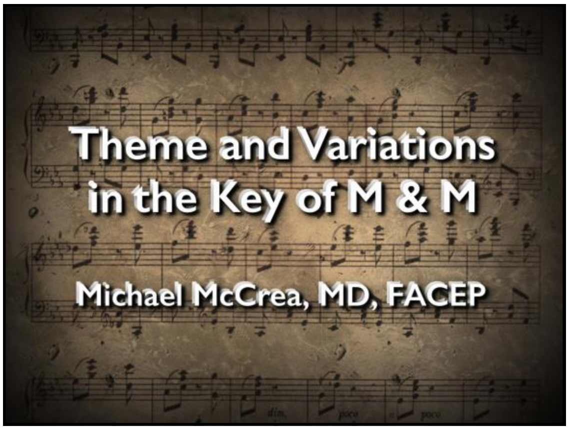

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Case #1

5

HPI and PEx

- 47 yom left ankle pain after "jumping over a fence"
- Ambulatory despite significant pain
- Documented
  - Intact pulses and sensation
  - Tenderness over Achilles tendon with discoloration posterior ankle

6

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Prelim radiology read

- Calcaneal mineralization is heterogeneous with serpiginous sclerosis and adjacent lucency suggestive of healing injury.
- Consider correlation with prior examination or MRI exam if acute on chronic process is suspected.

10

ED Disposition

- Patient given aircast ankle splint, crutches
- Prescribed Motrin
- Discharged home with PCP follow-up

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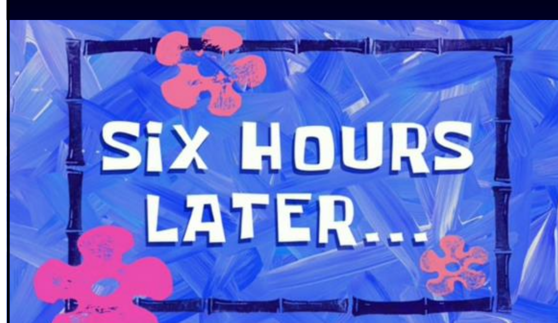


12

Formal Radiology Read

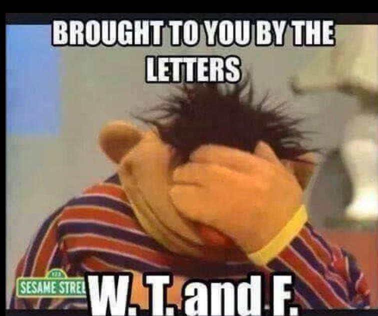
- Comminuted calcaneal fracture deformity

13

Timeline

- 2346 Images obtained
- 0028 Preliminary result Incoming Radiant Results From Powerscribe/Pacs
- 0036 Pt disposition discharge
- 0049 Pt ED departure
- 0638 Incoming Radiant Results From Powerscribe/Pacs
- 0718 Final signed report released (per rad)

14



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16

Second Visit

- "There is bilateral ecchymosis below the medial and lateral malleolus with exquisite tenderness on the bone.
- Patient has tenderness to palpation on his heel."

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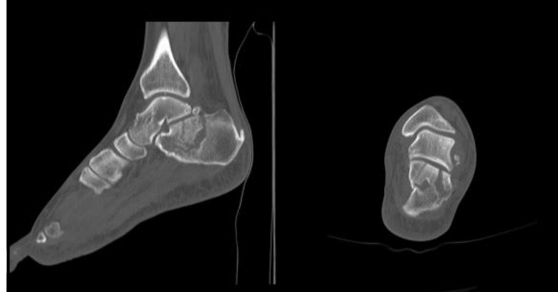

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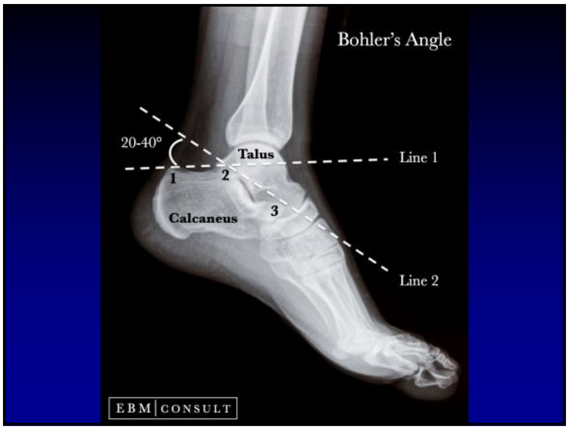

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22

Case #2

23

Case #2

- 68 yof presents with hip, ankle, and foot pain after tripped down one step.
- Patient was brought back to room in wheelchair

24

Physical Exam

- Resident PEx:
  - LOWER EXTREMITY:
  - LLE: normal exam, NVI;
  - RLE: normal exam, NVI
- Attending PEx:
  - Full ROM left hip no shortening or rotational deformity but has mild diffuse lateral tenderness
  - No knee or proximal fibular tenderness.
  - Does have lateral ankle tenderness only.
  - Strong pedal pulses intact sensation.

25

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28

Ankle X-ray

- **Preliminary Result**
- Soft tissue swelling over the lateral malleolus without acute fracture identified at the ankle.
- Mild irregularity question of the shaft of the 5th metatarsal.
- This may be artifactual in nature and correlation to clinical exam recommended.
- Dedicated imaging of the foot can always be obtained.

