Weekly Calendar
8/22: Noon report— Green team
8/23: Noon report— Orange team
8/24: Grand Rounds: Resident Poster Presentations, MSB 5051
8/25: AHD: High Yield review, Resiliency; Senior Prep: Anemia
8/26: Morbidity, Mortality, & Improvement

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://www.med.uc.edu/intmed/residency/internal-medicine/residency-feedback
**VA UPDATES**

In addition to the paracentesis trainer, the VA sim lab has a new LP training model, and are acquiring an arthrocentesis training model! Cool stuff happening at the VA!

**7NW Interdisciplinary Improvement Team Huddle**

Come be part of improving patient care through interdisciplinary teamwork! Great opportunities for QI projects!

**EVERY Tuesday at 2pm, Location: UH 7104 (NRR)**

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**Clinic Corner**

**Let’s talk Dexa!**

**What are we screening for:** Osteoporosis

**Who to screen:** USPSTF recommends screening for osteoporosis in women age 65 and older, and in women younger than 65 years old with a 10-year fracture risk equal or greater to the risk of a 65 year old white woman who has no additional risk factors.

**HUH?** How do we figure that out? Use the FRAX tool (google it!). A 65 yo white woman with no additional risk factors for fracture has a 10-year fracture risk of 9.3%. So, if a woman <65 has risks >9.3%, they should get a dxa.

**Why do we care?** Though no controlled studies have evaluated the effect of screening for osteoporosis on fracture rates or fracture related morbidity or mortality, in postmenopausal women who have no previous osteoporotic fractures, the USPSTF found convincing evidence that drug therapies reduce the risk for fractures.

**What about dudes?** USPSTF does not have a screening guideline for men. The Endocrine Society backs screening for men 50-69 years of age with risk factors like history of fracture, delayed puberty, hypogonadism, hyperparathyroidism, hyperthyroidism, COPD, use of glucocorticoids, alcohol abuse or smoking. Keep in mind that insurance may not cover these, and Medicare covers only an initial dxa scan in men with history of vertebral fractures, osteopenia on radiographs, or hyperparathyroidism, or who are on glucocorticoid therapy.

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**CODE VIOLET**

The Code Violet Committee is holding informational and feedback sessions regarding behavioral emergencies. These will be held in Mont Reid 144 from 2-3pm and 5-6pm on Aug 23 and Aug 31.

There is also a NEW order-set for behavioral emergency medications, called “Behavioral Emergency Medication,” or type in “Violet” and it will come up. Make this one of your favorites! It has meds for early intervention as well as emergencies, and suggests medications based on age and QTc!

**ITEs are here!**

Please check your ITE schedule for any possible conflicts! The ITE is required and is a great way to gauge your progress in becoming board certified physicians! The dates are 8/29, 9/6, 9/9, and 9/13. More details to come!
Noon Report Round-up!

Amar Doshi presented a patient in senior report who presented with significant jaundice. What is the diagnostic approach to the patient with jaundice? Let’s talk about it!

Jaundice results from hyperbilirubinemia and can be from overproduction of bilirubin, impaired bilirubin conjugation, biliary obstruction, or hepatic inflammation.

How do you figure it out? Take a thorough history and perform a careful physical exam! (This is usually the answer!)

What do you want to ensure that you ask? Use of medications, herbal supplements, recreational drugs, sexual history and HIV status, risk factors for viral hepatitis, history of inherited disorders, and for other associated symptoms, like fever, anorexia, malaise, abdominal pain, acholic stools.

Look for stigmata of liver disease and cirrhosis on exam!

This patient had predominantly cholestatic transaminitis, with profoundly elevated bilirubin (47!) with mildly elevated AST and ALT, intact synthetic function, and no stigmata of liver disease.

This patient was found to have biliary obstruction, and was diagnosed with cholangiocarcinoma, Klatskin type.
OSMOSIS Challenge!

There are tons of questions on Osmosis for you to test your knowledge and learn even more! We are having HIGH YIELD REVIEW WEEK this upcoming week, and want to challenge you all to build on the knowledge you’ve learned in the past 8 weeks and to “Make it Stick” by doing questions and flashcards.

