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Patient vignette #1 answer analysis

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One of the regular features of this section will be a review of the responses to the vignettes from the previous issue. Available from: http://surgicalneurologyint.com/downloadpdf.asp?issn=2152-7806;year=2014;volume=5;issue=14;spage=493;epage=495;aulast=Stecker;type=2 The following is the analysis of responses to the questions posed in Vignette #1: Unrecognized Seizure: The key elements of making the diagnosis.

- Question 1: When the readers of the vignette were asked about possible diagnoses; syncope, seizure, stroke, arrhythmia, and orthostatic hypotension were all considered likely according to the respondents. All of the respondents appropriately felt that there was an incomplete history and that obtaining a history from the patient's family members could add significant value to the care of the patient
- Question 4: When the respondents were asked what would be the most important additional piece of history obtained from the patient's sister, some respondents wanted more information about allergies and medications while others wanted more information about whether the patient had previously had a similar episode. The question posed a difficult one in that there is so much unavailable information that could be critically important. However, it is important to establish an exact description of what happened to the patient at what time. It is very often true that the initial description of what happened to the patient is conveyed as "I passed out" or by the family as "he had a seizure;" but accepting these short statements is tantamount to allowing the patient or family to make the diagnosis instead of the clinician. It is very important to get a good timeline of when the patient was last seen normal, what the initial symptoms were, how the symptoms progressed and how long the symptoms lasted. At a later time, the patient could, conceivably provide information on past medical history, medications and previous events; but the clinical scenario describes the patient as being unconscious during the event that brought them into the emergency room (ER) and so it is unlikely the patient will be sure of all the details. In fact, patients often confabulate a history that seems rational to them, but in reality, is incorrect. For example, many patients who have seizures say that they were awake during the event while people who witness the event all confirm that the patient was unresponsive
- Question 6: The respondents did feel that additional information was very helpful but not everyone would document the information, nor would they inform the physician of the new information. Once it is found that this information is important, it is vital to the care of the patient to both document and to let a physician know of the additional information. It is important to do both because it is highly likely that the source of the information may not be available when the physician comes to obtain a history
- Question 7: All the respondents felt appropriately that if the intern cannot be reached and the information is important then that information

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should be escalated to the resident or the ER physician. Inadequate communication is one of the most frequent sources of problems in patient care. In particular, the ability to communicate information like this may be lost if the nurse is distracted by another pressing issue. It is important to have a rigorous handoff process that will make sure that important information is captured even if the nurse is unable to provide this information immediately

- Question 9: A number of respondents felt that seizure was a more likely diagnosis, however, some respondents still felt syncope could also be in the differential diagnosis. In this case, syncope would be more unlikely since syncope does not occur in bed and rarely causes the patient to fall—the authors agree that stroke/TIA should also be considered in the differential diagnosis
- Question 11: After the event, most respondents wanted q1hr neuro checks. Frequency of neuro checks can be an issue since in many telemetry units; there is not enough staffing for this and so there is pressure to say that a longer interval might be acceptable. Neuro checks every hour is in fact the optimal answer; and if necessary, the patient should transferred to a location where the frequency of the neuro checks can be carried out such as an intensive care unit
- Question 12: Most respondents answered that the patient should be transferred and the authors agree with this response
- Question 13: Escalation as suggested by the respondents is appropriate for this question, but is often forgotten if more pressing issues are present
- Question 15: The respondents realized the importance of communication initially and agreed that the final diagnosis was pulmonary embolus.