding Interrogation device evaluation of Implantable Loop Recorder (ILR). He was implanted with ILR six months back due to multiple unexplained episodes of syncope/collapse affecting his daily activities. He complains of feeling, of discomfort with mild retrosternal pain at the implantation site of the device. Heart rhythm derived data analysis along with review of connection and recording was performed. The device was checked for battery depletion indicator function. There were no signs of pocket infection or skin irritation over the insertion site. Everything related to device functionality was normal. The patient was reassured and safety measures were discussed again along with training tips for recording events. Patient was advised to continue using OTC pain medication on as needed bases for pain. He was scheduled for his next follow up appointment.

OCP prescription

CLINICAL SCENARIO	A 21 year old female came to the family planning clinic for questions regarding contraceptive options and initiation of OCP. She has been using diaphragm as a contraception method, however she is worried about contraceptive failure rate. She is G0P0 and complains about having heavier menstrual cycles than in the past with mild dysmenorrhea. She has a 28 day cycle which is regular with moderate to heavy flow and last for 5 days. Her LMP was 2 days ago. She also complains about vaginal itching and burning during intercourse. She has been sexually active with one partner for 2 years. Her pap test was normal. She is a nonsmoker. ROS was unremarkable. Speculum examination showed a curdy white vaginal discharge. Wet Mount microscopic examination showed pseudohyphae on KOH prep. The patient was diagnosed with Vaginal Candidiasis. Vaginal cream was prescribed for application. Different contraceptive options were discussed along with their failure rate. The patient was interested to take oral Contraceptive pills. She was prescribed combination OCP. Withdrawal bleeding along with the method of administration was explained to the patient.

Type II DM(Uncomplicated)

CLINICAL SCENARIO	A 55 year old male came to the office for a follow up visit for type II Diabetes (uncomplicated) diagnosed 5 years back. The patient denies any active problem. His FBS and RBS levels checked at home with blood glucose meter were within normal range. His HbA_1C done 6 months back was 6.5%. He denies any episode of hypoglycemia, constipation, loss of sensation in hands or feet, vision problems and weight changes in last six months. He is on oral hypoglycemic medication (Metformin) since 5 years and is compliant with his medication. The patient is active and walks 15 min a day. He is adhering to diabetic diet and denies any erectile dysfunction. On physical examination, vitals were within normal limits. Fundal eye exam was normal with no diabetic retinopathy. Peripheral pulses were intact and palpable equally and bilaterally. His monofilament test was also normal. Patient's most recent Lipid Profile and Urine microalbumin were within normal limits. HbA_1C was ordered to check patient's glycemic index and patient was advised to schedule a dilated eye exam from an ophthalmologist.

Hypothyroidism

CLINICAL SCENARIO	A 48 year old woman presented to the clinic for a follow up visit of Hypothyroidism management which was diagnosed 6 weeks ago. She was put on long term hypothyroid treatment with synthroid (Levothyroxine) replacement therapy which she takes once daily. She feels more energetic than before and her constipation has resolved. Her weight has decreased 6 lb (2.5Kg) since last visit. Her pulse rate is now 65 beats/ min and her BP is 134/78 mmHg; and her temperature is 97.4. The patient is compliant with medication and no side effects from medication notified. No alteration in Levothyroxine dose was made. T4 and TSH levels along with CMP were sent to lab. The patient was advised to continue taking medication daily and her next follow-up visit in 8 weeks was scheduled.

Hyperlipidemia Follow-Up Visit

CLINICAL SCENARIO	A 54 year old man, who was diagnosed with Hyperlipidemia 6 months ago for which he was recently started on Atorvastatin, comes for an office visit for a follow-up appointment. He also has type II DM for 1 year and was placed on Metformin and Sulfonylurea, which controlled his glucose level most of the year. He is an adherent to his medication. The patient denies any muscle pain, feeling of tiredness, fever or change in urine color. His FBS and RBS readings are within normal range. He denies any episode indicative of hypoglycemia. On physical examination, vitals are WNL, CVS examination and neurological examination was WNL. Fundal eye exam was normal without any diabetic retinopathy. The patient was advised to reduce alcohol intake, start walking every day for 15 to 30 min and restrict diet high in fat. His HbA1C, Lipid Profile and urine micro albumin were ordered and sent to the lab. The patient was scheduled for the next follow up visit.