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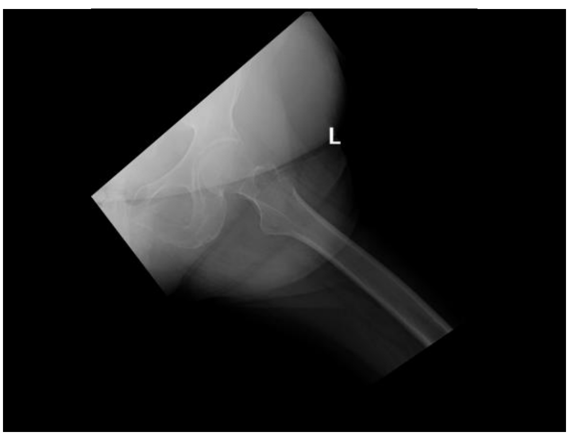

33

Left Hip with Pelvis X-ray

- **Preliminary Result**
- Age-indeterminate fracture of the pubic symphysis and superior pubic ramus on the left.
- Left hip appears grossly unremarkable in appearance.

34

Resident MDM

- **Left Ankle**
- Neurovascularly intact. Most likely ankle sprain with a foot contusion. Discussed conservative measures including rest, elevation, alternating application of ice, pain control and early ambulation as tolerated. No gross ankle instability. No evidence of maison-neue. Although there is midfoot point tenderness, there is no evidence of a LisFranc injury. Discussed follow up with PMD and given resources for ortho/sports medicine follow up as needed. Discussed strict return precautions for neurovascular insufficiency or need for repeat imaging/evaluation if pain not vastly improved in 5-7 days for possible occult fracture.

35

Resident MDM

- **Left Hip**
- Patient presents with left hip pain and mild swelling after injury. Neurovascularly intact distally. Given focal tenderness, considered ligamentous injury but there is no gross instability. No tibial plateau tenderness. XR without frank fracture. Low suspicion for vascular injury with dislocation-relocation. No ankle or knee pain. No back pain with low supicion for significant axial load. No systemic symptoms and nontoxic; given exam and history, low suspicion for septic arthritis, pyomyositis or necrotizing fascitis. No evidence of compartment syndrome or DVT. Pain control. Follow up with PMD and ortho as needed. Cautious return precautions discussed w/ full understanding.

36

ED Disposition

- Discharged home via wheelchair to parking lot

37

Patient Follow-up

- Followed up with PCP as instructed
- Additional x-rays ordered given worsening foot pain

38

39

40

41

Lessons Learned

- Look at your images
- Make sure you actually read all radiology reads
- We make fun of "clinical correlation recommended" but would have found both fractures
- Don't trust a third-year resident in June

42

43

Case #3

44

First Visit

- 28 yom presents with left wrist pain after "jumping off a car hood last night and landed on his wrist…patient admits to alcohol use."
- "Patient is writhing in pain in the room."

45

First Visit

- "Left wrist
  - has area of swelling,
  - patient refusing range of motion testing,
  - capillary refill less than 1 second on every digit,
  - sensation intact in all digits, no obvious deformity,
  - patient able to range left arm in abduction, adduction, flexion and extension"
- Attending documented "significant tenderness to palpation along dorsal aspect of the left wrist."

46

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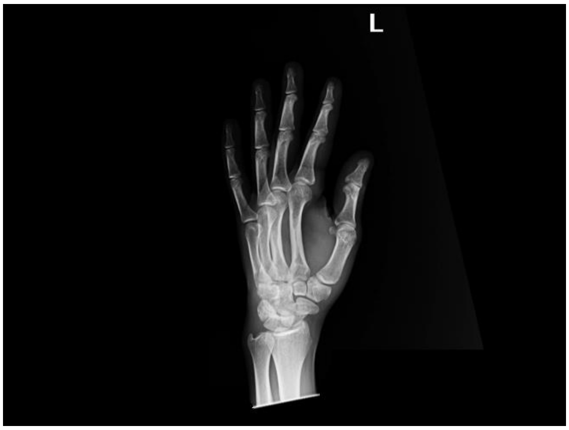


49

50

Radiology Report

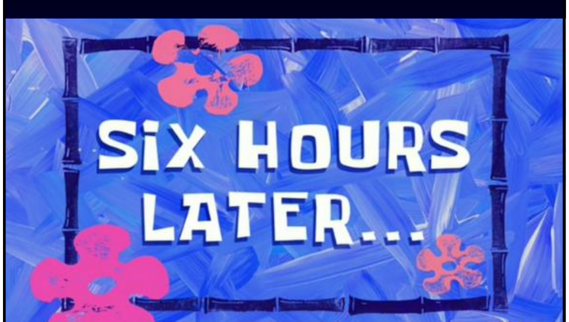
- No focal soft tissue abnormality. No acute bony process is seen. Joint spaces appear well maintained. No bony erosions.
- IMPRESSION: No acute bony process.

51

Disposition 0926

- Discharged home with cock-up wrist splint
- Follow-up with “ED”
- “Call as needed”

52



53

Second Visit

- Patient presented “requesting sling for arm”
- “Some swelling tenderness to the left anatomical snuffbox, good capillary refill good sensation good grip of the left hand”

54

Second Visit

- "Seen for left wrist injury, x-ray had been negative, will provide sling in addition to encouraging splint usage and follow-up appropriately in 2 weeks"

55

56

Third Visit

- Patient returns one week later after "He went back to work today but was unable to perform his duties."
- "He states that the swelling has gone down in his wrist and that he has been able to move the wrist a little more than he was last week."

57

58

Orthopedic Follow-up

- "lengthy discussion with the patient regarding further treatment options at this time.
- We will maintain the patient in a thumb spica cast.
- We discussed with the patient that he **may require cast immobilization for 2 to 3 months** depending on radiographic healing."

