Performance Overview for Martin Mutesasira on case Steven Van Dyke

The following table summarizes your performance on each section of the case, whether you completed that section or not.

Time spent: 6hr 22min 29sec
Status: Submitted

Case Section	Status	Your Score	Time spent	Performance Details
Total Score		55%		
History	Done	41%	56min 9sec	71 questions asked, 23 correct, 34 missed relative to the case's list
Physical exams	Done	60%	1hr 38min 23sec	62 exams performed, 18 correct, 1 partially correct, 10 missed relative to the case's list
Key findings organization	Done		6min 10sec	4 findings listed; 18 listed by the case
Problem Statement	Done		5min 54sec	128 words long; the case's was 156 words
Differentials	Done	38%	13min 45sec	8 items in the DDx, 3 correct, 5 missed relative to the case's list
Differentials ranking	Done	88% (lead/alt score) 50% (must not miss score)	3min 40sec	
Tests	Done	67%	13min 48sec	8 tests ordered, 6 correct, 3 missed relative to the case's list
Diagnosis	Done	100%	19sec	
Management Plan	Done		1hr 17min 9sec	612 words long; the case's was 674 words
Exercises	Done	40% (of scored items only)	25min 35sec	3 of 10 correct (of scored items only) 2 partially correct

History Notecard by Martin Mutesasira on case Steven Van Dyke

Use this worksheet to organize your thoughts before developing a differential diagnosis list.

1. Indicate key symptoms (**Sx**) you have identified from the history. Start with the patient's reason(s) for the encounter and add additional symptoms obtained from further questioning.
2. Characterize the attributes of each symptom using **"OLDCARTS"**. Capture the details in the appropriate column and row.
3. Review your findings and consider possible diagnoses that may correlate with these symptoms. (Remember to consider the patient's age and risk factors.) Use your ideas to help guide your physical examination in the next section of the case.

HPI	Sx =Chest pain	Sx =	Sx =	Sx =	Sx =	Sx =
Onset	1 month ago					
Location	Under the breastbone, but gripping all around					
Duration	5-20 minutes					
Characteristics	Squeezing					
Aggravating	Probably exercise					
Relieving	Deep breathc/Resting/stopping what he's doing					
Timing / Treatments	About twice a day					
Severity	8/10					

Problem Statement by Martin Mutesasira on case Steven Van Dyke

Steven is a 36-year-old Caucasian male presenting with complaints of acute-onset chest tightness, with a history of similar episodes for the past one month occurring with exercise and work-related stress. He also complains of shortness of breath and choking sensation when the pain starts. He reports palpitations, dizziness, lightheadedness, and nausea during the episodes. He fears that he might be having a heart attack (fear of dying) and expresses his anxiety and worries about the same. The patient has diaphoresis, tachycardia, tachypnea, and an elevated blood pressure. He has been avoiding exercise since the start of the episodes. He also presents with postural trembling and fidgeting with hands and legs. His father died of a myocardial infarction and his mother has a history of untreated anxiety and depression.

Attempt: 3052958

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Management Plan by Martin Mutesasira on case Steven Van Dyke

Assessment

Panic Disorder (ICD-10: F41.0): According to the DSM 5 criteria, panic disorder characterizes recurrent unexpected attacks that cause intense discomfort or fear, reaching a peak within minutes. The attacks are associated with at least four symptoms, including palpitations, sweating, trembling/shaking, shortness of breath, feelings of chocking, chest pain or discomfort, nausea, abdominal distress, dizziness, lightheadedness, or fainting, heat sensations or chills, fear of dying, fear of losing control, paresthesia, and derealization or depersonalization (American Psychiatric Association, 2022). The patient has symptoms characteristic of the disorder, including palpitations, chest pain, feeling of chocking, shortness of breath, dizziness, sweating, nausea, light-headedness, and endorses a fear of dying. Psychosocial risk factors, including work-related stress and pressure, are associated with a significant risk for panic disorders (Kim et al., 2021). While initial attacks are often spontaneous or provoked by emotional or physical excitement or trauma, substances such as caffeine, nicotine, and alcohol could precipitate subsequent attacks (Manjunatha & Ram, 2022).

