Weekly Calendar

10/12: Noon Report: **VPP: Special Guest: Sam Quinones**
10/13: Noon Report: **Red Team**
10/14: Grand Rounds: **Chris Droge, PharmD:** “You Can Run, But You Can’t ESKAPE: Perspectives on Antimicrobial Resistance”
10/15: Weesner Prep: NONE
       Academic Half-Day: **The Difficult Patient** with Dr. Warm
10/16: Noon Report– **Senior and Intern: Purple Team**

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](http://intmed.uc.edu/education/residency/feedback.aspx)
The Center for Community Solutions, a nonprofit research and advocacy organization that focuses on human service policy, is bringing award-winning journalist and author Sam Quinones to Cincinnati on October 12, 2015. Mr. Quinones has written extensively on the opiate addiction epidemic that is taking so many lives in Ohio and across the country. His latest book, Dreamland: The True Tale of America’s Opiate Epidemic, weaves together many threads of the story, from changes in pain-relief prescribing practices, to the heroin distribution pipeline from Mexico, and the responses of parents, law enforcement, and communities to these issues. The growth and decline of the "pill mill" industry in southern Ohio and the efforts of communities like Portsmouth to recover from the opiate epidemic play a large role in the book. Mr. Quinones will discuss the evolution of the opiate epidemic and examples of how communities have responded to this challenge.

**Nocardia**

**Organism:** weakly pathogenic bacteria, live in soil

**Primary infection:**
- Pulmonary: productive cough, high fever, chills, weight loss, pleural effusions
- Cutaneous: pustules, pyoderma, paronychia, abscesses, lymphangitis (traumatic introduction of contaminated soil)

**Systemic disease:**
- CNS: most common, more than 40% of cases, abscesses of brain, less commonly spinal cord and meninges
- Also heart, Kidneys, bones, eyes

**At-risk patients:**
- AIDS (CD4<100 usually), lymphoproliferative disorders, solid neoplasias, cirrhosis, transplant, chronic granulomatous disease, immunosuppressive medication

**Diagnosis:**
- CXR: fluffy or reticulonodular infiltrates, upper lobe cavities
- Biopsies/cultures: aerobic filamentous Gram-positive, weakly acid-fast bacteria

**Treatment:**
- High dose Bactrim is the ONLY proven therapy
- Alternatives: Imipeneim, minocycline

**PMID:** 22469352
Dermatomyositis

Idiopathic inflammatory myopathy—both humoral and cellular immune systems responsible with characteristic lymphocytic muscle infiltrates; Dermatomyositis results from dysregulation of the humoral system, whereas polymyositis is caused by T-cell–mediated cytotoxicity.

Onset may occur at any age, peak age is between 40 and 60. Dermatomyositis has a bimodal distribution with peak of onset in childhood (<18 years) and again in mid-life. Women are affected more often than men (ratio of 3:1).

Clinical Manifestations:

- Symmetric proximal muscle weakness with little or no pain; onset is usually acute or subacute with episodic or persistent disease progression. Neck flexor muscles may be involved; in late disease, respiratory muscle weakness may lead to respiratory failure.

- Photosensitive rashes occur over the face, chest, and hands. Heliotrope rash, the V sign, the shawl sign. Gottron papules are erythematos, violaceous, clumped papules over the extensor surfaces of the MCP joints, PIP joints, elbows, and knees and are pathognomonic for dermatomyositis. “Mechanic’s hands” may occur and are characterized by roughened erythematos hyperkeratotic fissuring of the palmar and lateral aspects of finger.

- Interstitial lung disease occurs in 65% of patients with polymyositis and dermatomyositis screened with high-resolution CT, not all of whom are symptomatic.

Diagnosis is based on the presence of progressive proximal muscle weakness, elevation in muscle-associated enzymes, characteristic EMG findings, and chronic inflammation on muscle biopsy. Dermatomyositis: presence of characteristic rash.

Malignancy is strongly associated with the idiopathic inflammatory myopathies, particularly dermatomyositis; screening for occult malignancy is mandatory in adults with these diseases. Assessment for cancer should be age- and sex-appropriate, including urinalysis, chest radiography, colonoscopy, prostate-specific antigen in men, and gynecologic examination with Pap testing and CA-125 in women. Additional testing usually includes pelvic ultrasonography or CT to exclude ovarian cancer.