59

Case #4

60

First Visit 1522

- "Patient had a FOOSH injury after tripping over bricks today." Occurred one hour PTA

61

Physical Exam

- UPPER EXTREMITY
- Elbow evaluation shows, LEFT elbow to have, no deformity, no ecchymosis, no swelling, no hematoma, no erythema, no warmth, full range of motion, Held in 90 degrees of flexion, distal pulse intact, capillary refill less than 2 seconds, distal motor intact, distal sensory intact, Tenderness to palpation, of radial head, Active range of motion:, causes pain, Wrist evaluation shows, LEFT wrist to have, no deformity, no ecchymosis, no hematoma, no erythema, no warmth, no scaphoid tenderness, normal tendon function, radial pulse intact, ulnar pulse intact, capillary refill less than 2 seconds, distal motor intact, distal sensory intact, Swelling noted, volar, dorsal, of radius, of ulna, Active range of motion:, limited, causes pain, Passive range of motion, limited, causes pain, Hand evaluation shows, LEFT hand to have, no deformity, no ecchymosis, no swelling, no tenderness to palpation, full range of motion, radial pulse intact, ulnar pulse intact, distal motor intact, distal sensory intact, Active range of motion:, causes pain

62

63

64

65

Disposition 1700

- All x-rays interpreted as "negative"
- Discharged home in commercial cock-up wrist splint with Motrin and Vicodin

66

67

Second Visit 0417

- Chief complaint: “that his pain has worsened and that he can’t sleep.”

68

Second Visit Documentation

69

Second Visit Summary

- Pt rec’d two Percocet for pain in ED
- No additional imaging done
- No comment on splint
- No doctor’s note on plan of care
- No documentation that first visit x-rays reviewed

70

Second Visit Disposition

- Discharged home 0606 with #20 Percocet

71

Documentation…

- Resident note completed 28 hours later…
- Attending note completed five days later with “…Tenderness over distal radius and metacarpals…”
- Also no radiology discrepancy sent to ED with read of “lunate dislocation.”

72

73

Third Visit 0430

- Seen at sister hospital in town
- "Was dx with wrist sprain day of fall and went back yesterday d/t uncontrolled pain (was upgraded from Vicodin to Percocet with no relief)."

74

75

76

Fourth ED Visit 0535

- Pt transferred to St. V's by private vehicle with dx of "perilunate dislocation"

77

4^{th} ED Visit Course

- Pt seen by orthopedics in ED
- Procedural sedation by ED with Propofol to reduce lunate dislocation by ortho

78

79

Fourth ED Visit Disposition

- DC home at 1147h
- Rx for Percocet #25
- Follow-up with ortho in clinic scheduled for the next day

80

One Day More

81

Fifth ED Visit

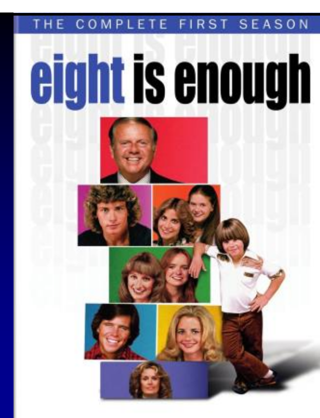
- Returned for splint too tight
- Splint re-applied and discharged with planned ortho follow-up next day

82

Final Outcome

- Pt had surgery six days after first seen in ED
- Had three more ED visits post-op over next three weeks for
  - paresthesias,
  - pain control,
  - splint concerns
- For those counting at home…

83



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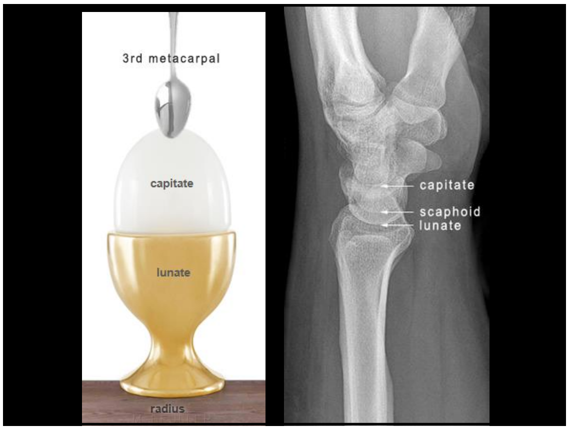

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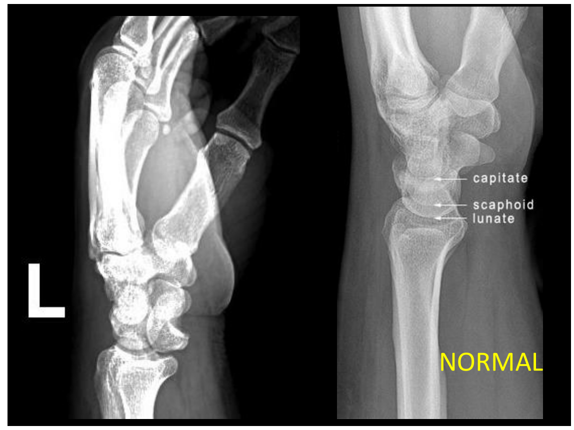

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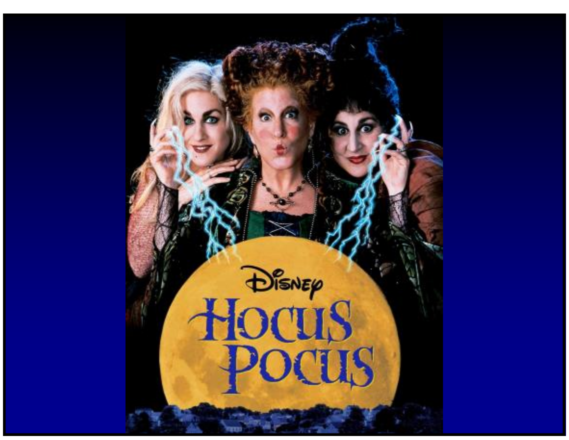
Lessons Learned

- Look at your own x-rays
- Know that preliminary reports are just that and that formal reports can change
- Have mechanism for radiology discrepancies

87

Case #5

88



89

Attending History and Physical

- 32 yof presents with abdominal pain, cramping, and nausea
- Positive home hCG test, ~6 weeks by LMP
- Intermittent vaginal spotting
- Normal physical exam except
  - Minimal tenderness suprapubic, inguinal regions
  - No rebound or guarding
  - Pelvic exam: white physiologic discharge, no tenderness on bimanual exam. Cervix closed.