Acute Coronary Syndrome (ICD 10: I24.9: ACS presents with symptoms such as chest pain, dyspnea (shortness of breath), nausea, vomiting, diaphoresis, and light-headedness. Often, chest discomfort occurs at rest in more than 70% (Bhatt et al., 2022). Physical examination often identifies increased blood pressure and heart rate, alongside abnormal extra heart sounds, peripheral vasoconstrictions, or pulmonary findings of congestion (Schwinger, 2021). However, chest pain in ACS usually occurs around the substernal region, spreading to the arms or jaw. Smoking is a significant risk factor for ACS (Nohria & Viera, 2024). Although the patient has sinus tachycardia, his electrocardiogram reveals normal intervals and axis, with no signs of ischemia, ventricular hypertrophy, or atrial enlargement. Therefore, this diagnosis is ruled out.

Hyperthyroidism (ICD 10: E05): The disease is associated with a range of symptoms, including palpitations, tachycardia, diaphoresis, heat intolerance, lid lag, and tremors. In addition, patients present with systolic hypertension, increased pulse pressure, tachypnea, and jugular venous distension (Guerri et al., 2019). Anxiety is among the prevalent psychiatric symptoms of hyperthyroidism. Steven presents with symptoms that lead to the suspicion of hyperthyroidism. However, thyroid function tests show no evidence of elevated thyroid hormone. In addition, the PE does not reveal an enlarged thyroid gland, which is among the most common physical features of the disease. Therefore, the diagnosis is ruled out.

Plan

Steven is diagnosed with panic disorder. Fluoxetine 20 mg PO once daily is prescribed. The medication may be increased to a maximum of 60 mg daily divided into several dosages over the course of treatment and depending on response to medication. Alprazolam 0.25 mg TID is prescribed to address anxiety and panic symptoms, but the dose may be increased to a maximum of 4mg daily depending on response to treatment (Raju et al., 2023). Fluoxetine and alprazolam have been shown to be effective and well-tolerated in the treatment of panic disorder (Guaiana et al., 2023). The following specifics are included within the treatment plan, including discharge planning and the follow-up care.

- The patient is educated about the common side effects of fluoxetine. a selective serotonin reuptake inhibitors (SSRIs), including gastrointestinal disturbances, insomnia, restlessness, changes in appetite, and poor concentration.
- Discuss the risk of medication nonadherence and the potential of dependence. Emphasize that abrupt cessation of alprazolam could lead to withdrawal symptoms.
- Reassess patient every two weeks to determine the effectiveness of the medications, side effects, and need to change the dosage.
- Continue fluoxetine for six months and consider medication withdrawal with a month’s follow-up to assess the risk of relapse
- Taper alprazolam depending on response to treatment
- Encourage the patient to return in case chest pain and SOB continue, despite taking medication
- Follow-up scheduled in four weeks.

Electronic Health Record by Martin Mutesasira on case Steven Van Dyke

History of Present Illness

Category	Data entered by Martin Mutesasira
Reason for Encounter	"Am I having a heart attack?"
History of present illness	The patient is a 36-year-old Caucasian male smoker presenting to the ED following an acute onset of a squeezing, non-radiating chest tightness lasting between 5 and 25 minutes. The symptoms started while he was watching TV, but states that he started experiencing chest tightness about a month ago that have been increasing in intensity. The first episode started while exercising but the subsequent episodes have been random, occurring while working or during work-related meetings. This is the first episode to occur while resting and outside the workplace setting. The patient also complains of palpitations, shortness of breath, dizziness, chocking sensation, sweating, dizziness, and a "fear of having a heart attack." The associated symptoms often occur alongside the chest pain.

