From this case scenario, there were a couple of red flags that popped up while doing the history and physical examination. The patient was having sudden back pain after moving furniture around. At first, I thought she had just pulled a muscle. She then stated the pain was not getting better and she was not taking any medications for it. When asking her what medications, she takes regularly, she had stated she had increased her steroid dosage. When getting her complete history, I realized she might have broken something from weak bones and was now worried if she had possibly broken a bone. This broken bone might have possibly caused a rupture in her abdomen somewhere.

Based on the key pertinent findings on the physical examination, I realized the worst possible scenario might now be something neurologically related due to the numbness she was having unilaterally in one leg. By locating the history, physical exam, and proper diagnostic testing, these make up the important components to accurately narrow down and identify the patient pathophysiology and differential diagnosis. Low back pain incorporates three distinct sources: axial lumbosacral, radicular, and referred pain (Urits et al., 2019). Being able to distinguish and narrow down the reasoning of what happened with the proper key findings on exam with diagnostic testing, it helps rule out important red flags.

The lessons I learned from this case that I can apply to my future professional practice is looking at the whole picture. When the patient stated back pain, I immediately thought I knew what was going on. I thought she was just having a muscle spasm due to her old age. I also learned I should not judge a patient by her age. If this was a younger person, I might have thought of other differential diagnoses as well. I learned not to judge anyone and assume what is going on.