Case Study: Adult with Multiple Sclerosis

1. CASE AUTHORS

Name
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2. TOPIC OF THE CASE:

Adult with Multiple Sclerosis

3. LEVEL OF EXAMINEE THIS CASE IS BEING WRITTEN FOR:

[X] Nurse Practitioner

4. CATEGORY OF CLINICAL PROBLEM THIS CASE ADDRESSES:

[ ] Acute Serious
[ ] Acute Limited
[X] Chronic Subacute
[ ] Psychiatric/Behavioral
[ ] Well-Care/Prevention
[ ] Other:

5. PURPOSE OF THIS CASE:

[X] Teaching **[X] Assessment** **[X] With Feedback**

6. TIME ALLOTTED FOR ENTIRE TASK (includes SP/examinee encounter + interstation activity):

FIFTEEN MINUTE STATION W/SP + 5 MIN INTERSTATION

7. DISTRIBUTION OF TIME AND TASKS

Divide time allotted into tasks required of the examinee:

Check off skills this case is intended to evaluate or teach:	Estimate # min you believe examinee needs to perform each task:	
[X] Data Gathering (History-Taking)	5	min.
[X] Education	2	min.
[X] Physical Examination	5	min.
[X] Advise Patient of Diagnosis	2	min.
[X] Feedback from SP	5	min.

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8. FACILITY/ROOMS RESERVED FOR THIS ACTIVITY:

[X] Clinical Learning Lab/ SP Rooms
[ ] Seminar Rooms
[ ] Auditorium
[ ] Campus
[ ] Other:

9. INTERACTION FORMAT:

Participants

[X] With SP Feedback
[X] With Videotape
[X] 1 Trainee, 2 SP (1 Adult and 1 Adolescent)

10. SETTING OF THE INTERACTION:

[X] Nurse Practitioner Care

11. FURNISHINGS IN THE EXAM ROOM:

[X] Desk, Chairs, and Exam Table

EQUIPMENT/PROPS IN THE EXAM ROOM:

[X] X-Ray View Box
[ ] X-Ray Calipers
[ ] Reflex Hammer
[X] Stethoscope
[ ] Tuning Fork
[ ] Neuro Exam Kit
[ ] Cardiac Monitor
[ ] Roll Board
[ ] I.V. Pole + Solution
[ ] Crutches
[ ] Collar - Type:
[ ] Other:

EQUIPMENT/PROPS AT THE STUDENT CARRELS:

[ ] X-Ray View Box
[ ] X-Ray Calipers
[ ] Other:

12. LIST POSSIBLE DIFFERENTIAL DIAGNOSES (asterisk actual diagnosis):

*Multiple Sclerosis
Musculoskeletal Strain
*Health Maintenance
Cardiac Disease (HTN Tachycardia)
Pain*

13. PHYSICAL CHARACTERISTICS THE ACTUAL SP SHOULD HAVE:

Gender:	[ ] Male	[X] Female		[X] Immaterial
Age:	Range 40-50			[ ] Immaterial
Race/Ethnicity:				[X] Immaterial
Body Type:	[X] Slender	[ ] Average	[X] Overweight	[ ] Immaterial
Ideal Height/Weight:				[X] Immaterial

14. ESSENTIAL "REAL" PHYSICAL FINDING(s) OR ATTRIBUTES THE SP SHOULD HAVE:

None, but will need to be in a wheelchair.

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15. PHYSICAL FINDINGS THE SP SHOULD NOT HAVE:
N/A

16. PHYSICAL EXAM REQUIRED:

[X] Abdominal	[X] Cardiac	[X] Respiratory
[X] Skin	[X] Musculoskeletal	[X] Neuro

17. CASE REQUIRES THE SP TO SIMULATE THE FOLLOWING PHYSICAL FINDINGS:
[X] Wheelchair Bound
[X] Middle and lower back pain

INSTRUCTIONS FOR THE EXAMINER

CASE INFORMATION: Patient is a 48yo female who is well known to your practice. She was diagnosed with relapsing progressive MS in 2004. *She is here today for routine health maintenance visit and because her sister was recently diagnosed with breast cancer*. Her MS is managed by a local Neurologist and she sees a Pain Management team. She is scheduled to see the pain team today. VS afebrile-112-24-164/78

Chief complaint: Pain and burning on urination and fever x 3 days

DURING THE ENCOUNTER:
[X] Obtain a focused and relevant history
[X] Perform a focused and relevant physical exam
[X] Offer some initial recommendations to the patient and parent (see NOTE immediately below)

The task in this case is to look at and facilitate health maintenance of a 48yo female.

