# Case Study: Adult with Intellectual Disability: Otalgia

## 1. CASE AUTHORS

**Name**
**Department of Nursing – NP Programs**
**Phone**
**FAX**

**Name**
**Department of NP**
**Phone**
**FAX**

## 2. TOPIC OF THE CASE:

**Adult with Down Syndrome: Otalgia**

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

| | |
|---|---|
| [X] Nurse Practitioner | [ ] Physician's Assistant |
| [ ] Medical Student – PGY 1 | [ ] Medical Student – PGY 2 |
| [ ] Medical Student – PGY 3 | [ ] Other |

## 4. CATEGORY OF CLINICAL PROBLEM THIS CASE ADDRESSES:

| | |
|---|---|
| [ ] Acute Serious | [ ] Psychiatric/Behavioral |
| [X]] Acute Limited | [ ] Well-Care/Prevention |
| [ ] Chronic Subacute | [ ] 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 | 5-10 min. |
| [X] Physical Examination | 5 min. |
| [X] Advise Patient of Diagnosis | 5 min. |
| [X] List of Different Diagnoses | 1 min. |
| [X] Feedback from SP | 2 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

[ ] Small group w/ms 1 SP, 1 preceptor
[X] 1 Trainee, 1 SP
[X] With SP Feedback
[X] With Videotape
[ ] 1 Trainee, 2 SP (1 adult and 1 child)

## 10. SETTING OF THE INTERACTION:

[ ] General internal medicine out-patient office
[ ] Emergency room
[X] Family practice office
[X] Nurse practitioner care
[ ] Hospital room
[ ] Home
[ ] Other:

## 11. FURNISHINGS IN THE EXAM ROOM:

[ ] Desk, chairs only
[ ] Exam table only
[X] Desk, Chairs, and Exam Table
[ ] Other:

### EQUIPMENT/PROPS IN THE EXAM ROOM:

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

### EQUIPMENT/PROPS AT THE STUDENT CARRELS:

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

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

*Otalgia
Acute otitis media
Otitis externa
Sinusitis
Mastoiditis
*Hypothyroidism
*Obesity

## 13. PHYSICAL CHARACTERISTICS THE ACTUAL SP SHOULD HAVE:

| | | | | |
|---|---|---|---|---|
| Gender: | [ ] Male | [ ] Female | | [X] Immaterial |
| Age: | Range 45-55 | | | [ ] Immaterial |
| Race/Ethnicity: | | | | [X] Immaterial |
| Body Type: | [ ] Slender | [X] Average | [X] Overweight | [ ] Immaterial |
| Ideal Height/Weight: | Less than 5'5 if possible | | | [ ] Immaterial |

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**14. ESSENTIAL "REAL" PHYSICAL FINDING(s) OR ATTRIBUTES THE SP SHOULD HAVE:**
None.

**15. PHYSICAL FINDINGS THE SP SHOULD NOT HAVE:**
None.

**16. PHYSICAL EXAM REQUIRED:**

[X] EENT
[X] Cardiac
[X] Head and Neck
[X] Respiratory

**17. CASE REQUIRES THE SP TO SIMULATE THE FOLLOWING PHYSICAL FINDINGS:**
[X] Right ear pain with and without touch

## INSTRUCTIONS FOR THE EXAMINER

**CASE INFORMATION: You have been seeing this 45 year old patient for 3 years. He/She has been seen in this Family Practice for 10 years. He/She has an intellectual disability but is competent and reliable historian. The pt shares an apartment with a friend. Last visit: 6 months prior, Immunizations UTD, medications Tylenol 500 mg every 6 hours for pain, Levothyroxin 50mcg PO daily.**

**Ht: 64 inches; Wt: 150 lbs; Temp: 99; HR: 70; RR: 14; BP: 120/80**

**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 assess the EENT status of a 45 year old individual with an intellectual disability using history-taking with patient.***

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## STANDARDIZED LIFE SKETCH

18. **Setting of Encounter: Primary Care Office**
**SP: Seated on the exam room fully clothed.**

**EXAMINER WASHES HANDS ON ENTERING EXAMINING ROOM**

19. **What do you want the SP to say to the examinee's first query:**
**SP:** ***"Hi. My name is (XXX). My right ear is hurting. I hope you can fix it. But I don't like needles."***

20. **IF THE EXAMINER REMAINS SILENT, or acts as if waiting for more information, or asks an open-ended question:**
**SP:** ***"My ear never hurt before. Do you want me to take my shirt off?"***

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).**

**IF THE EXAMINER ASKS:** ***"Do you have any drainage from your ear?"***
**SP:** ***"Yes and it is really smelly."***

**IF EXAMINER ASKS:** ***"How long has your ear been hurting?"***
**SP:** ***"Two weeks I think. I go to the swimming pool every Saturday, and I can't swim now because my ear hurts."***

