Weekly Calendar
3/28: Noon Report: ORANGE Team
3/29: Noon Report: None—Senior Change Day
3/31: Weesner Prep: none
       AHD: COPD with Elise
4/1: Intern Orientation to Wards
     Senior Noon Report with Dr. Mathis

Congrats to the Under Dogs for the story book come-from-behind victory at AHD Quiz Bowl!

Anonymous Feedback
Our website has a section for anonymous feedback. Think of this like an electronic suggestion box that you can use at any time. The message will be sent directly to Dr. Warm, and is completely anonymous. If you have constructive feedback that you would like to share, please use this tool. The link is: http://intmed.uc.edu/education/residency/feedback.aspx
**Pancreatic Adenocarcinoma**

- Most common symptoms:
  - weight loss, abdominal pain, and jaundice.
  - Jaundice is characteristic of tumors in the pancreatic head (most common location).
  - Back pain is characteristic of tumors that are located in the body or tail of the pancreas and affect the celiac ganglia.
  - 2/3rds of patients have new-onset diabetes within 36 months prior to cancer diagnosis.

- CT provides staging information.
- EUS does not significantly affect staging but has greater sensitivity in detecting tumors smaller than 2 cm and allows tissue diagnosis by FNA when required.

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**Do NOT place One-time Antibiotic Orders**

When antibiotics are not ordered as a standing medication, there is a chance for patients to miss vital antibiotics. There is almost never an indication to order one-time antibiotics, especially for new admissions.

Clarification: national Emergency Medicine guidelines recommend ED physicians ONLY order one-time antibiotics. **It is the admitting physician’s responsibility to order the admitted patient’s antibiotic regimen.**

This service alert is in response to multiple reported Safety Events that were reviewed at the Inpatient Clinical Core Governance Committee.

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**Know your Care Coordinator**

Hopefully, all residents are aware that each medicine team now has a dedicated Care Coordinator who may be either a nurse case manager or social worker and who coordinates disposition planning and facilitates global patient care issues.

**Starting in April, Care Coordinators will join team rounds!**

This is another step in the movement towards interdisciplinary patient-centered rounding. Please incorporate your Care Coordinators in the bedside rounding discussion. Ask for updates, discuss barriers to discharge, and make sure needs are addressed on rounds. We hope that this step will allow teams to better work together to improve communication between all care providers and ultimately patient care.
HIV + LYMPHADENOPATHY

Differential Diagnoses for Generalized lymphadenopathy:

- **Common causes:**
  - Nontender adenopathy primarily involving axillary, cervical, and occipital nodes develops in majority of individuals during the second week of acute symptomatic HIV infection, concomitant with the emergence of a specific immune response to HIV.
  - Mycobacterial infection: TB, MAC
  - Systemic Lupus Erythematosus
  - Infectious Mononucleosis

- **Uncommon causes:**
  - Castleman's disease: angiofollicular lymph node hyperplasia
  - Kawasaki Disease
  - Amyloidosis

**VA Improvement updates**

The goal of VA Wards improvement is to target the following resident-driven concerns:

- No clear rules/guidelines for number of admissions per daytime shift or when long call will begin admitting
- High number of admissions and discharges over the same time period
- Teams admitting every day in the setting of the above issues
- Easily can have a long day the day prior to long call, resulting in working until 7-8pm on a pre-call day
- Night shift arriving to multiple holdovers on a routine basis

Goals for the new ward structure development include the following:

- Create a ward structure that can handle high census periods of up to 60-64 patients on a medicine service
- Develop strategies that target our high admitting hours (1-8pm) with multiple teams admitting during that time
- Create a culture that allows for clear expectations of what each admitting shift will entail with respect to number of admissions and when your team should anticipate admissions during the day.
- Develop a true non-admitting day or better protect the day prior to long call with a clear limit of admissions in a certain time period, in order to protect duty hours and the feeling that you are working 2 long hour days in a row. This is with the understanding that long call will likely be busy with high number of admissions in order to protect the pre-call team.

We discussed many options on how to target the above issues which will be discussed with VA leadership over the next week. As those discussions occur we will provide more information on what options are realistic and will continue to pursue the best options for our residents, VA faculty, and Veterans.

Thank you for your participation in this process.
The Incoming Class:

NEW interns are coming. And they’re amazing.

Internal Medicine/CSTP/Preliminary Residents by the numbers:

3 PhDs
4 Masters Degrees
4 are AOA/SSP
5 are Humanism in Medicine winners
12 are Phi Beta Kappa
62 published papers
Average Categorical Step Scores: Step I 233, Step II 244 (highest in history for 3rd year running)
Speak 12 different languages (English, Hindi, Spanish, Vietnamese, Urdu, Italian, Chinese, Persian, Telugu, French, Russian, Gujarati, Korean).

