Weekly Calendar

9/7: LABOR DAY Holiday– No Noon Report

9/8: Noon Report: Green Team

9/9: Grand Rounds: Dr. Eckman, “Fundamentals of Cost-Effectiveness Analysis in Medicine”

9/10: Weesner Prep: GI Bleed with Elise

Academic Half-Day: Antibiotics with Rachel

9/11: Noon Report: Red Team

We have Voceras! In an effort to improve patient care and safety, the VA ward teams all now have junior and senior resident Voceras. Want to speak to your patient’s nurse directly? Vocera. Want to know if a lab has been drawn? Vocera. Want to re-enact your childhood with walkie-talkies? Vocera.

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
Alcoholic Hepatitis

The diagnosis of ALD is made by documentation of alcohol excess and evidence of liver disease. No single laboratory marker definitively establishes alcohol to be the etiology of liver disease. AST is typically elevated to a level of 2–6 times the upper limits of normal in severe alcoholic hepatitis. Levels of AST more than 500 IU/L or an alanine aminotransferase (ALT) 200 IU/L are uncommonly seen with alcoholic hepatitis (other than alcoholic foamy degeneration, or concomitant acetaminophen overdose), and should suggest another etiology. In about 70% of patients, the AST/ALT ratio is higher than 2, but this may be of greater value in patients without cirrhosis. Ratios greater than 3 are highly suggestive of ALD.

<table>
<thead>
<tr>
<th>Name</th>
<th>Derivation Set</th>
<th>Elements</th>
<th>Test Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maddrey (modified)</td>
<td>n = 66</td>
<td>MDF = 4.6 (Patient’s PT – control PT) + total bilirubin (mg/dL).</td>
<td>Poor prognosis if score ≥ 32</td>
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<td>Discriminant Function</td>
<td>(1989)</td>
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<td>2. MELD score (2001)</td>
<td>n = 1179</td>
<td>MELD Score = 3.8 * log₂(bilirubin in mg/dL) + 11.2 * log₁₀(INR) + 9.6 * log₅(creatinine mg/dL) + 6.4</td>
<td>Poor prognosis if &gt;18</td>
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<td>(2001)</td>
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<tr>
<td>3. Glasgow Alcoholic Hepatitis</td>
<td>n = 241</td>
<td>Score*:</td>
<td>Poor prognosis if score &gt; 8 (for score calculated on hospital day 1 or day 7)</td>
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<tr>
<td>score (2005)</td>
<td></td>
<td>Age &lt;50</td>
<td>1</td>
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<td></td>
<td></td>
<td>≥50</td>
<td>2</td>
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<td></td>
<td></td>
<td>≥15</td>
<td>3</td>
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<td></td>
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<td>WCC &lt;15</td>
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<td></td>
<td></td>
<td>≥15</td>
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<td></td>
<td></td>
<td>Urea (mmol/L) &lt;5</td>
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<td></td>
<td></td>
<td>≥5</td>
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<td></td>
<td></td>
<td>PT ratio &lt;1.5</td>
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<td></td>
<td></td>
<td>1.5–2.0</td>
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<td></td>
<td></td>
<td>≥2</td>
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<td></td>
<td></td>
<td>Bilirubin (mg/dL) &lt;7.3</td>
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<td>7.3–14.6</td>
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<td></td>
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<td>≥14.6</td>
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Therapeutic Algorithm for the Management of Alcoholic Hepatitis

Establish Disease Severity

Low Risk: MDF <32 and 1st week decrease in bilirubin, or MELD <18 and 1st week decrease in MELD by 2 points

Nutritional Assessment / Intervention

Supportive Care & Close follow-up

High Risk: MDF ≥ 32, presence of HE, or MELD ≥18

Nutritional Assessment / Intervention

Consider Liver Biopsy if Diagnosis is uncertain

If steroid contraindications or early renal failure

Prednisolone

Pentoxifylline

AASLD: Alcoholic Liver Disease Practice Guideline, updated 2015
Low Back Pain: benign or harbinger of doom?

Clinical evaluation of patients with low back pain should focus on identification of features that indicate a potential serious underlying condition, radiculopathy, and psychosocial factors associated with development of chronicity. Clinicians should classify low back pain as acute, subacute, or chronic because the trajectory for improvement varies and treatment options can differ with duration. Most patients with acute symptoms will not require imaging tests, which should be reserved for patients with a high pretest probability of serious underlying systemic illness, fracture, cord compression, or spinal stenosis or for whom surgery is being considered.