**IF THE EXAMINER ASKS:** ***"Do you hurt anywhere else?"***
**SP:** ***"No, just my ear."***

**IF THE EXAMINER ASKS:** ***"Have you ever had an earache before?"***
**SP:** ***"Maybe a long time ago."***

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

**Belly pain:**

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

**Fever:**

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

**Any diarrhea before being constipated:**

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

**How many times a day do you eat:**

**SP:** ***"I like to eat snacks but I know I am not supposed to eat too many. I like a snack before I go to bed and sometimes after lunch. I eat my breakfast, lunch, and dinner. I need to watch my weight."***

22. **IF THE EXAMINER ASKS about when the last time you went swimming:**

**SP:** ***"Before my ear started to hurt. I couple weeks ago, my friend said I shouldn't go swimming if I hurt."***

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

**IF THE EXAMINER ASKS what bothers you besides the pain:**

**SP:** ***"I'm getting very grumpy and yell at my friend because my ear hurts. And I can't wear my hearing aid."***

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

**IF THE EXAMINER ASKS what have you tried so far to fix your ear:**

**SP: "***I took some Tylenol but it didn't help. My friend told me to put a warm towel on my ear but it still hurt."*

**IF THE EXAMINER ASKS do you clean your ears with anything:**

**SP: "***I clean the water our with a Q-Tip. But I don't put it in too far."*

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

**SP:** ***"I think I did something to my ear when I was using my headphones. Maybe they were too loud."***

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## B. PAST MEDICAL HISTORY: HISTORIAN: PARENT SP AND CHILD SP

**26. Medical:**

**All history is documented. Diagnosed with mild mental retardation in infancy. History of frequent upper respiratory infections during winter months.**

**27. Surgical:**

**SP:** ***"I had surgery on my belly when I was a baby. I was told I had a problem with food."***

**28. Chief Complaint: Right ear pain**

**29. Allergies:**

**SP:** ***"None."***

**30. Medications:**

**SP:** ***"Every day I take a vitamin and medicine for my thyroid. I know not to take them the same time. I take the medicine for my thyroid as soon as I get up and the vitamin later. Now I take 1 Tylenol every 6 hours for my ear."***

## D. FAMILY HISTORY:

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

**SP:** ***"My parents are still alive. I think they are ok. I only have 1 brother and he is a doctor. He lives far away. My grandparents are dead."***

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

**Parent SP:** ***"I don't know the dates. I think you can look at my chart. My mother helped me with that when I first came here."***

## E. PSYCHOSOCIAL HISTORY

**Present/Past:**

**33. Marital status:**

**Parent SP:** ***"I have a girlfriend. We might get married some day."***

**34. Home Environment:**

**SP:** ***"I live in an apartment. We have a swimming pool there and a gym."***

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**37. Tobacco/alcohol/illicit drug use?:**

**SP:** ***"I never smoke or drink. It's not good for you. I only take medicine the doctor gives me or tells me to take, like Advil."***

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

**SP:** ***"My parents help me with my money. I get Social Security disability and I think I have Medicaid and I work Monday to Friday in a workshop mailing things."***

**39: Employment:**

**SP:** ***"My dad is retired and my mom doesn't work."***

## F. MENTAL STATUS EVALUATION

**42. Past psychiatric history?**

**No.**

**43. Anxiety?**

**No.**

**44. Mood changes?**

**No.**

**45. Memory or cognitive changes?**

**No.**

**46. Disturbing thoughts or ideas?**

**No.**

**47. Other?**

**Mild intellectual disability.**

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## G. FUNCTIONAL STATUS:

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

SP: *"Yes, I do everything myself except I need help with my money."*

## 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: *"Earache and smell."*

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

SP: *"Fix my ears but no needles."*

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

Sitting on exam table in clothes. Neat, clean, hair combed.

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

Patient appears to be in pain but pleasant.

**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?

No.

**57.** Question the SP should ask the examinee: use caution when considering this section. 1) Do not complete unless the examinee's answer is being evaluated by the SP. 2) Be certain examinees have the knowledge and skills to answer the question. Students feel angry and exploited when SPs pose questions they have not yet been trained to address.

N/A

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## SKILLS PERFORMED

1) Addresses patient as reliable historian
2) Speaks to patient as adult to adult
3) Responds to patient using appropriate level language
4) Takes adequate health history
5) Inspects pt head to toe
6) Inspects and palpates head and neck
7) Performs ears, nose, mouth, throat assessment
8) Performs complete respiratory assessment
9) Asculates heart sounds

## CONTENT CHECKLIST

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

1) Past medical and psycho-social history
2) History of present chief complaint including onset and duration
3) Management of problem
4) Immunizations
5) Allergies
6) Medications
7) Behaviors
8) Living environment

**PHYSICAL EXAM EVALUATION: did the examinee perform:**

[ ] Head to toe inspection
[ ] Palpate head and neck
[ ] Ausculate anterior, posterior and lateral lung sounds
[ ] Ausculate heart sounds
[ ] Examine pupils, sclera, conjunctiva with light
[ ] Inspect ears externally and interally with otoscope bilaterally

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## SKILLS CHECKLIST

### I. DATA GATHERING SKILLS

**Did the examinee …**

1) Introduce self and explain what he or she was going to do during the visit?
2) Allow the SP to finish opening statement without interruption?
3) Ask 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?
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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