Weekly Calendar

2/23: Noon Report: Orange Team
2/24: Noon Report: Renal Team
2/25: Medical Grand Rounds: “Personalized Medicine in Cystic Fibrosis” - Dr. Anjaparavanda Naren
2/26: Categorical Intern Retreat!
2/27: M, M & I — Michael Hellmann

Fun Times at Chez VA

Didn’t step over the Pink Line to get these!

Hard at Work

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
**IgA Nephropathy**

Diagnosed by renal biopsy, showing deposits IgA, C3 and IgG in mesangium and along capillary wall.

**Indications for biopsy:** (i.e. do not have to bx if no AKI but + hematuria)

1. Severe or progressive disease (Uprotein > 1g/day, inc Cr)
2. HTN

**How does it present?** 3 Typical presentations.

1. 40-50% present with recurrent episodes hematuria < 5 days after URI (or concurrently with URI). May have flank pain and low-grade fever.
2. 30-40% present with microscopic hematuria/proteinuria discovered incidentally
3. 10% present with nephrotic syndrome or acute RPGN (edema, HTN, AKI, hematuria

**Indications for biopsy:** (i.e. do not have to bx if no AKI but + hematuria)

1. Severe or progressive disease (Uprotein > 1g/day, inc Cr)
2. HTN

**Prognosis:** If < 1g/day proteinuria, low risk progression. If > 1g/d proteinuria or inc Cr --> ESRD 20% at 10 y, 30% at 20 years

**Treatment:**

- BP control + ACEi if proteinuria
- Steroids—indications less clear, but suggested when...
  - Persistent protein > 1g/day after 3-6mo of ACEi
  - Rapidly dec GFR
  - Active disease on biopsy

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**Hyperbilirubinemia**

**Unconjugated (indirect)**

- Overproduction
  - Hemolysis
  - Hematoma
  - Sepsis/stress

- Impaired conjugation
  - Hyperthyroidism
  - Gilbert’s syndrome
  - CNI and CN II

**Conjugated (direct)**

- Biliary Obstruction
  - Choledocholithiasis
  - Cholangioca
  - PSC
  - Pancreatitis
  - Strictures
  - AIDS cholangiopathy
  - Parasites (liver fluke, ascarsis)

- Intrahepatic cholestasis
  - Hepatitis/ESLD
  - PBC
  - Drugs/toxins
  - Infiltrative disease
  - TPN/Postop cholestasis
  - Hepatic crisis in sickle cell disease
  - Pregnancy

**Hepatic Disease in Sickle Cell Patients**

- **Acute sickle hepatic crisis**— 2/2 sinusoidal obstruction/ ischemia:
  - RUQ pain, N/V, jaundice, fever
  - AST, ALT < 300s, Total bili < 15
  - Tx = IVF and analgesia

- **Intrahepatic cholestasis**
  - Above Sx + AKI, bleeding and encephalopathy.
  - AST/ALT higher, Alk phos also inc., Bill higher than 200 reported

- **Acute Sequestration Crisis**
  - RUQ pain, hepatomegaly, falling Hb/Hct
  - Tx = Exchange transfusion

**Additional entities to keep in mind with SCD:**

- **Hepatic Iron Overload**
- **Cholelithiasis**
- **Viral hepatitis**

**BOARDS QUICK HIT:** What else causes hematuria after UTI?

**Post-strep GN:** Hematuria 1-3 weeks after GAS pharyngitis; 3-6 weeks following strep skin infxn.
Epic Confessions: Part Two

Spending all your time popping in each patient’s chart to see if a lab is back or if a consultant has left a note? If you use the **time-mark function**, you can know if anything new has come back on your patient, and be taken directly to that result.

**Step 1:** You must access your team from the My Lists. I suggest dragging the team you are on (i.e. Red Team) into the “inpatient” section of My Lists.

**Step 2:** Set your list up: Click edit list —> Properties. Then select the items you’d like to appear on your patient list (name, mrn, attending, etc.) Be sure to click “New Result Flag” and “New Note”

**Step 3:** Use time mark function. If you look at your patient list, there will now be a column for New Results and New Notes. If a new result or note is available, a “!” or “note” icon will appear. To access a new result, double click on the exclamation point. This will take you to results review. New results will be in *italics*. Click View —> New results View. This will take you to new results —> This is great because if a culture ordered days ago comes back positive, you will be taken right to it, without having to search for it. When done reviewing, click time mark. The new results will un-italicize. Now when you look at your patient list, the “New Result” column will be blank, and you know you are up to date.

Similarly, if a new note is written it will appear as a note icon. Double click on this to be brought to the new notes. When you’re done, click the time mark icon. Then you will know you are up to date in reviewing notes.

As always, find me if you need help!
WIDE COMPLEX TACHYCARDIA: IS IT VT OR SVT WITH ABERRANCY??

Last week’s trivia was SVT with aberrancy. It can be really tricky to distinguish this from VT. Let’s go over some tricks on how to do it...

The following features make VT more likely:

- Absence of RBBB or LBBB morphology
- Extreme axis deviation: QRS + avR and (-) I and aVF
- QRS > 160
- Capture beats: A “normal” QRS that sneaks by and gets conducted
- Fusion beats: A hybrid of a sinus and a ventricular beat
- AV dissociation: As in complete heart block, P’s firing at their own rate and are independent of QRS’s. P’s will march out, but occur throughout the QRS’s:

- + or (-) concordance in V1-V6 (either all + or all (-))
- Brugada’s sign: > 100 ms between onset QRS to nadir of S
- Josephson’s sign: Notching at nadir of S
- RSR’ with taller L rabbit ear

The Brugada algorithm is a tool to help decide SVT vs. VT and involves many of these signs. AV dissociation is one of the easiest to see, and once you see it you’re done —> it’s VT.

The algorithm and description of features not discussed here is available at the website below!

For more info: http://lifeinthefastlane.com/ecg-library/basics/vt_vs_svt/

The good news: It’s okay if you’re not sure!
They can be treated the same:
If unstable (but not pulseless): synchronized cardioversion
If stable: amiodarone

Research Corner: A Slice of UC’s Cutting Edge

Dr. Schauer made the front page of Cincinnati.com this week, with an article written about his research regarding mortality and BMI in bariatric surgery patients. Dr. Schauer’s data was published in Annals of Surgery and was also presented recently at grand rounds. Check out this article for more details, and congrats Dr. Schauer!

The Weekend To-Do List— February 18-22


2) Crosstown showdown: Feb 18, 50 West Brewing Co. Beer tasting battle btwn 50 West and Listermann with a 5 course meal! $50.


5) Broadway in Cincinnati—Anything Goes: Through Feb 22, Aronoff Center. $29+.

Medical Trivia

First person to email to Dana with the correct rash diagnosis gets a Starbucks card!

Medical Trivia Image

Congrats to Dorothy Jung for correctly identifying SVT with aberrancy!

SHOUT OUTS!!! (Let us know who Rocks)

Shout out to Steve Rudick for taking in a “homeless” resident

Shout out to Alicia, Barbie and the Orange Team from a senior resident for handling a busy call like champs!

Shout out Tim Reed and Stephen Evans from an attending for doing an outstanding job with bedside rounds!

Props to Danny Peters for having a positive attitude and making an effort to come to conferences while off-service!