90

Attending Differential Diagnosis

- 32-year-old female, pregnant unclear of gestational age presenting with lower abdominal cramping and spotting for 2 days.
- Concern for threatened miscarriage.

91

Attending Plan

- We will perform bedside ultrasound, check hCG Quant, pelvic exam, will give Tylenol.
- Patient is Rh+ on review of previous type and screen, no need for Rhogam

92

Labs

- ß-hCG quant 36,539

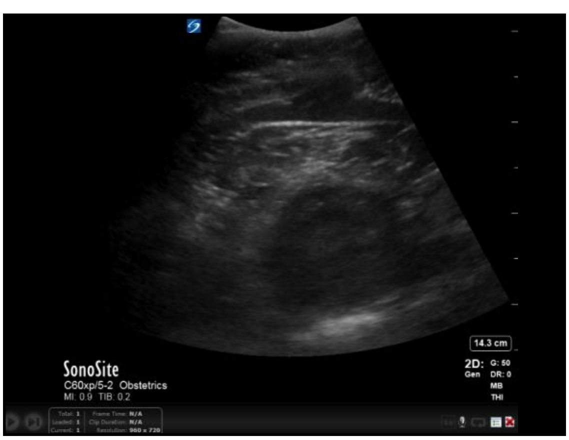
93

POC ULTRASOUND:

- EARLY PREGNANCY ULTRASOUND: A limited, bedside pelvic ultrasound was performed using a transabdominal probe. The medical necessity was to evaluate for signs of an intrauterine versus ectopic pregnancy. The structures studied were the uterus and its contents, bladder, ovaries, vesicouterine space, and rectouterine space.

- FINDINGS:
- Evidence for an IUP was seen.
- 6-7 week fetus with cardiac motion, Unable to obtain heart rate using M-mode
- The study was technically adequate.

94



95

ED Disposition

- Patient left prior to completing treatment approximately 12:30pm
- Was contacted by phone to return for prescription for Flagyl for Trich.

96

97

Triage Chief Complaint 1746

- Vaginal Bleeding x1 hour, pt. was treated earlier today for abdominal pain, pt. is approximately 8 weeks pregnant, G6p5
- Jaw Pain pt. fell at home hitting face

98

Triage Vitals

- 115/84
- 117
- 16
- 99%
- 36.8

99

Resident HPI

- "Patient states she left, had some prescriptions given to her when she left, but was not feeling well so she went home and did not fill them yet.
- She states that she was feeling lightheaded, continued to have abdominal cramping and felt like she was going to pass out."

100

Resident HPI

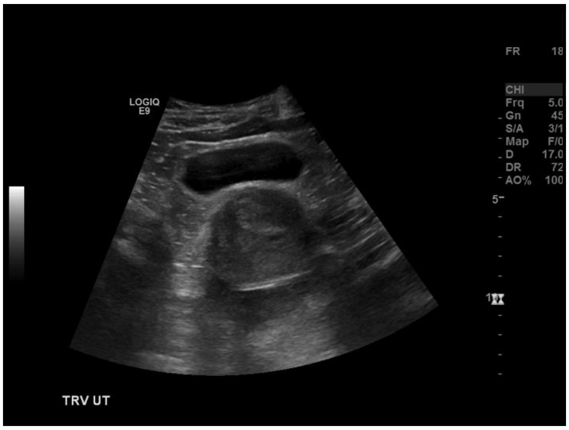
- "She then called EMS, and then believes she did pass out, and then awoke shortly before EMS arrived.
- Per EMS report, patient was hypotensive and they started IV fluids on her, which improved her blood pressure."

101

Resident Physical Exam

- **Uncomfortable, nontoxic-appearing, appears pale**
- Cardiovascular: Regular rhythm. No murmur heard. **Tachycardic to 130s**
- Abdominal: She exhibits no mass. **Gravid abdomen, Abdomen is mildly distended, patient reports mild discomfort with exam, but no focal tenderness, she does have mild rebound, but no guarding**
- Skin: **Abrasion noted to the bottom of lip in the midline**

102



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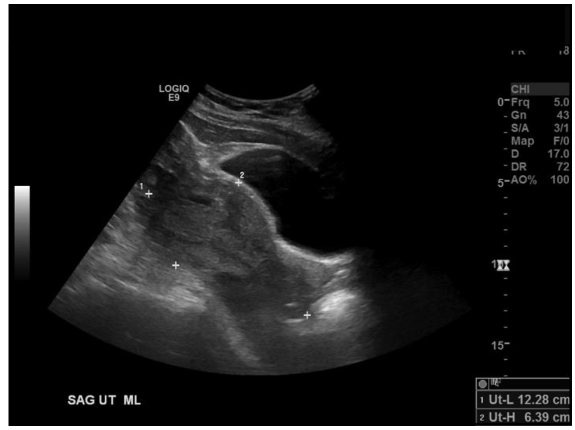