The Osmosis Challenge consists of everyone trying their best to do the questions and flashcards associated with each module. Each day we will be assigned a different module!

   Monday – Acid Base
   Tuesday – Syncope and Hypertension
   Wed – Pneumonia
   Thurs – Acute Coronary Syndrome
   Friday – Inflammatory Arthritis

The residents who do all the questions in the module get a special shout-out (and bragging rights), plus a little prize (to be determined, but taking suggestions—Thomas will be giving free rides in his Mercedes for the lucky winners!)

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THE STETHOSCOPE
Q: A 21 year old previously healthy female presents to the ED for evaluation of abdominal pain, nausea, and vomiting. On evaluation, her heart rate is 115 bpm, BP 100/70 mmHg, normal temperature, respiratory rate 18 breaths per minute, and normal O2 sat’s on room air. She appears fatigued, her mucous membranes are dry, and her abdominal exam is unremarkable. Her labs are notable for sodium of 140, potassium 3.1, chloride 86, bicarbonate 22, and elevated BUN and creatinine to 26 and 1.6, respectively. Her serum glucose is 456. Her arterial blood gas on room air shows a pH of 7.39, PCO2 37, PaO2 of 98, with a bicarbonate of 22. What is her acid-base disturbance?

A: The answer is D, anion gap metabolic acidosis, metabolic alkalosis, and respiratory alkalosis. The approach to this question needs to include the application of Dr. Warm’s 7 steps to Acid-Base questions, or you are very likely to miss this triple disorder! The danger with an acid base question like this (and the real world presentation of this) is that the numbers typically don’t look that bad - the bicarb, pH, and PCO2 are all pretty close to normal, but this patient’s acid base status is all screwed up! First, note the presentation (concern for DKA with vomiting causing a metabolic alkalosis), then determine anion gap (elevated at 32!), and then apply Winter’s formula (indicates that appropriate compensation would be PCO2 between 39-43), and you’ve just diagnosed an increased anion gap metabolic alkalosis with a respiratory alkalosis. Then, if you calculate the delta gap/delta bicarb, you’ll find that the patient has a metabolic alkalosis as well (delta delta is 10). Even if you don’t calculate the delta delta, cognitively you can see that if you have an anion gap that high, your bicarb should be low and not near normal at 22, so that is your indicator that this is a mixed disorder.
Weekend to-do!


Saturday: Hamilton Dragon Boat Festival, 10 a.m.-2 p.m., RiversEdge Park, 116 Dayton St., Hamilton. Races in real dragon-disguised boats, Chinese food, culture, and dance. Free. rowhamilton.com/dragon-boat-festival.


TRIVIA

What is your diagnosis?
What is your plan going forward (diagnosis, management, explanation to patient, etc)?

SHOUT OUTS!!!

- To Joe Cooley for stepping up to the challenge and exchanging a misplaced central line over a wire in the VA-MICU when a patient was tanking while on pressors. “Kudos Dr. Coolio!” From a thankful VA MICU intern.
- To Emerlee Andersen for “knowing when to grab a senior to see sick people!” From a thankful senior!
- To Leila Borders for refilling outpatient meds like a boss!
- To Suchin Khanna, Elyse Harris, Danny Peters, Megan Caroway, Joel Gabre, Michael Sabbah, Kantha Medepalli, Cody Lee, Kelly Laipply, Marc Guerini, Brendan Collins, Jose Gomez-Arroyo, Alan Hyslop and Javier Baez for working together, covering shifts for one another, and exemplifying the camaraderie and collaborative spirit that makes our residency special. Whether its for interviews, ITEs, personal events, our residents go above and beyond to help one another out, and you guys make us so proud.
- To Kantha Medepalli for appropriately caring for a sick patient, triaging them, and getting them to the right level of care. From a thankful Attending!
- To Harika Gorti for already prepping for next week’s High Yield Review AHD! Ask her about SAAG and ascites!