Other amazing qualities:
Olympic Triathlon 4th place finisher, Junior Tae Kwan Do national finalist, several classically trained pianists, a jazz flautist, collegiate swimmers, runners, and soccer players, an Americorp Teach for America teacher, painters, rock and roll band members (several), a rugby player, and one person who has seen virtually all of the AFI top 100 American Films of all time!

Coming from 27 Different Medical Schools in 18 states and 3 countries!
### DEPARTMENT OF INTERNAL MEDICINE
#### 2016 MATCH RESULTS

**INTERNAL MEDICINE-CATEGORICAL**
- Syeda Ahmed: Pennsylvania State University College of Medicine
- Ashley Catran: University of Cincinnati College of Medicine
- Brendan Collins: Chicago College of Osteopathic Medicine of Midwestern University
- Matthew Cortese: State University of New York Upstate Medical University
- Matthew Doers: Medical College of Wisconsin
- Connie Fu: University of Cincinnati College of Medicine
- Zulma Garcia: Edward Via College of Osteopathic Medicine
- Borna Ghoorkhanian: University of Cincinnati College of Medicine
- Harika Gorti: Medical College of Georgia at Georgia Regents University
- Weixia Guo: University of Michigan Medical School
- Natalie Hood: University of Cincinnati College of Medicine
- Alan Hyslop: Indiana University School of Medicine
- Rachel John: University of Florida College of Medicine
- Eejung Kim: Yonsei University College of Medicine
- Jeffrey Miller: The University of Toledo College of Medicine
- Alex Niu: Oregon Health & Science University School of Medicine
- Yevgeny Novikov: University of Cincinnati College of Medicine
- Andrea Portocarrero Castillo: Universidad Peruana Cayetano Heredia
- Srirutha Reddy: Texas Tech University Health Sciences Center School of Medicine
- Saagar Sanghvi: Wright State University Boonshoft School of Medicine
- Akshita Sharma: Northeast Ohio Medical University
- Brian Shaw: Creighton University School of Medicine
- Anuj Shukla: University of Tennessee Health Science Center College of Medicine
- Sarah Weiskittel: Wright State University Boonshoft School of Medicine
- David Young: Baylor College of Medicine

**INTERNAL MEDICINE-CLINICAL SCIENTIST TRAINING PROGRAM (CSTP)**
- Jose Gomez-Arroyo: Escuela de Medicina Ignacio A. Santos
- Jennifer Leddon: University of Cincinnati College of Medicine

**INTERNAL MEDICINE-PEDIATRICS**
- Tarun Aurora: Medical College of Georgia
- Kathryn Beaulieu: University of Wisconsin School of Medicine and Public Health
- Julie Broderick: University of Cincinnati College of Medicine
- Scott Call: Virginia Tech Carilion School of Medicine and Research Institute
- Caitlyn Kenny: Florida International University Herbert Wertheim College of Medicine
- Amanda Rutishauser: Michigan State University College of Human Medicine-Grand Rapids
- Allison Stickles: Oregon Health and Science University

**PRELIMINARY INTERNAL MEDICINE**
- Kyle Burton: University of Central Florida College of Medicine
- Tyler Derr: Indiana University School of Medicine
- Ashwin Jain: University of Missouri-Kansas City School of Medicine
- Sean Maloney: New York Institute of Technology College of Osteopathic Medicine
- Catherine Nguyen: University of California, Irvine School of Medicine
- Kory Schrom: Northeast Ohio Medical University

**PRELIMINARY - NEUROLOGY**
- Emerlee Andersen: University of North Dakota School of Medicine and Health Sciences
- Forrest Foster: University of Texas Medical Branch School of Medicine
- Jonathan Hartsorn: Oakland University William Beaumont School of Medicine
- Jacqueline Janecek: Rush Medical College of Rush University Medical Center
- Jack Shen: Wake Forest School of Medicine of Wake Forest Baptist Medical Center
- Stefanie Wolf: Indiana University School of Medicine
- Chelsea Zale: Lake Erie College of Osteopathic Medicine
NEW sepsis and septic shock definitions and clinical criteria were published in JAMA in February 2016. Here are the highlights from the new guidelines (Sepsis-3) and our recent Academic Half Day:

- What is sepsis? Difficult to define syndrome with no gold standard test; 2016 definition = life-threatening organ dysfunction caused by a dysregulated host response to infection AKA among patients with suspected/documented infection…who is really sick?
- SIRS is out! - a. inflammation is appropriate response to infection, new definition of sepsis is dysregulated response to infection b. also, lack sensitivity and specificity
- SOFA and qSOFA are in! - a. mortality predictor scores both in (SOFA) ICU and outside (qSOFA) ICU b. emphasize life-threatening nature of sepsis and septic shock
- Management principles remain the same: a. prompt consideration and recognition b. aggressive resuscitation c. infectious treatment with source control and appropriate antibiosis d. support organ dysfunction as necessary

http://www.qsofa.org/

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<th>OLD</th>
<th>NEW</th>
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<tr>
<td><strong>Sepsis</strong></td>
<td>SIRS + suspected infection</td>
<td>[Suspected/documented infection + 2 or 3 on qSOFA] OR Rise in SOFA score by 2 or more</td>
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<tr>
<td><strong>Severe Sepsis</strong></td>
<td>Sepsis + SBP &lt;90, lactate &gt;2, bilirubin &gt;34, UOP&lt;0.5, creatinine&gt;1.7, Ptts&lt;100k, SaO2&lt;90% RA</td>
<td>Redundant Term, do not use.</td>
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<tr>
<td><strong>Septic Shock</strong></td>
<td>Sepsis + Hypotension after adequate volume resuscitation</td>
<td>Sepsis + vasopressor requirement for MAP&gt;65 + lactate &gt;2 after adequate volume resuscitation</td>
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How to improve the delivery of O2? A. increase FiO2 B. increase PEEP C. optimize Cardiac Output (CO=HR x SV) d. Increase Hb (transfuse)

Delivery of Oxygen = Cardiac Output x (1.34 x Hb x SaO2)

Q: A 55-year-old man is evaluated for a 1-year history of postprandial indigestion. Associated symptoms are nausea, oily stools, and a 4.5-kg (10.0-lb) weight loss over the past 6 months. His medical history is significant for a recent diagnosis of prediabetes. His current medications are ibuprofen, acetaminophen, and omeprazole. PE: vital signs are normal; BMI is 25. Scleral icterus is present. Abdominal examination reveals epigastric abdominal pain without guarding or rebound. The remainder of the examination is normal. Upper endoscopy is normal. Contrast-enhanced CT scan shows a solid 2.5-cm hypoattenuating lesion suspicious for pancreatic adenocarcinoma confined to the head of the pancreas. Dilation of the upstream pancreatic duct and common bile duct is noted. There is no regional lymphadenopathy. The liver parenchyma appears normal. **What is the next best step in management?**

A: In patients who have imaging that is characteristic of resectable pancreatic cancer, tissue sampling prior to potential curative resection is not appropriate, and definitive resection without prior tissue confirmation should be pursued. This patient likely has localized and potentially resectable pancreatic adenocarcinoma. Strong supportive data include clinical risk factors (age ≥50 years, cigarette smoking, new-onset diabetes mellitus), symptoms (weight loss, dyspepsia), and CT imaging findings (a discrete, solid, low-attenuating mass with dilation of the upstream pancreatic duct and common bile duct [“double-duct sign”]). Percutaneous or endoscopic ultrasound-guided tissue sampling is generally not recommended in patients who are operative candidates with potentially resectable (localized) pancreatic cancer because negative results may simply represent sampling error and are insufficient to rule out the presence of cancer. Thus, they entail risk and do not affect management.  

PMID: 24183261

**UPCOMING RESIDENCY EVENTS**

**7NW Inpatient Interdisciplinary Team Meeting**

Please come to be a part of improving patient care through interdisciplinary teamwork on the inpatient side.  
**Tues March 29, 2pm**  
Location: UH 7104 (NRR)

**Master Teacher Program**

Invited Guest Facilitator:  
**Dr. David Hirsh, MD** from Harvard will be presenting a very special Master Teacher Program program you won’t want to miss.  
**Tues March 29, 5:30pm**  
Location: UH 7104 (NRR)

**Residency Research Roundtable**

We are starting a new recurring noon conference where residents can present their research projects for interactive discussion and feedback. Joel and Megan will kick it off!  
**Tues April 19, noon**  
Location: UH 7104 (NRR)
"Big ups to the night floaters [Owen Baldwin and Sarma Singam] for protecting a lone senior her first night flying solo, and for being an incredible sounding board to help give critical patients the care they need. Couldn't do it without you. #team"

to Patricio Alzamora and Betsy Larder for leading the Under Dogs to victory in AHD quiz bowl!
to Joe Cooley for "always going over and beyond when working up his patients and staying late to help admit a patient for ANOTHER team!!!" Take that, Dr. Merriman.

shout out to Betsy Larder and Megan Caroway for representing residents at the meeting to establish the Inpatient Interdisciplinary Team!
to all of the dedicated residents who came to the VA Improvement meeting: Nikki Levin, Joe Cooley, Tim Reed, Lauryn Benninger, Danielle Clark, Tim Reed, Beverly Srinivasan, Devon Carr, Robbie Bach, Owen Baldwin, Thomas Getreu. We are looking forward to how we can work together to improve the resident experience and we appreciate your time and effort!