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STANDARDIZED LIFE SKETCH

18. **Setting of Encounter: NP Office**
    SP: Seated in wheelchair in exam room fully clothed
    The Mother SP is sitting in waiting room.

EXAMINER WASHES HANDS ON ENTERING EXAMINING ROOM

19. **What do you want the SP to say to the examinee's first query:**

    SP: ***"There is so much going on with my family, I need to get checked out."***

20. **IF THE EXAMINER REMAINS SILENT, or acts as if waiting for more information, or asks an open-ended question:**

    SP: ***"I'm really nervous, my little sister was diagnosed with breast cancer a few months ago and I haven't had a mammogram or GYN exam in YEARS."***

A. HISTORY OF PRESENT ILLNESS/DIMENSIONS OF SYMPTOMS:

21. **Expand on your history and characteristics of major symptoms from onset to present in the form of a time line; *if pain, please include*: onset, duration, location, quality, radiation, intensity, exacerbating, alleviating, past experience w/symptom(s).**

    History given by SP:

    SP: ***"My last mammo was in 2009 and last GYN exam/PAP in 2008."***

    IF THE EXAMINER ASKS: ***"Why has it been so long since your last exams?"***

    SP: ***"I have been a little busy with my MS."***

    IF EXAMINER ASKS: ***"How are you feeling physically?"***

    SP: ***"I am in a terrible amount of pain today but am headed to the pain doctor when I leave here."***

    IF THE EXAMINER ASKS: ***"When did the pain get worse?"***

    SP: ***"About 3 days ago."***

    IF THE EXAMINER ASKS: ***"Where is the pain? Can you describe it?"***

    SP: ***"Middle and lower back spasms."***

    IF THE EXAMINER ASKS: ***"Was your medication working well until 3 days ago?"***

    SP: ***"Yes."***

    IF THE EXAMINER ASKS: ***"When do you see your Neurologist again?"***

    SP: ***"I have an appointment in a month but can call if I need to be seen sooner."***

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IF THE EXAMINER ASKS, SP RESPONDS TO THE FOLLOWING QUESTIONS:

Insomnia:

SP: ***"Yes."***

Fatigue:

SP: ***"Yes."***

Pain anywhere else:

SP: ***"No."***

Changes in vision:

SP: ***"Yes, increasingly blurry."***

Self breast exams:

SP: ***"No."***

Sexual activity:

SP: ***"Yes. I am in a monogamous relationship."***

Last menstrual period:

SP: ***"2 weeks prior."***

Bowel patterns:

SP: ***"No change, use suppository every 3 days or so for chronic constipation."***

Appetite:

SP: ***"Poor secondary to pain."***

Bladder problems:

SP: ***"Straight caths 3x day but becoming tougher because of loss of dexterity."***

Musculoskeletal/Neuro:

SP: ***"Increasingly difficult to transfer by herself and cannot stand without assistance."***

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22. **IF THE EXAMINER ASKS about exercise:**

    SP: ***"I go to PT 2 days a week when my insurance company will pay for it."***

    IF THE EXAMINER ASKS: ***"How long have you been in a wheelchair?"***

    SP: ***"I would guess it has been all the time for about 4 years."***

23. **Psychosocial consequences: How does the problem influence or affect the pt?**

    IF THE EXAMINER ASKS:

    SP: ***"It is really frightening…first the MS now this scare."***

24. **Response to symptoms: What has the patient done about the symptoms (other than seeking health care)?**

    IF THE EXAMINER ASKS:

    SP: "I just keep trying."

25. **Meaning of the illness: patient's ideas/feelings about causes, implications, fears about problem/illness?**

    SP: ***"I wouldn't wish this on my enemies."***

B. PAST MEDICAL HISTORY: HISTORIAN: SP

26. **Medical:**

    MS with neurogenic bowel and bladder (2004)
    Perimenopausal (symptomatic)
    Osteoperosis
    Right hip fracture s/p fall (2009)

27. **Surgical:**

    Right THA (2009)
    Implantable Pain Pump (2011)
    Colposcopy-no dysplasia (2005)

28. **Chief Complaint:** ***"I need to get checked out."***

29. **Allergies:**

    SP: ***"None that I know of."***

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30. Medications:

MVI 1 po qd
Calcium with D 600/400mg 1 po q 12h
Boniva 150mg po q month
Baclofen pump (per pain management) 400mcg IT qd
Gabapentin 200mg po q8hrs
Copaxone 20mg sq qd
Senna tabs 2 tabs po q12hrs
Miralax 17g po qd
Estradiol/norethindrone 0.5/0.1mg 1 po qd
Straight caths for self caths q8hrs

D. FAMILY HISTORY:

31. Current and past health of parents, sibs, adolescent:

Mother: alive, 69yo, breast cancer 2009
Father: alive, 70yo
Sister: 38yo breast cancer 2011
Son: 13yo. No health issues

32. Deaths: dates and age at death of family members:

SP: ***"Oh, I don't know but I think my mom's mom had breast cancer too."***

E. PSYCHOSOCIAL HISTORY

Present/Past:

33. Marital status:

Divorced, single mom w/ 13yo son. Has boyfriend of 3 years.