End-stage Renal disease

CLINICAL SCENARIO	A 69 year old woman presented in clinic for routine care of End -stage renal disease for 5 years and is on dialysis since last year. She had her most recent dialysis procedure 6 weeks back. Patient complains about generalized musculoskeletal pain, moderate in intensity which is relieved by taking Opioids. She also has secondary Hyperparathyroidism and Anemia of chronic disease due to End-stage renal disease. Her past medical history is significant as she has Hypertension for 12 years and diabetes for 8 years. She is currently receiving the calcium replacement, vitamin D, oral phosphate binder and erythropoietin for her renal disease. She takes Lisinopril, Nifedipine, Sitagliptin and Glyburide for HTN and DM. Her review of systems revealed mild generalized bone pain. She denies any abdominal pain, altered bowel habits, loss of interest in daily activities and a feeling of worthlessness. Her vitals are within normal limits and no signs of erythema or edema noticed around AV fistula site. Her medications and their dosages were evaluated. No new medication was added nor was any alteration in dosage made. Lab orders for AST and ALT levels in blood, BUN and creatinine and lipid profile were sent. The patient's current health condition was discussed and she was advised to consider advance care directive. She was scheduled for her next follow up care appointment.

Carpal Tunnel Syndrome

CLINICAL SCENARIO	A 43 year old woman presents to the physician's office with painful burning and tingling sensations in her right hand. She works as an administrative assistant at a local salon. She has recently noticed an inability to grasp her coffee mug from her right hand due to intense pain. Her symptoms get worse at night. Shaking her right hand and wrist alleviates the symptoms somewhat. She also complains of tingling in her right lateral fourth and fifth fingers of her hand. Her past medical history is insignificant and ROS revealed a feeling of hotness in her hands. Physical exam showed tingling in right hand induced after 90 seconds of flexing the wrist. Phalen and Tinel signs were positive. The patient was diagnosed with Carpal Tunnel Syndrome of right hand. Conservative management with wrist splint was prescribed. The patient was advised to wear a wrist splint with her hands in a neutral position. Other treatment options such as steroid injections and surgery were discussed which can be considered if the patient does not feel better with wrist splint. She was scheduled for a follow-up visit in 4 weeks.

Strep Throat Infection

CLINICAL SCENARIO	A 28 year old male school teacher came to clinic with chief complain of sore throat since 3 days and fever for 2 days. She has 6/10 intensity throat pain which hurts more when she swallows anything. She denies any cold symptoms. Her fever started 2 days ago, stays between 100.9^{o}F to 100.1^{o}F without chills and night sweat and accompanied with headaches. She takes Acetaminophen 200mg 2 tabs X 6 hourly for headaches and fever. She gets some relief in symptoms after taking medicine. She denies any recent travel and GI problems. She notified that there are few students in her class and one teacher who recently got diagnosed with Strep throat. Her ROS was insignificant. Past medical and surgical history was insignificant. Denies drug and food allergies. VS WNL except temperature 100.3 F. HEENT examinations showed Pharynx red with swollen tonsils with white patches on it. The neck was supple with no lymphadenopathy. The rapid Strep test was done and cultures were sent. RST came positive, the patient was diagnosed with Streptococcal throat infection and Amoxicillin was started.

Screening for Colorectal Cancer

CLINICAL SCENARIO	A 51 year old male came for his scheduled colonoscopy for screening of colon cancer in the hospital. The patient denied any rectal bleeding, dark colored stool, constipation, decrease in the caliber of stool and altered bowel habits. His yearly occult blood testing was negative. This is his first colonoscopy. His Past Medical History has been indicative of HTN for 5 years, which is well controlled with medicine. His surgical history is insignificant. His Family HX is indicative of Colon Cancer in first degree relative diagnosed at age 60. He never smoked and is a social drinker. Colonoscopy was performed under deep sedation, no biopsies were sent nor any abnormal findings or growth notified on Colonoscopy. The patient was sent home the same day after 4 hours of observation with pain medication.

