Weekly Calendar

11/16: Renal Team Noon Report—Noon report room
11/17: Hem/Onc Team Noon Report with CANDIDATES in MSB 5051
   ***note location change for recruitment season***
11/18: Grand Rounds: Jason Blackard, PhD: “Hepatitis B: At Home and Abroad”
11/19: Weesner Prep: none (Thanksgiving following week)
   AHD: Solid Tumors with Stephen
11/20: Yellow Team Noon Report with CANDIDATES in MSB 5051
   ***note location change for recruitment season***

Updates from Residency Council:

- Procedures must be supervised by an attending at all times. Policy is on Dropbox. If you have any questions, contact Rachel (day) or chief on call 24/7.
- Dayfloat may be more helpful at the VA. At the request of residents, we are going to trial Dayfloat assistance at the VA.
  - Fleeces are coming soon. Watch your inbox!
  - Per resident request, we agreed on guidelines for communication with the chiefs:
    1. Chiefs are expected to respond to email within 2 business days.
    2. If no response in 2 days, please contact again. Although every effort is made to respond to email in a timely manner, the chiefs regret that they are not immune to error, i.e. missed email.
    3. If more urgent communication is needed, please call, text, page, or find in person. For urgent needs after hours, please contact chief on call.

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
On Tuesday, the GI team discussed the evaluation of chronic diarrhea at noon report. History is key to narrowing testing for specific categories of disease. Volume, timing (nocturnal, post-prandial), characteristics (bloody), extra-intestinal symptoms (rash), and family history are all essential to get to the right diagnostic path.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Diagnostics</th>
<th>Clues/Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcerative Colitis</td>
<td>Colonoscopy w/ bx</td>
<td>bloody diarrhea, tenesmus</td>
</tr>
<tr>
<td>Crohn's Disease</td>
<td>Ileocolonoscopy with bx, small bowel imaging</td>
<td>weight loss, abd pain, perianal dx</td>
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<tr>
<td>Microscopic Colitis</td>
<td>Colonoscopy w/ bx</td>
<td>secretory diarrhea</td>
</tr>
<tr>
<td>Celiac Disease</td>
<td>Serologies (tTG, IgA), EGD with SB bx</td>
<td>extraintestinal features, family history</td>
</tr>
<tr>
<td>Small Intestinal Bacterial Overgrowth</td>
<td>EGD, small-bowel cultures, hydrogen breath test</td>
<td>bloating, excess flatus, malabsorption</td>
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<tr>
<td>Carbohydrate Malabsorption</td>
<td>detailed history, hydrogen breath testing, stool osmotic gap</td>
<td>bloating, excess flatus</td>
</tr>
<tr>
<td>Pancreatic Insufficiency</td>
<td>chronic pancreatitis on imaging (CT, EUS, MRCP), 48-72hr fecal fat, pancreatic function tests</td>
<td>known pancreatic dx/resection, weight loss</td>
</tr>
<tr>
<td>Bile Acid Malabsorption</td>
<td>history, response to cholestyramine</td>
<td>terminal ileal resection (&lt;100cm)</td>
</tr>
<tr>
<td>Bile Acid Deficiency</td>
<td>history, steatorrhea, response to medium-chain triglyceride diet</td>
<td>terminal ileal resection (&gt;100cm)</td>
</tr>
<tr>
<td>Ischemia</td>
<td>Colonoscopy w/ bx</td>
<td>low-flow states, CV risk factors</td>
</tr>
<tr>
<td>Radiation Enteropathy</td>
<td>History, colonoscopy with bx</td>
<td>prior radiation to abdomen/pelvis</td>
</tr>
<tr>
<td>IBS</td>
<td>History with Rome criteria, exclude other disease</td>
<td>symptoms relieved after BM</td>
</tr>
<tr>
<td>Eosinophilic enteritis</td>
<td>eosinophilia on small-bowel bx or full-thickness bowel bx</td>
<td>atopic history, peripheral eosinophilia</td>
</tr>
<tr>
<td>Whipple Disease</td>
<td>small-bowel bx with PAS+ macrophages that are acid-fast neg, PCR biopsied affected tissue</td>
<td>arthralgia, lymphadenopathy, neurologic symptoms</td>
</tr>
<tr>
<td>Iatrogenic</td>
<td>history</td>
<td>initiation of enteral nutrition or meds</td>
</tr>
<tr>
<td>Factitious</td>
<td>dx of exclusion</td>
<td>High volume/frequency, bulimia/anorexia, weight loss, stool Mg &gt;90mEq/L may be diagnostic</td>
</tr>
</tbody>
</table>
At Academic Half Day, we reviewed the diagnostic approach to joint pain with a focus on chronic inflammatory arthritis. The emphasis was on:
1. Characteristics to narrow the differential (figure at right)
2. Disease scripts (table below)
3. Management of RA and gout for the internist