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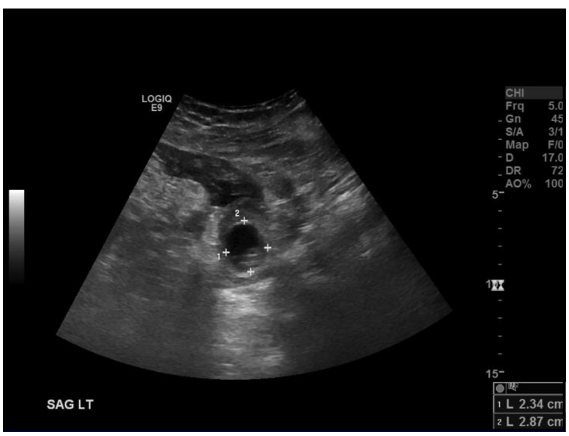

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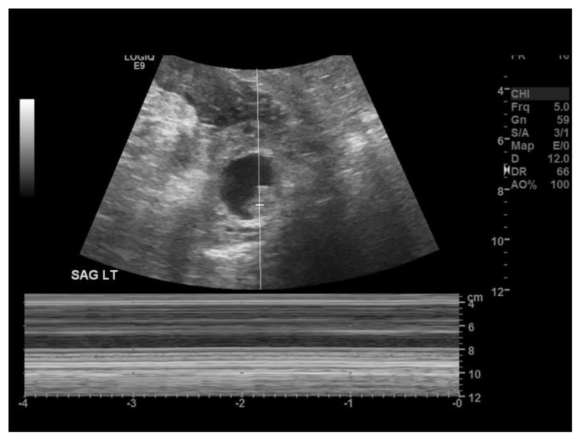

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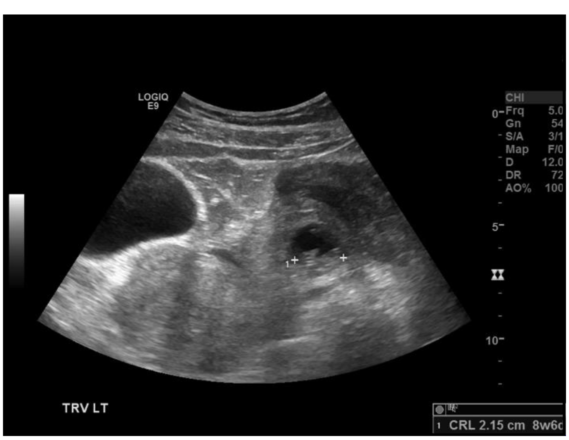

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108

OR Note

- Left salpingectomy
- Evacuation of 500 mL of hemoperitoneum.

109

Lessons Learned

- Know the limitations of your own POCUS skills and abilities
- If it's not textbook quality good imaging, order the formal US study

110

111

Case #6

112

Triage Note 0144

- Pt arrives to the ED via LS2.
- Pt was found down with head abrasion on the posterior head.
- Pt arrives with head wrapped.
- Pt unable to follow commands, pt cannot complete sentences.
- Speech is slurred.
- Pt was incontinent of urine.

113

History and Physical Summary

- "67 y.o. male who presents for evaluation of acute EtOH intoxication. Pt found lying outside bar covered in urine, lethargic, smelled of etoh, arousable only to painful stimuli."
- HENT: Atraumatic
- Neurologic: Alert & oriented x 3, no focal deficits noted

114

Attending Note

115

Labs

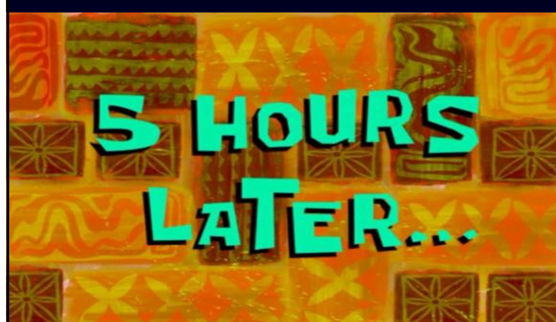
- EtOH 277

116

Resident Medical Decision Making

- “Sx c/w acute alcohol intox, will check level, re-assess when sober by calculation and re-evaluate.
- Sober time is 1200, s/o to Dr [EM3] with plan to d/c then or earlier if he has sober ride.”

117



118

Day Shift Sign-out 0700

- Resident sign-out “SO for doctor [EM3]. Found down. Per EMS contusion on R face is old.
- Did not CT head, intoxicated, sober time calculated at noon.
- Will assess at noon.”
- Attending sign-out templated “pull note,” no typed comments

119

RN Note 0915

- “Pt resting on stretcher no acute distress noted continue to monitor”

120

RN Note 1015

- "resp even non-labored no acute distress noted continue to monitor"

121

RN Note 1145

- "Report received from [lunch break] RN, pt resting on stretcher no acute distress noted continue to monitor"

122

RN Note 1220

- "Dr. [EM3] to bedside to reassess,
- pt standing up urinating in garbage can leaning against the wall,
- pt does not appear clinically sober,
- pt incontinent of urine and stool in brief, brief changed,
- pt assisted back to stretcher,
- pt provided with warm blankets, continue to monitor"

123

Resident Reassessment

- Patient awakened at 12 noon.
- Patient is somewhat drowsy, still groggy, not describing any pain, however the patient is unstable with ambulation, appears drunk, he urinated in garbage can.
- We'll give patient fluids reassess in 2 hours.

124

Afternoon Attending 1500

- "Sign-out from Dr. [Attending]
- Patient came in last night intoxicated, sober time was noon, however patient did not seem ready to go.
- Repeat evaluation by resident at this time patient is still difficult to arouse.
- He does have ecchymosis forehead.
- Reviewing the workup, patient had not had imaging.
- We'll take patient to CT directly."

125

126

Afternoon Attending 1600

- Addendum:
- “I was called to CAT scan by resident that patient does have a subdural on CT.
- Patient is still awake at this time in no distress.
- We'll proceed with trauma and neurosurgery consults, admit to ICU”

127

Hospital Course

- Admitted to trauma, neurosurgery consult
- Two repeat head CTs showed no additional changes
- Discharged home on hospital day 2 without neurosurgical intervention.