Underlying systemic disease that causes back pain is rare but must be considered. Prevalence is 4% for compression fracture, less than 1% for nonskin cancer, 0.3% for ankylosing spondylitis, and 0.01% for infection

A history of cancer is the strongest risk factor for cancer-related back pain; other factors, such as unexplained weight loss, no relief with bed rest, pain lasting more than 1 month, and increased age are also risk factors but only increase risk slightly

Osteomyelitis should be considered if there is a history of intravenous drug use, recent infection, or fever. Increased age, white race, trauma, or prolonged cortico-steroid use are associated with compression fractures.

Patients with at least 4 of the following characteristics require further evaluation for ankylosing spondylitis: morning stiffness, decreased discomfort with exercise, onset of back pain before age 40 years, slow symptom onset, and pain persisting for more than 3 months. However, because of the low prevalence of ankylosing spondylitis, the positive predictive value of these characteristics is still low

The absence of any of these worrisome features is highly sensitive but not specific for excluding patients with systemic illness. The presence of these features may indicate a need for further evaluation.

Ann Intern Med. 2014 Jun 3;160(11):ITC6-1. In the Clinic: Low Back Pain. PMID: 25009837

Would you like home CPRS access? (who wouldn’t??) You’re in luck! Email Li’ Rowley or Adam Rose and they will gladly help you get this set up.

Please welcome our newest Internal Medicine Staff Member:

Jillian Nolte!
Q: A 62-year-old man is hospitalized after being found on the floor of his apartment by a neighbor. The patient is confused and can provide only minimal history and says that he was involved in a fight several days ago. He states that he has high blood pressure and high cholesterol but does not know the names of his medications. The neighbor notes that the patient has a history of alcohol abuse. On physical examination, the patient is thin, disheveled, and malodorous. He is sleepy but arousable, and he is able to move all extremities but has pain when doing so. Numerous bruises and mild lacerations are seen on his body. He is oriented only to his name. Temperature is 37.3 °C (99.2 °F), blood pressure is 165/85 mm Hg, pulse rate is 102/min, and respiration rate is 18/min. There is no icterus; mucous membranes are dry. Cardiac examination is normal. Lungs are clear to auscultation. The abdomen is soft with diffuse, mild tenderness and no distention. There is no peripheral edema. The cranial nerves appear intact. The labs are as shown.

What is the next best step in management of this patient?

A: Aggressive volume resuscitation with NS! The most likely diagnosis is pigment nephropathy from rhabdomyolysis, which develops when muscle injury leads to the release of myoglobin and other intracellular muscle contents into the circulation. Nephrotoxicity results from kidney ischemia and tubular obstruction. Rhabdomyolysis most commonly develops after exposure to myotoxic drugs, infection, excessive exertion, or prolonged immobilization. Diagnosis should be considered in patients with a serum creatine kinase level above 5000 units/L. Another clue is heme positivity on urine dipstick testing in the absence of significant hematuria. The dipstick heme assay detects the presence of myoglobin. This patient presented with bruises and lacerations from a fight, and he was found immobile after consuming alcohol, all of which are risk factors for muscle damage and rhabdomyolysis.

Spotlight on Resident Research:

Our very own Katie Donnelly received a Medical and Pediatric Resident Research Award from the Rheumatology Research Foundation and will be presenting her research at the annual American College of Rheumatology Annual Meeting this fall in San Francisco! Congratulations Katie!!

PMID: 19571284
Weekend To-Do: Labor Day Edition


Sept. 5-Oct. 25: Ohio Renaissance Festival, 10:30 a.m.-6 p.m. Saturday-Monday, Ohio Renaissance Festival, 10542 E. Ohio 73, Harveysburg. Fair with 16th century theme; discounts available online. 513-897-7000; www.renfestival.com.

Through Sept. 6: AVP Pro Beach Volleyball, noon-10 p.m. Friday, 10 a.m.-10 p.m. Saturday, 9 a.m.-4 p.m. Sunday, Lindner Family Tennis Center, 5460 Courseview Drive, Mason. Men’s and women’s professional sand volleyball tournament. 513-253-0545


Sept. 6: Rubber Duck Regatta, 3-4 p.m., Purple People Bridge, Downtown. Nearly 200,000 ducks race along Serpentine Wall for prizes. Advance purchase required. 513-929-3825; www.rubberduckregatta.org.

TRIVIA

This man is said to have refused taking a medicinal compound he previously discovered a world-changing application for.

Shout out to Kelly Laipply for correctly identifying both ACE inhibition and the Brazilian lancehead venom from which it is derived.

First correct answer to Stephen wins a $5 Starbucks gift card!

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

- to Javier Baez and his jumping model capabilities
- to the VA NMT: John Muriithi and Stephanie Ritter for an action-packed week of excellent patient care
- to the entire VA Ward teams: 20 total admissions in a 12 hour time period
- to Dr. Rachel Bensman from her VA team for being present so late in the day, running codes, and just being an overall “awesome, helpful chief”