A few tips from Dr. Ware:
- remember to prophylax with colchicine when initiating urate-lowering therapy (allopurinol) - for about 6 months or until at goal uric acid (<6)
- BUT, respect the kidney. Do NOT use long-term colchicine in CKD patients.
- if in doubt, hold biologic DMARDs on admission to hospital. Most have long half lives and a temporary hold until you can discuss with your local friendly rheumatologist is unlikely to cause a problem.

<table>
<thead>
<tr>
<th>Arthritis</th>
<th>Inflammation</th>
<th>Pattern</th>
<th>Symmetry</th>
<th>Axial</th>
<th>Extra-articular</th>
<th>F:M, age</th>
<th>Labs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid Arthritis</td>
<td>Yes</td>
<td>Small + large</td>
<td>Yes</td>
<td>Cervical</td>
<td>subcutaneous nodules, carpal tunnel</td>
<td>3:4:1</td>
<td>RF, CCP</td>
</tr>
<tr>
<td>SLE</td>
<td>Yes</td>
<td>Small</td>
<td>Yes</td>
<td>No</td>
<td>malar rash, serositis, oral ulcers, anemia</td>
<td>9:1</td>
<td>Anti-DSDNA, Anti-Smith</td>
</tr>
<tr>
<td>OA</td>
<td>No</td>
<td>LE, PIP and DIP</td>
<td>Yes/No</td>
<td>cervical, lumbar</td>
<td>none</td>
<td>1:1, old</td>
<td>normal acute phase reactants</td>
</tr>
<tr>
<td>Ankylosing Spondylitis</td>
<td>Yes</td>
<td>large</td>
<td>Yes</td>
<td>Yes</td>
<td>iritis, tendonitis, aortic insufficiency</td>
<td>1:1-5, young</td>
<td>HLA B27</td>
</tr>
<tr>
<td>Psoriatic Arthritis</td>
<td>Yes</td>
<td>Large + small</td>
<td>No</td>
<td>Yes/No</td>
<td>Psoriasis, tendonitis, dactylitis, nail dystrophy</td>
<td>1:1</td>
<td>HLA B27</td>
</tr>
<tr>
<td>Adult onset Still’s Disease</td>
<td>Yes</td>
<td>Large, wrists</td>
<td>No</td>
<td>No</td>
<td>evanescent salmon rash, spiking fevers</td>
<td>1:1, young</td>
<td>transaminitis, elev ferritin, leukocytosis</td>
</tr>
<tr>
<td>Reactive arthritis</td>
<td>Yes</td>
<td>LE&gt;UE, any</td>
<td>No</td>
<td>Yes</td>
<td>conjunctivitis, preceding GU or GI illness, rashes</td>
<td>1:1, young</td>
<td>culture negative, HLA B27</td>
</tr>
</tbody>
</table>
BOARD REVIEW WITH THE CHIEFS:
DUST OFF THOSE OLD STETHOSCOPES, FOLKS. KEEP ON TRACK FOR BOARDS STUDYING.

Q: A 55-year-old man is evaluated after being found unconscious outside of his home by family members. He was difficult to arouse and confused. He was breathing spontaneously, but rapidly and shallow. PE: AF, BP 135/91, HR 110, and RR 24/min. He is arousable only with noxious stimuli. Other than tachycardia, cardiopulmonary examination is normal. The abdomen is soft. There are no focal findings on neuro exam. Tox screen is negative for ethanol, opioids, benzodiazepines. Chest radiograph shows no lung infiltrates or masses. There is very little urine in the bladder, but urine obtained by catheterization contains many erythrocytes and envelope-shaped crystals. What is the most appropriate treatment?

