Weekly Calendar


4/5: Noon Report: **Blue Team**

4/6: Grand Rounds: “**Updates in Pre-Operative and Peri-Operative Medicine**” Dr. Arshia Ali, MD

4/7: Weesner Prep: **Vasculitis with Li’**

AHD: **AHD with Dr. Warm**


Senior Noon Report: **Red Team**

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**Monday is an unofficial Cincinnati holiday: Reds Opening Day 2016!**

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**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)
“A common preventable and treatable disease characterized by airflow limitation that is usually progressive and associated with an enhanced chronic inflammatory response in the airways and the lung to noxious particles or gases. Exacerbations and comorbidities contribute to the overall severity in individual patients.” – GOLD, WHO, NHLBI, 2016

<table>
<thead>
<tr>
<th>Therapy for Stable COPD</th>
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<tbody>
<tr>
<td><strong>SA = short acting; LA = long acting; ICS = inhaled corticosteroid</strong></td>
</tr>
<tr>
<td><strong>ALL patients:</strong> Smoking cessation and avoidance of noxious gasses, physical activity, influenza vaccine, Pneumovax</td>
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<table>
<thead>
<tr>
<th>Patient Group</th>
<th>Recommended 1st choice</th>
<th>Alternative choice</th>
<th>Other possible treatments</th>
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<tbody>
<tr>
<td><strong>A</strong></td>
<td>SA anticholinergic PRN or SA beta-2 agonist PRN</td>
<td>LA anticholinergic or LA beta-2 agonist or SA beta-2 agonist and SA anticholinergic</td>
<td>Theophylline</td>
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<tr>
<td><strong>B</strong></td>
<td>LA anticholinergic or LA Beta-2 agonist</td>
<td>LA anticholinergic and LA beta-2 agonist</td>
<td>SA beta-2 agonist and/or SA anticholinergic</td>
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<td><strong>C</strong></td>
<td>ICS and LA beta-2 agonist or LA anticholinergic</td>
<td>LA anticholinergic and LA beta-2 agonist or PDE-4 inhibitor</td>
<td>SA beta-2 agonist and/or SA anticholinergic</td>
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<tr>
<td><strong>D</strong></td>
<td>ICS and LA beta-2 agonist and/or LA anticholinergic</td>
<td>ICS and LA anticholinergic or ICS and Long acting beta-2 agonist and PDE-4 inhibitor or LA anticholinergic and LA beta-2 agonist or PDE-4 inhibitor</td>
<td>SA beta-2 agonist and/or SA anticholinergic</td>
</tr>
</tbody>
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Patients with FEV1 <60% should be prescribed ICS (ATS, ACP, ERS, ACCP, 2011)

Pulmonary rehabilitation for categories C-D (FEV1 <50% predicted) (ATS, ACP, ERS, ACCP, 2011)

Oxygen for hypoxemia: PaO2 ≤55mmHg or SpO2 88%

**What defines an acute exacerbation?** 3 cardinal symptoms: increased dyspnea, increased sputum volume, increased sputum purulence

**How do you grade their exacerbation?** MILD = 1/3, MODERATE/SEVERE = 2 or 3/3

**Any complicating factors?** >65 y/o, presence of cardiac disease, >/= 3 exacerbations per year, FEV1<50%

**Questions to consider:** what is the optimal tailored regimen of bronchodilators, steroids, and does pt require Abx? How does supplemental oxygen increase CO2 retention in patients with COPD??
Testing Update:

- “I’m sure you’ve noticed the break from the blackboard testing program. Hopefully you haven’t forgotten the importance of testing, spacing, and interleaving. These key learning principles were covered in Wednesdays Grand Rounds with Dr. David Hirsh.

- We are currently in the process of transitioning from blackboard questions to a different platform that will hopefully better capitalize upon these learning principles. This new platform is called Osmosis and it is used in several Medical Schools with 25,000 questions answered daily. We will hopefully begin trialing out Osmosis in the next couple of months, so stay tuned for more information. If you’re interested, I need help editing the current questions we have to make sure the format and content fit the new platform. Please email me if interested!” : kellehmw@ucmail.uc.edu

Procedures Update:

Coming Soon:

Paracentesis Assessment Tool Pilot

- We will be piloting our assessment tool on **April 15th, 28th and 29th** in the VA simulation lab

- **We need volunteers of all different skill level so the tool can be validated**

- Once the tool is validated, we will begin our training curriculum

- **Dana Sall** will send out an email with a sign up and details— stay tuned!
April Fools Day: Hospital Edition

- **Anesthesia** – After giving your coworker a morning break during a prone IV sedation case, have an empty syringe of rocuronium in your hand when they return and say, “I just gave this since the patient was moving. Seeya.”

- **Gastroenterology** – After a colonoscopy, leave a fake plastic snake under the sheets for the PACU nurse to find.

- **Emergency Medicine** – Print out an EKG with ST segment changes and tell a medical student to take it to another staff physician and say, “Oops, I forgot to show you the EKG of the patient we just discharged.”

- **Pediatrics** – After taking a newborn baby for a checkup, bring back the wrong baby to the mom, just to see the look on her face or if they even pick up on it.