128

Practice Changer

- At shift change, bedside attending sign-out for all intoxicated and psychiatric patients

129

Case #7

130

First Visit

- “45 y.o. female who presents with complaints of progressive onset frontal headache associated with nausea, vomiting, photosensitivity, neck stiffness x 2 days.
- Patient states symptoms began last night and have worsened since that time.
- Patient states she does suffer from migraines at baseline but they don't generally persist for this long or is this severe.”

131

Resident Physical Exam

- **EYES:** PERRL, EOMI
- **NEUROLOGIC:**
  - MAEx4,
  - no focal sensory or motor deficits,
  - brudzinki negative, kernig's negative,
  - jolt attenuation (+)

132

Attending Note

- "History of migraines. Similar pain now"

133

Resident MDM

- 45 y.o. female with frontal headache with nausea, vomiting x 2 days
- **Assessment/Plan**
  - Migraine cocktail
  - Move into opioids
  - Anticipate discharge

134

ED Medications

- 1957
- Decadron 10 mg IV
- Benadryl 25 mg IV
- Reglan 10 mg IV
- 1L NS

135

RN Note 2017

- Pt states no relief from discomfort after getting medication
- Given multiple rounds of additional medications

136

ED Course

- 10:41PM
- "Giving last round of dilaudid"

- 2241 Dilaudid 2 mg IV
- 2245 Phenergan 12.5 mg IV

137

Disposition 2309

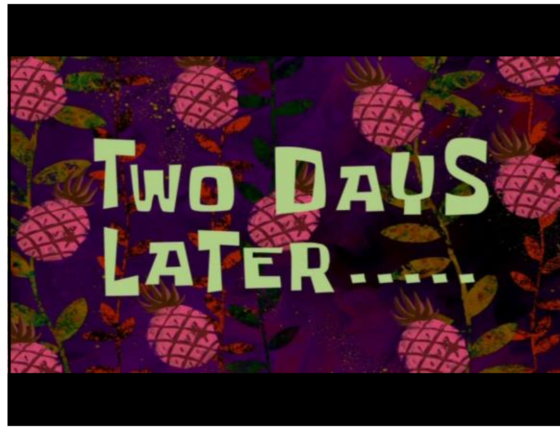
- Discharged home
- Follow-up with PCP

138

ED Medication Summary

- 1957 Decadron 10 mg IV, Benadryl 25 mg IV, Reglan 10 mg IV, 1L NS
- 2032 Valium 2 mg PO
- 2123 Dilaudid 1 mg IV
- 2156 Dilaudid 1 mg IV, Valium 5 mg PO, Benadryl 25 mg IV
- 2241 Dilaudid 2 mg IV
- 2245 Phenergan 12.5 mg IV

139



140

Second Visit

- "Patient states the headache has persisted and progressively gotten worse. Reports this in both of her eyes going from left-to-right and back and forth. States that she does have photophobia and phonophobia. Some nausea without vomiting.
- ...history of migraines in which she states that this migraine is worse than usual.
- She also complains of neck pain."

141

Second Visit Physical Exam

- Eyes:
  - EOM are normal.
  - Funduscopic exam difficult, as the pupils are fairly constricted.
- Neck: Neck supple.
  - No spinous process tenderness and no muscular tenderness present.
  - No rigidity.
  - Decreased range of motion present.

142

Second Visit Physical Exam

- Neurological:
  - She is alert and oriented to person, place, and time.
  - She has normal strength.
  - No cranial nerve deficit or sensory deficit. She exhibits normal muscle tone.
  - Negative Romberg sign.
  - Coordination and gait normal.
  - 2+ bicep and patellar reflexes bilaterally

143

Second Visit Attending Note

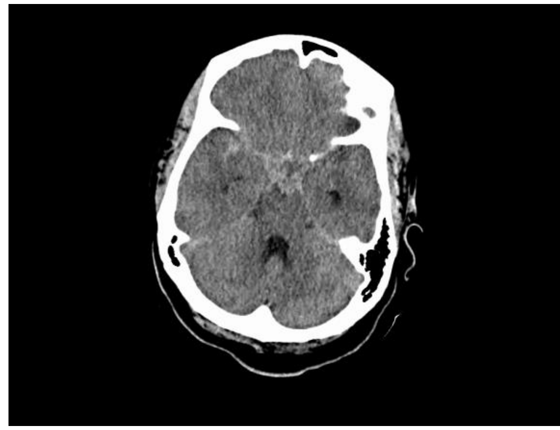
- "This woman with known headaches has repeated ha Was here two days ago;
- very unhappy, tearful, in dark room, no focal sing,"

144

Resident MDM and ED Course

- "Concern for migraine headache, headache, intracranial hemorrhage, meningitis.
- Patient is afebrile, with no meningismus signs. She does have some neck tenderness.
- Otherwise she appears to be very uncomfortable. Suspicion of this time is migraine headache however we'll do a CT scan of her head that she was recently here and discharged.
- She has no previous CT scan of the head in the system and declines ever getting a head CT in the past."

145



146

CTA Head and Neck

- Diffuse atresia of the intracranial internal carotid arteries, middle cerebral arteries, and posterior circulation.
- Differential considerations include
  - diffuse cerebral vasospasm.
  - Reversible cerebral vasoconstriction syndrome may also be a consideration.
- No discrete aneurysm is identified although sensitivity is limited. Follow-up catheter angiography is recommended.