Past Medical History

Category	Data entered by Martin Mutesasira
Past Medical History	Reports asthma as a child.
Hospitalizations / Surgeries	None

Medications

Category	Data entered by Martin Mutesasira
Medications	None

Allergies

Category	Data entered by Martin Mutesasira
Allergies	No history of allergies

Preventive Health

Category	Data entered by Martin Mutesasira
Preventive health	Unsure of last physical exam and immunization status

Family History

Category	Data entered by Martin Mutesasira
Family History	Father: deceased from a history of heart attack Mother: Alive, reported struggles with depression and anxiety after husband's (Steve's father) death Two brothers (34 and 38 years): Alive and healthy

Social History

Category	Data entered by Martin Mutesasira
Social History	Steven works as a financial planner, a job he claims to be stressful. He lives with his mother and two brothers. He reports social drinking (2-3 drinks) but drinks a bit more on Fridays and Saturdays (4-5 drinks). He endorses tobacco use, with a 20-year history smoking about half a pack a day. He takes about two cups of coffee daily, but not close to bedtime.

Review of Systems

Category	Data entered by Martin Mutesasira
General	Denies fever, chills, fatigue, or tiredness. Reports excessive sweating, especially when experiencing the episodes of chest pain.
Integumentary / Breast	Non-contributory
HEENT / Neck	Non-contributory
Cardiovascular	Reports palpitations, shortness of breath, and chest tightness; not precipitated by exercise;
Respiratory	Reports shortness of breath or difficulty catching breath. Denies coughing, wheezing, sputum production. Denies SOB with exercise. Denies recent upper respiratory tract infection.
Gastrointestinal	Non-contributory
Genitourinary	Non-contributory
Musculoskeletal	Non-contributory
Allergic / Immunologic	Non-contributory
Endocrine	Non-contributory
Hematologic / Lymphatic	Non-contributory
Neurologic	Non-contributory
Psychiatric	Reports anxiety

Physical Exams

Category	Data entered by Martin Mutesasira
General	Appears of the stated age. Alert and oriented X3. Anxious but with fair eye contact. Mild postural tremor. Fidgeting of hands and legs. Slightly fast speech with deep breaths between phrases. Slight sweaty body odor
Skin	Short well-groomed hair Slight body odor and sweating apparent No scaling, excoriations, or signs of IV drug use No pallor, icterus, rash, or skin lesions No clubbing or cyanosis
HEENT / Neck	Head: Normocephalic, atraumatic, no lesions, masses, deformities, scars, or rashes Eyes: Wearing corrective glasses; sclera non-injected, pupils equal, round, and reactive to light and accommodation Ears: No external structures, deformities, or edema. No hearing difficulties. Normal Weber and Rinne tests Nose: No discharge, edema, or tenderness of frontal and maxillary sinuses. Mouth: Orpharynx not injected, clear mucosa, tonsils without exudate, no swelling Neck: No scars, deformities, or lesions. Trachea midline, freely mobile. Thyroid WNL. No cervical lymphadenopathy. No JVP
Cardiovascular	PMI non-distended S1 and S2 No palpable thrill No jugular vein distension No swelling, cyanosis, or edema of the extremities
Chest / Respiratory	Thorax atraumatic, no lesions. Increase in respiratory effort but no use of accessory muscles. Deep breaths between spoken phrases No local thoracic tenderness to palpation Normal tactile fremitus; no egophony Lungs resonant to percussion Normal sounds to auscultation; no crackles, wheezes, or rubs
Abdomen	Non-distended Normoactive bowel sounds in all quadrants upon auscultation No hepatospleenomegaly or palpable masses; soft, non-tender throughout exam No tympany or shifting dullness to percussion
Genitourinary / Rectal	Deferred
Musculoskeletal / Osteopathic Structural Examination	Deferred
Neurologic	Deferred
Psychiatric	Deferred
Lymphatic	No pathologically enlarged lymph nodes in the cervical, supraclavicular, or inguinal chains