RT Hemicolectomy of Colorectal

CLINICAL SCENARIO	A 55 year old African American male was admitted to hospital for a surgical procedure “Right Laparoscopic Hemicolectomy” as he was diagnosed with right sided mucinous subtype Adenocarcinoma of the colon. Abdominal barium study was performed pre-operatively to delineate the primary lesion. The patient also had a CT scan of Abdomen and Pelvis for the purpose of staging of cancer. He was diagnosed with stage II Adenocarcinoma of the right side colon and Right laparoscopic hemicolectomy was performed under general anesthesia. The patient recovered fully postoperatively without any major post-operative complications. Patient’s hospital LOS was 6 days.

Spinal Cord Injury

CLINICAL SCENARIO	A 22 year old male college student was hospitalized following a motor vehicle accident in which he sustained a C6 vertebral fracture leading to incomplete spinal cord injury (Acute) at C5 and C6 level. Diagnosis was confirmed by CT scan (whole body). He sustained this injury while the car he was driving collided with another car with an approximate speed of 50 miles/hour. 48 hours after admission patient went for surgical procedure “Open approach anterior decompression cervical laminectomy”. Subsequent MRI of the head and Neck was performed post operatively which was negative for hematoma. His hospital LOS was 7 days.

Asthma Office Visit

CLINICAL SCENARIO	A 21 year old male came to Physician's office with a chief complaint of wheeze during breathing, SOB and Dyspnea for 2 days accompanied with intermittent dry cough which is worse at night. He noticed that cold weather and exercise are the aggravating factors for wheeze and cough lately. His wheeze gets worse at night that has interrupted his sleep and woke him up multiple times this month. He stated that he has never experienced such symptoms before. He took some OTC cough and cold medications for his current condition but did not see any improvement. He does not have a fever. The patient had Upper Respiratory Infection 1 months ago for which he was prescribed antibiotic. His Past Medical history indicates childhood Asthma mild in nature managed with medications and resolved at age 16. He denies any hospitalization and surgery in the past. His family history is positive of Asthma in first degree relative. Vital signs are WNL. On Physical Examination, patient's general appearance is lethargic with no obvious signs of respiratory distress. Auscultation of chest showed generalized coarse breath sounds bilaterally in all fields of lungs but no distinct rhonchi. O2 saturation was WNL on pulse Oximeter. Office Spirometry showed FEV1= 65%. Chest X-ray was ordered which came normal. CVS and Abdominal Examination was WNL. The patient was given Albuterol via nebulizer and FEV1 after nebulizer was 80% and his chest was clear on auscultation with normal breath sounds bilaterally. The patient was diagnosed with the primary diagnosis of Extrinsic Asthma and education regarding his condition along with the use of inhaler was given. He was prescribed with Albuterol Inhaler as needed basis. Follow up appointment was scheduled for further evaluation of his current condition and management.

Insertion of Intra Uterine Cont

CLINICAL SCENARIO	A 34 year old multipara woman came to fertility clinic for a scheduled visit of insertion of intrauterine contraceptive device. She visited the clinic two weeks back to discuss long term contraception options and decided to get IUCD. Her OBGYN history reveals that today is her 2nd day of menstruation; her menstrual cycle is 5/29 days, it is regular with moderate flow and mild dysmenorrhea. All her previous pregnancies were vaginal deliveries without any pre and post natal complications. Currently she does not complain of any vaginal discharge. Her past medical and surgical history is insignificant. She does not have a history of PID nor STD. She is currently not taking any OCP and use condoms for contraception. She is a non-smoker and social drinker. She has been in a monogamous relationship for more than 15 years. Her family history is devoid of any malignancies and fibroids. Her urinary Beta HCG levels done a week ago came negative. General physical and pelvic examination was unremarkable. The patient took 600mg NSAIDS before the procedure. Side effects related to IUD were discussed with the patient. Under sterile conditions Levonorgestrel-releasing intrauterine device (52 mg) was inserted into the uterine cavity. The patient was instructed on how to locate a thread to verify the location of IUD after each menstruation and immediately contact physician's office in case of failure to locate the thread. The patient was advised to contact office in case she experiences excessive vaginal bleeding, fever, vaginal infection or any complication from procedure.