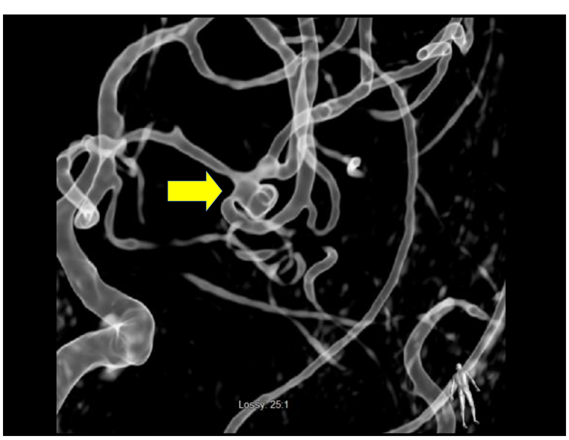
147

Interventional Angiogram

Impression:

1. An MCA bifurcation elongated irregular aneurysm was noted. The aneurysm length was estimated at approximately 5 mm and 2-3 mm in height, with 2 mm neck.
2. Diffuse circle of Willis vasospasm involving both MCAs, ACAs proximally and distal intracranial supraophthalmic ICAs.

148



149

Hospital Day #2

- Debatge of interventional coil vs. neurosurgical clipping to treat aneurysm
- Decision for coiling
  - Also notes describe that could treat cerebral vasospasm at same time via IA route

150

Endovascular Intervention HOD #3

PROCEDURES:
1. Transarterial Coil Embolization of Ruptured Right MCA aneurysm using Balloon Assistance
2. Transarterial Balloon Angioplasty for Right MCA/ICA SAH Induced Cerebral Vasospasm
3. Transarterial Slow Infusion of Nicardipine, Verapamil, and Magnesium for Bilateral MCA and Bilateral ICA SAH Induced Cerebral Vasospasm
4. Mechanical Thrombectomy for MCA and ICA clots using Solitaire Device

151

Hospital Day #3

- Post-coiling pt off sedation, paralysis of entire left side.
- Repeat CT shows several strokes
- Decision made to do hemicraniectomy with drain due to edema

152

Hospital Day #6 Chaplin Note

- “spoke to family about patient's "very poor prognosis" and explained again about her aneurysm and subsequent vascular spasms.
- Family did not have questions about her condition except related to her ED visit on Monday for a headache.

153

Palliative Care Note HD #6

- Family inquired if patient was "brain dead" to which the response was that she is very close. Dr. explained process if patient should go into cardiac arrest and family wants everything done at this point to give her a "fighting chance".
- Family has many questions as to why patient was sent home upon the first visit to ED

154

EEG HD #11

- IMPRESSION:
- This electroencephalogram is concordant with electrical cerebral silence

155

Final Outcome

- Pt coded HD #14
- PEA arrest, 7 rounds of epinephrine
- Code called

156

First Visit Medication Summary

- 1957 Decadron 10 mg IV, Benadryl 25 mg IV, Reglan 10 mg IV, 1L NS
- 2032 Valium 2 mg PO
- 2123 Dilaudid 1 mg IV
- 2156 Dilaudid 1 mg IV, Valium 5 mg PO, Benadryl 25 mg IV
- 2241 Dilaudid 2 mg IV
- 2245 Phenergan 12.5 mg IV
- 2309 Discharged

157

PMHx

- Sickle cell trait (HCC);
- Osteoarthritis;
- Irritable bowel syndrome;
- Mitral valve prolapse;
- Carpal tunnel syndrome, bilateral;
- Chronic leg pain;
- Rheumatoid arthritis;
- Migraine
- Asthma;
- Frozen shoulder syndrome;
- Bowel obstruction;
- Bulging lumbar disc;
- Back pain, chronic;
- Depression, acute;

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Previous ED Visits

- Shoulder contusion
- Leg pain
- Facial abscess
- URI
- Leg pain, myalgias
- Hidradenitis
- Leg pain

- **What's not here? Headache or sickle crisis!**

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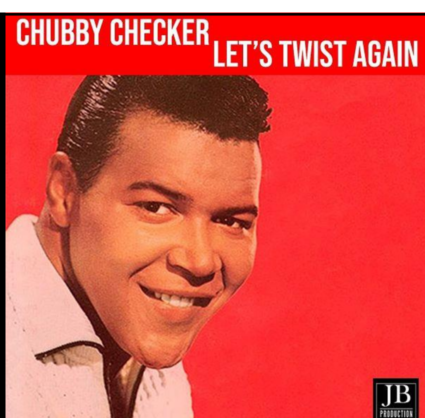
Case #8

160



161

Resident HPI

- 36 y.o. female who presents with a chief complaint of right lower quadrant pain, onset 1 AM earlier today, duration is intermittent since onset, quality is cramping, severity is severe.
- Patient reports she is 12 weeks pregnant. Patient reports associated nausea and vomiting.
- Patient denies vaginal bleeding or discharge.

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Resident Physical Exam

- Constitutional: She appears distressed.
- Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is tenderness **(RLQ and suprapubic)**. There is guarding **(voluntary)**. There is no rebound.
  - Vagina normal. [no rash or external lesions]. Uterus is enlarged and not tender.
  - Cervix exhibits motion tenderness and discharge **(thin, white)**. Cervix exhibits no friability.
  - Right adnexal tenderness , no mass or fullness
  - Left adnexa normal
- Psychiatric: **Her speech is rapid and/or pressured. She is agitated.**

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Resident Differential Diagnosis

- **DIFFERENTIAL DIAGNOSIS:**
- **Abdominal Pain:**
- pancreatitis, cholecystitis, appendicitis
- Renal: pyelonephritis, nephrolithiasis, acute cystitis
- **Female**: pregnancy, ectopic pregnancy, ovarian torsion, Tubo-ovarian abscess, ovarian cyst, PID, Mittelschmerz, period/ fibroid, Fitz-Hugh-Curtis, cervicitis, STD (trichomonas, gonorrhea, chlamydia), bacteria vaginosis, vaginal candidiasis

164

Radiology Result 0906

- **Impression**
- Unremarkable RLQ ultrasound. Non demonstration of the appendix/

165

Resident ED Course 0925

- Bedside ultrasound demonstrates IUP with heart rate 167 BMP

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Resident ED Course

- Pelvic exam notable for right adnexal tenderness and moderate thin white discharge. Cervical os is closed. Mild CMT.
- Will give empiric treatment for G/C for possible cervicitis.
- Anticipate that MRI will demonstrate TOA if there is one.
- Doubt ovarian torsion as patient had minimal pain on bimanual exam.

