QUICK SOLUTION GUIDE

ACUTE ISCHEMIC STROKE IN CAROTID SEVERE STENOSIS

SCENARIO #293

NAME
FRANK BUTLER

SPECIALTY
Neurology

DIFFICULTY LEVEL
INTERMEDIATE

SIMULATION ENVIRONMENT
INTRA HOSPITAL - EMERGENCY ROOM

Dialogues

Ask the following questions to the patient:

History Taking

Chief Complaint

- What happened to you?

History of Present Illness

- When did your symptoms start?
- Have you had any similar symptoms before?

Medications and Allergies

- What medication have you been taking?

Physical examination

Perform the following physical examinations:

Breathing

- O2 Sat (%)

Circulation

- Blood pressure (mmHg)
- Heart rate (bpm)

Disability

- Blood glucose (mg/dL)
- Glasgow Coma Scale

Medical tests

Request the following medical tests:

Decision aids

- Stroke scale (NIHSS)

Imaging

- Cerebral angiography
- Head CT

Treatments

Administer the following treatments:

Thrombectomy

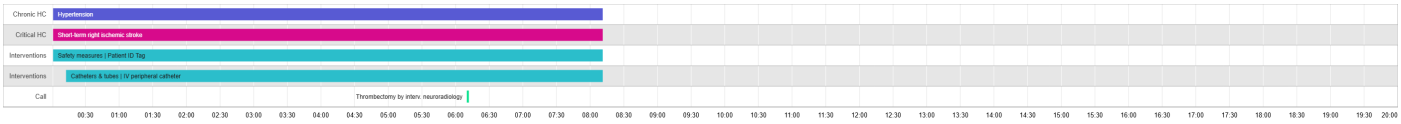
- Call | Thrombectomy by interv. neuroradiology

Baseline

Visualize the baseline approach. The baseline predicts scenario behavior assuming no actions by the trainee, which usually represents the worst-case scenario.

Optimal approach

Visualize the optimal approach to end your simulation successfully.



Assessment question(s) after simulation

Questions presented to the trainee in order to have a more detailed evaluation of the use of the clinical scenario.

Summative Multiple Choice Question:	
Question	What is the most likely diagnosis?
Correct answer	Right hemisphere ischemic stroke
3 Incorrect answer(s)	Basilar artery stroke
	Right hemisphere hemorrhagic stroke
	Brain tumor

Handoff question

Question presented to the trainee to assess their ability to effectively communicate patient information during a transition of care. This question is optional.

Question	Summarize this Body Interact scenario using a structured handoff pattern.
Review handoff pattern	SBAR (Situation, Background, Assessment, Recommendation): Includes current condition and reason for handoff, relevant history and context, assessment details, and recommended actions.
	SOAP (Subjective, Objective, Assessment, Plan): Covers patient-reported symptoms and history, measurable data and

findings, clinical impressions and diagnoses, and the treatment plan.

I-PASS (Illness Severity, Patient Summary, Action List, Situation Awareness and Contingency Planning, Synthesis by Receiver): Encompasses illness status, patient background, tasks and actions, potential changes and plans, and confirmation of understanding.

AT-MIST (Age, Time of incident or onset of symptoms, Mechanism of injury/Medical Complaint, Injuries or Inspections head-to-toe, vital Signs, and Treatments): Describes the cause of injury or medical complaint, findings from head-to-toe inspection, vital signs, and treatments provided.