Best Case/Worst Case Hypothetical Case Vignettes

Case A:

SBO

Mrs. Rodgers is an 83-year-old woman with multiple co-morbidities including previous stroke, pulmonary embolism 6 months ago for which she is on warfarin, and s/p CABG 5 years ago. She lives at a retirement home and is somewhat dependent on family and visiting nurses because of weakness related to the stroke.

She underwent left hemicolectomy for ischemic colitis many years ago then developed a large midline incisional hernia which was repaired with mesh 2 years ago. Two days ago she presented with nausea and abdominal pain at a recurrent ventral hernia site and was found to have a partial SBO with a transition point at the hernia on CT scan.

She has been receiving conservative management for the SBO for 3-4 days without return of bowel function.

Exam: distended, hernia larger than usual per patient, not reducible, tender around hernia site HR: 80, BP: 145/60. WBC 11.5.

Physician Instructions: You are about to meet with Mrs. Rodgers and her family to discuss treatment options. You have met with her daily since her admission. The focus of this conversation should be on breaking bad news, describing the treatment options and the decision-making process.

Please assume that you are the patient's primary surgeon. While you may indicate that you would like to discuss further with your attending, we would like you to practice making a treatment recommendation.

General Surgery: Option 1

Newly diagnosed cancer

Mrs. Johnson is a 92-year-old female with history of CAD s/p CABG, paroxysmal afib, HTN, CKD stage III, and severe pulmonary hypertension who was transferred here with newly diagnosed colon cancer. She initially presented to a referring facility with melena (no transfusion required). Colonoscopy revealed an ulcerated mass near the hepatic flexure which biopsy confirmed to be adenocarcinoma. She lives independently but requires some assistance with housework from family who live nearby.

Exam: abdomen soft, non-tender, non-distended, HR irregularly irregular
HR: 72, BP 171/70
Hbg 8, Hct 24

Imaging:
Colonoscopy: Annular ulcerated non-obstructing mass near the hepatic flexure
PET: negative for metastatic disease
Echo: EF 59%, no obvious wall motion abnormalities, severely elevated pulmonary artery systolic pressure

Physician Instructions: You are about to meet Mrs. Johnson and her family to discuss treatment options. You have met her yesterday when she was initially admitted here. She was told at the referring facility that she had colon cancer but that due to her cardiac history she was transferred to your hospital for a second opinion. The focus of this conversation should be on breaking bad news, describing treatment options in the context of this new diagnosis and the decision-making process.

Please assume that you are the patient's primary surgeon. While you may indicate that you would like to discuss further with your attending, we would like you to practice making a treatment recommendation.

General Surgery: Option 2

Acute appendicitis

Mrs. Chang is a 95-year-old female with a history of HTN, HL, CVA with mild residual deficit in the RUE, AAA s/p EVAR, and Alzheimer's dementia who presented to the ER with RLQ abdominal pain. She currently lives in a nursing home and is ambulatory but entirely dependent for all ADLs.

Exam: oriented only to self, falls asleep during questioning, abdomen soft but tender in RLQ without guarding or rebound
HR 69, BP 121/61
WBC 14.5

Imaging:
CT: consistent with acute appendicitis with peri-appendiceal phelgmon concerning for tip perforation

Physician Instructions: You are about to meet with Mrs. Chang and her son/daughter who is her designated healthcare power of attorney to discuss treatment options. You are meeting them for the first time in the emergency room but the ER physician has already informed them of the diagnosis of acute appendicitis. The focus of the conversation should be on breaking bad news, discussing treatment options and the decision-making process.

Please assume that you are the patient's primary surgeon. While you may indicate that you would like to discuss further with your attending, we would like you to practice making a treatment recommendation.

Vascular Surgery

Limb ischemia and gangrene

Mr. Starr is a 75-year-old man with critical limb ischemia and wet gangrene on the left D1-5. He has a history notable for a previous BKA on right leg, and left sided hemiparesis from CVA. He is a current smoker, lives at home with his daughter, but is fully dependent on her for all ADLs. He has developed waxing and waning delirium in hospital

Exam: Elderly man, frail appearing, alert but not oriented
Large, tender left D1 ulceration with smaller ulcerations between each toe, malodorous, only palpable femoral pulse

Imaging:
CTA: long segment occlusion from distal SFA to peroneal artery as the only runoff

Previous hospital Course: Revascularization attempted percutaneously, unsuccessful, no other endovascular options, vein mapping shows adequate vein for bypass

Physician Instructions: You are about to meet with Mr. Starr and his son/daughter to discuss treatment options, given she/he is his designated healthcare power of attorney and Mr. Starr has altered mental status. You have met with them daily since Mr. Starr's admission. Your team has already briefly discussed Mr. Starr's CT scan results and told the family that you were going to speak with them regarding prognosis and possible treatments. The focus of this conversation should be on breaking bad news, discussing treatment options and the decision-making process.

Please assume that you are the patient's primary surgeon. While you may indicate that you would like to discuss further with your attending, we would like you to practice making a treatment recommendation.

Urology:

Renal mass

Mrs. Grady is an 88-year-old female with COPD on 3L of home oxygen with hospitalizations for frequent exacerbations and morbid obesity. She presented to the ER with worsening flank pain and gross hematuria. During her workup a CT scan demonstrated a mass on her left kidney; based on comparison to prior scans it appears to have grown and there is concern for malignancy. She lives in assisted living and uses a walker to get around but is able to do most of her ADLs independently.

Exam: awake and conversant, abdomen soft, left flank tender to palpation

Labs: Cr 0.88, Hgb 7.2

Imaging:
CT: 8 cm heterogeneously enhancing left renal mass concerning for RCC. No evidence of thrombus, lymphadenopathy or metastatic disease.

Physician Instructions: You are about to meet with Mrs. Grady and her family to discuss treatment options. She has been told by another member of your team that there is a kidney mass but it is your job to discuss the treatment options. The focus of the conversation should be on breaking bad news, discussing treatment options and the decision-making process.

Please assume that you are the patient's primary surgeon. While you may indicate that you would like to discuss further with your attending, we would like you to practice making a treatment recommendation.

Cardiothoracic:

Esophageal perforation

Mrs. White is a 79-year-old woman with history of HTN, gastroparesis from type 2 DM, morbid obesity and prior PE on warfarin who presents with severe vomiting, retching and several hours of severe chest pain. Esophagram demonstrates an esophageal perforation. She lives in a SNF. She is cognitively intact but needs help with nearly all activities of daily living.

The patient was intubated in the ER for severe sepsis and admitted to the ICU. She is currently sedated.

Exam: intubated/sedated, BP 82/48 on norepi and vasopressin, pulse 122, $Sp0_2$ – 92%

Imaging:
CXR: large right hydropneumothorax

Physician Instructions: You are about to meet with Mrs. White's family to discuss treatment options. They have been told by another member of your team that there is an abnormal finding on the esophagram but it is your job to discuss the treatment options. The focus of the conversation should be on breaking bad news, discussing treatment options and the decision-making process.

Please assume that you are the patient's primary surgeon. While you may indicate that you would like to discuss further with your attending, we would like you to practice making a treatment recommendation.