167

MRI Impression

- Right ovarian enlargement and adjacent edema. The right ovary contains a 4.2 x 4.3 cm dermoid. The possibility of torsion or pelvic inflammatory process should be considered. Further evaluation with pelvic ultrasound is recommended.
- The appendix is not identified. No secondary signs of acute appendicitis are appreciated.

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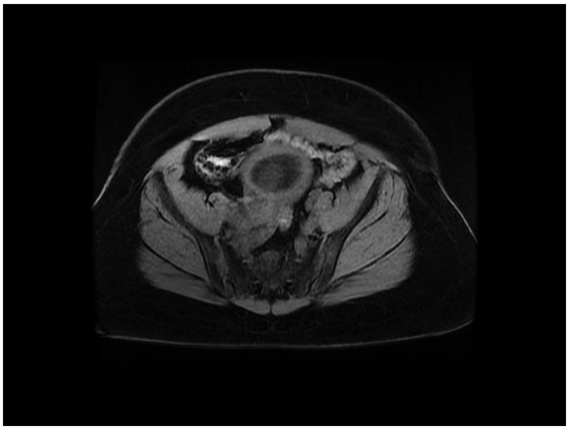

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Pelvic US Result

- **Impression**

1. Dermoid cyst noted in the right ovary, as was previously seen on the MRI. This measures up to 4.6 cm on the ultrasound. There appears to be preservation of color flow in the periphery of the right ovary, but this doesnot completely exclude a diagnosis of incomplete torsion. Torsion remains in the differential, particularly given the appearance on MRI. Clinical correlation is necessary.
2. Unremarkable sonographic appearance of the left ovary. No free fluid.

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Shift Change 1500

- New attending, two new nurses

171

ED Disposition 1604

- Discharge home
- No additional documentation completed in real time

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APP History and Physical

- [summary of day before visit]
- Patient states she is trying Tylenol but is not helping
- Patient tearful
- Abdomen: soft. There is tenderness throughout lower abdomen
- Bedside US FHR 170

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ED Attending Note

- OB to be consulted as patient was seen yesterday MRI showing an edematous enlarged ovary symptoms now radiating to the buttocks high suspicion for ovarian torsion at this point

175

Pelvic OB US

- Single live IU gestation. FHR is 146 BPM
- Right adnexal lesion is again seen likely a dermoid. This area measures 8.5 x 6.7 cm. Limited arterial blood flow.
- Abnormal appearance of the right ovary likely related to a dermoid. Limited blood flow. Findings could indicate partial torsion or torsion-detorsion.

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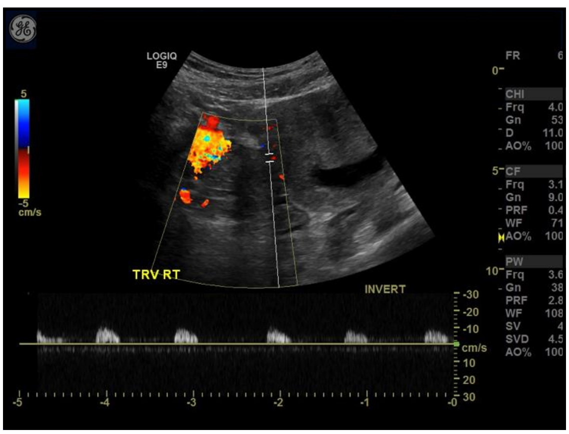

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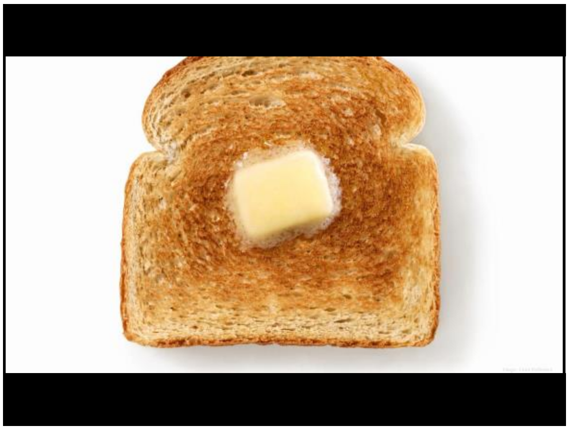

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~~Ten~~ Eleven Take Home Points

1. Always look at your own x-rays
2. Actually read radiology reports all by your big grown-up self
3. Beware of preliminary reports…formal reports change. Have mechanism for review

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~~Ten~~ Eleven Take Home Points

4. If your patient used to walk, walk your patients with lower extremity injuries/complaints before discharge
5. Know the limitations of your own POCUS skills, if it's not textbook, order the formal US
6. Always review prior visits with fresh perspective

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~~Ten~~ Eleven Take Home Points

7. Be careful of templated macros and “dot phrases” for physical exam and MDM
8. Common/classic presentations are uncommon but can’t be missed
9. Beware of presentation different from baseline and order the broader workup

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~~Ten~~ Eleven Take Home Points

10. Beware of diagnostic momentum at sign-out and recheck your patients when plan of care isn’t what you were told
11. Avoid confirmation bias and anchoring aka search satisfaction

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