34. Home Environment:

Lives in ground floor apartment of a duplex, her parents live upstairs.

37. Tobacco/alcohol/illicit drug use?:

SP: ***"No."***

38. Significant events in pt's life: stresses, pleasures, death, divorce, financial hardships?:

I spend a lot of time home alone, busy with my son and helping organize his life. Thank goodness for my parents. Unemployed. Unable to drive. Gets social security disability plus help from her ex-husband.

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39: Employment:

Unemployed

F. MENTAL STATUS EVALUATION

42. Past psychiatric history?

No.

43. Anxiety?

Yes.

44. Mood changes?

No.

45. Memory or cognitive changes?

No.

46. Disturbing thoughts or ideas?

No.

47. Other?

No.

G. FUNCTIONAL STATUS:

49. Pt able to take care of daily activities? (school, dressing, washing self?)

SP: ***"I can but I need more and more help because it is all just so hard and I am so slow."***

H. OTHER:

50. Other than HPI, any other medical/psychosocial problems the pt is currently facing?

SP: ***"No."***

51. What is your biggest worries/main concerns?

Parent SP: ***"Make sure I don't have any cancer either."***

52. Patient expectations: what does the patient expect/want from health care provider?

SP: ***"Help getting tests done."***

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53. Adolescent SP Appearance: clothing, grooming, etc. (ex: neat, disheveled, in hosp. gown, etc., or: clothing and/or appearance unimportant to the case)?

Fully dressed in wheelchair neat and well put together.

54. Affect/Behavior: body language, mannerisms, eye contact, angry, sad, talkative, nervous, happy to see NP today?

Anxious.

55. Do any questions posed by the examinee change the SP's appearance or affect (disturb either of the SPs or make either sad, fearful, reassured)?

No.

56. Creating empathic opportunities: what do you want the SP to say, or what kind of behavior would create an opportunity in this case, for the examinee to express empathy?

You are right. Your sister is young and combined with your family history, you have a right to be concerned.

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SKILLS PERFORMED

1) Addresses patient
2) Assists patient into gown and onto exam table
3) Takes adequate health history
4) Inspects pt head to toe
5) Completes following exams:
    a. Neuro
    b. Cardiac
    c. Respiratory
    d. Breast
    e. Abdomen
    f. Musculoskeletal
    g. Skin

CONTENT CHECKLIST

Category 1. Data gathering. I TOLD THE EXAMINER or /THE EXAMINEE ASKED ABOUT:

1) Past medical and psycho-social history from parent and adolescent
2) History of present chief complaint including onset and duration
3) Management of problem
4) Immunizations
5) Diet and activity
6) Allergies
7) Medications
8) Behaviors
9) Living environment
10) Management of CP - (therapies, home management)

PHYSICAL EXAM EVALUATION: did the examinee perform:

[ ] Head to toe inspection
[ ] Neuro exam
[ ] MSK exam
[ ] Cardiac exam
[ ] Respiratory exam
[ ] Breast exam
[ ] Abdomen exam
[ ] Skin exam

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SKILLS CHECKLIST

I. DATA GATHERING SKILLS

Did the examinee …

1) Provide a safe environment for the adolescent?
2) Allow the SP to finish opening statement without interruption?
3) Get the chronology of the present concern from the beginning until now?
4) Use "open-to-close cone" question style?
5) Repeat or summarize information I've given at least once?

II. INTERPERSONAL SKILLS

Did the examinee…

6) Offer encouraging, supportive or empathic comments?
7) Demonstrate attentive listening?

III. INFORMATION GIVING SKILLS

Regarding the parent SP: Did the examinee…

8) Explain reasons for recommendations?
9) Ask about barriers to adherence/testing? Mammo for wheelchair dependent female? GYN office that is handicap accessible?
10) Check my understanding at least once and/or solicit the parent's questions?
11) Use language I can understand?

IV. ORGANIZATIONAL SKILLS

Did the examinee…

12) Demonstrate organizational skills during the entire encounter?

V. PATIENT SATISFACTION

13) Overall, I was satisfied with this NP/patient interaction

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