Amyopathic dermatomyositis is a rare subset of dermatomyositis that presents as a rash without muscle symptoms. Muscle symptoms may be subclinical in some patients, with myositis seen only on imaging studies or biopsy; however, other patients with amyopathic dermatomyositis show no evidence of muscle inflammation, even on biopsy.
**Pearls from the Neuro Exam**

**7th Nerve Palsy:**
- EYEBROW DROOPS
- SMOOTHING OF FOREHEAD AND NASOLABIAL FOLDS
- CORNER OF MOUTH DROPS
- PALPEBRAL FISSURE WIDENS
- CROCODILE TEARS
- SHAVING IS DIFFICULT
- CANNOT PURSE THE LIPS
- FOOD GETS LODGED IN CHEEK

Upper vs Lower lesion:
- LMN lesion results in paralysis of all muscles of facial expression ipsilateral to the lesion; atrophy
- UMN spares forehead

**What does Romberg test?**
Proprioception via the dorsal columns
3 inputs are available for perception of body in space, 2 are necessary at all times:
1. Proprioception
2. Vestibular
3. Visual cues
Remove visual cues and if unable to maintain balance, proprioception is impaired.

**Romberg tests proprioception, NOT the cerebellum**

**Bitemporal hemianopsia:** think pituitary tumor
**Homonymous hemianopsia:** think stroke

**Forehead affected:** think Bell’s Palsy
**Forehead spared:** think stroke

**Monocular diplopia** = local eye disease, most often refractive error
**Binocular diplopia** = ocular misalignment, concerning for lesion of CN III, IV, or VI
Q: 61-year-old woman is evaluated for intermittent abdominal discomfort and a bloating sensation. Approximately 2 months before the swelling started, the patient had a pruritic, gradually progressive rash characterized by redness of the face, and a pruritic rash on her chest, upper back, shoulders, hands, and lateral hips. She has no muscle pain, weakness, or joint pain. Pertinent family history includes breast cancer in her mother and ovarian cancer in her grandmother. Mammogram, Pap test, and colonoscopy, all performed within the last year, were normal. VS are normal. There is violaceous erythema of the periorbital region. She has reticulate and poikilodermatous erythema of the V-neck of the chest with areas of cutaneous ulceration. There are small, flat-topped erythematous papules over the distal and proximal interphalangeal joints. Lungs are clear. There is no lymphadenopathy or hepatosplenomegaly. The patient has normal strength. Pelvic examination is normal. Laboratory findings reveal normal CBC, CMP, LFTs, CK, and aldolase. EMG of R arm and leg is normal. What is the next best step in evaluation?

A: Transvaginal ultrasound to evaluate for ovarian cancer in a patient with amyopathic dermatomyositis: typical rash and histologic findings of dermatomyositis but in the absence of clinical myopathy. In these patients, as well as in patients with classic dermatomyositis, ovarian cancers are overrepresented, and these patients should be evaluated with appropriate imaging. Patients with dermatomyositis and cutaneous ulcerations may be at an even higher risk of malignancy. Given this patient's symptoms of increasing abdominal girth, along with her family history, ovarian cancer is a reasonable concern.

PMID: 19258446

Shout out from the White House

A patient recently cared for at our Cincinnati VA wrote a letter describing their appreciation for the phenomenal care they received here at the hands of our medicine teams. Singled out were Charlotte So, Owen Baldwin, Jensine Norman, Elliott Welford, Kantha Medepalli, Bo Franklin, and Jesse Rhodes. They will be receiving a letter of appreciation from the Secretary of the VA in recognition of their service. Way to represent Cincinnati!
Weekend To-Do:


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**TRIVIA**

_Name this eye finding and the associated disease._

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

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

-to **Nikki Levin**, **Elyse Harris**, **Clay Turner**, **Betsy Larder**, **Leslie Applegate**, and **Bo Franklin** for being courageous and skillful in their Neuro exam performances at AHD!

-to **Jess Scott** for going the extra mile to be a fantastic team player!

-to **Betsy Larder** and **Elliott Welford** for going the extra mile (60 miles, actually!) to learn more about a resiliency program we want to bring to UC!

-to **Monique Jindal** for her dedication to optimizing care for a dying patient and her family.

-to **Amar Doshi**, **Nikki Levin**, and **Aditi Mulgund** for staying relentlessly curious and positive despite a very busy work load.