A: IV Fomepizole and Hemodialysis. This patient has acute toxicity from ingestion of ethylene glycol, a component of antifreeze and solvents. Metabolism of ethylene glycol by alcohol dehydrogenase generates various acids, including glycolic, oxalic, and formic acids. Initially this causes neurologic manifestations similar to ethanol intoxication, and seizures and coma can rapidly develop. If this condition is not treated, noncardiogenic pulmonary edema and cardiovascular collapse may occur. Approximately 24 to 48 hours after ethylene glycol ingestion, patients may develop flank pain and kidney failure that are often accompanied by calcium oxalate crystals in the urine. Fomepizole is an inhibitor of alcohol dehydrogenase and should be given to decrease metabolism of ethylene glycol, which is itself not toxic. Hemodialysis should be started in this patient because there is evidence of end-organ damage to the kidney (elevated serum creatinine, oliguria, and hematuria), an osmolar gap (104 mosm/kg [104 mmol/kg]), and significant anion gap metabolic acidosis (anion gap, 36 meq/L [36 mmol/L]), even though the acidosis may be masked by concomitant respiratory alkalosis and metabolic alkalosis from vomiting.

Hemodialysis plays a crucial role in ethylene glycol poisoning, particularly in patients with impending acute kidney failure. Hemodialysis alone would remove toxic metabolites, but without any competitive inhibition, ethylene glycol would continue to be converted into additional toxins.

PMID: 20090509

BUN 14 mg/dL
Creatinine 1.9 mg/dL
Sodium 138 meq/L
Potassium 4.1 meq/L
Chloride 90 meq/L
Bicarbonate 12 meq/L
Glucose 90 mg/dL
Lactic acid 2.8 mg/dL
Serum osmolality 390 mosm/kg
pH 7.24
Arterial PCO₂ 28 mm Hg
Arterial PO₂ 102 mm Hg

Have a case of the Mondays?
Do you like caffeine? Do you like to be given things without having to pay for them? Then be sure to head down to Copper Moon before 10AM and receive FREE Coffee for the whole month of November!

Master Teacher Program
Next session in this week! We will be reviewing how to write and successfully achieve learning objectives.
5pm November 17th
Location: UH 7104 (Noon Report Room)
Weekend To-Do:

Nov. 14: UC Bearcats Football, 7:30 p.m., Nippert Stadium, University of Cincinnati, University Heights. vs. Tulsa. $38 and up. 513-556-2287; www.gobearcats.com.


Nov. 13-15: Greater Cincinnati Holiday Market, 10 a.m.-6 p.m. Friday-Saturday, 10 a.m.-5 p.m. Sunday, Duke Energy Convention Center, 525 Elm St., Downtown. More than 100 displays from one-of-a-kind boutiques and specialty retailers. $9, free ages 12 and under with paying adult. 513-797-7900; www.hartproductions.com

Open now: U.S. Bank Ice Rink, noon-10 p.m. Monday-Thursday, 9 a.m.-11 p.m. Friday-Saturday, 9 a.m.-9 p.m. Sunday, Fountain Square, Fifth and Vine streets, Downtown. Through Feb. 15. $6 admission, $4 skate rental. 513-381-0782; www.myfountainsquare.com.

TRIVIA

This young woman presented with several months of progressive amblyopia and bilateral vision loss. What is her most likely underlying systemic disorder?

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

NOBODY got trivia last week. I know someone out there can “see” what’s happening here...

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

to Nikhil Shukla for winning an ICARE award at the VA! Way to represent!

to Sherri, Patricio, Greg, Greg, and Kate for presenting great cases at applicant noon report this week! We really appreciate the participation!

to Charlotte So for miraculously getting food in the lounge on Veterans Day when the fridge was EMPTY. We applaud your advocacy!

to Jane Neiheisel and Charlotte So for catching a STEMI on a transfer patient just as they arrived to our floor. Huge safety catch for patient care!

to Long Davalos and Brian May for going the extra mile to help a long call resident finish her work. Yay team!

to the entire night float squad on for the EPIC Epic downtime last weekend. Way to stick with it and take care of patients. You rock!