- **OB/GYN** – Put a water cup on top of the staff obstetrician break room door. Record simulated FHT sounds in the 50s and then play it really loud.

- **Hospitalist** – Call orthopedics and tell them there is a non-operative patient in the ER that you want them to admit to their service, with the hospitalist service consulting.

- **Radiology** – End a dictation, “With 100% and absolute certainty and no need for clinical correlation, this film demonstrates clear… click.”

- **Residents** – Actually setup a mandatory naptime area for yourselves, ask for milk.

- **Cardiology** – Recommend more fluid for the patient.

- **Neurology** – Don’t identify the lesion, but offer a treatment plan.

- **Pediatrics** – After giving vaccines to a kid, just start laughing and say “Cha-Ching! Another check from big pharma coming for me!”
Drug-Induced Thrombocytopenia

VA-Team 2 presented a case of sudden onset severe thrombocytopenia after receiving vancomycin and piperacillin/tazobactam. This was the 2nd presentation with severe thrombocytopenia after receiving vancomycin and piperacillin/tazobactam, now having developed thrombocytopenia less than 24 hours after admission. The team excluded other causes of thrombocytopenia and ordered antibody testing to confirm a diagnosis of DITP. Antibodies to piperacillin were positive.

Clinical Presentation:
- Acute onset, typically sudden onset or recurrent acute episodes that is unexpected
- Onset is on average 6.5 days after initial continuous exposure of drug
- However if the patient has been exposed previously to the drug then thrombocytopenia can develop within 24 hours of exposure
- Thrombocytopenia is often severe with a nadir platelet count of <20,000
- Typically the only lab finding is thrombocytopenia, with no other blood lines affected. Petechiae, purpura or mucosal bleeding may occur

Diagnosis:
- DITP is a clinical diagnosis and must exclude other potential causes of thrombocytopenia
- Confirm thrombocytopenia with repeat CBC
- Rule out potential viral infections, nutrient deficiencies, TTP, unrecognized inherited platelet disorders, and myelodysplastic syndrome
- Often if the above causes of thrombocytopenia have been ruled out and there is a clinical history of new exposure to a drug known to cause DITP, diagnosis can be made with history alone.
- However, if multiple new medications have been given or medications not known to cause DITP have been given then it is reasonable to order antibody testing

Mechanism of DITP in setting of Piperacillin:
- Thrombocytopenia develops due to accelerated platelet destruction from drug dependent, platelet-reactive antibodies

Treatment of DITP:
- Remove the offending agent
- Platelet transfusions for plts <10,000, clinically significant hemorrhage, or need for emergency invasive procedures

http://www.ncbi.nlm.nih.gov/pmc/articles/
7NW Interdisciplinary Team Mtg

Improving inpatient care with everyone at the table

1. Have an issue/problem on 7NW you would like to address?
2. Write it on the NRR whiteboard (HIPAA! - no patient ID please)
3. Come be part of the solution!

Beginning **April 11th** you must log-on to all VA computers using your PIV badge and PIN number. If you do not have a badge or do not remember your PIN number to please Li’:

bartholm@ucmail.uc.edu
BOARD REVIEW WITH THE CHIEFS:
DUST OFF THOSE OLD STETHOSCOPES, FOLKS. IT'S BOARDS STUDYING TIME!

My patient is asymptomatic, but has elevated Ca and elevated intact PTH consistent with a diagnosis of primary hyperparathyroidism. How do I know when to refer for parathyroidectomy?

Know the surgical indications for primary hyperparathyroidism: significantly elevated Ca, evidence of renal dysfunction: Creatinine clearance <60 mL/min, bone mineral disease by DEXA scan: T-score of -2.5 or worse at Lumbar spine, total hip, femoral neck, or distal radius, or age <=50 years. Patients with these indications will have the best benefit from parathyroidectomy.

Serum Ca > 1mg above ULN
Creatinine clearance <60mL/min
T-score of -2.5 or worse
Age <= 50 years old

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Sports on Sundays!

Warm weather have you feeling great? Miss the chance to run around a grass field chasing things?

We are bringing back Sports on Sundays. Soccer, football, ultimate Frisbee, baseball, dodgeball, kickball— you name it and we can organize it. If interested— email Stephen — all are invited!

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Clinic Corner:

Interns! AME next week 4/4-4/8 Latent TB – find in your Dropbox folder or in Medhub

Long Blockers! AAP – none; Mathis Exam Review: Endocrine 4/6 5PM Noon Report Room

Call your patients and tell them to get their sneakers on!

Walk with a Doc 4/14 4PM after Diabetes Education Class in Derm/Ophtho Conference Room

Walk with a Doc 4/30 12PM at Washington Park


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Guidelines for the Management of Asymptomatic Primary Hyperparathyroidism: Summary Statement from the Fourth International Workshop

PMID: 25162665
**Weekend to-do! Opening Day Edition**

**Cincinnati Gorilla Run**, 11 a.m., Montgomery Inn Boathouse, 925 Riverside Drive, Downtown. Registration begins 9 a.m. 5K fun run/walk. Everyone who takes part gets full gorilla or banana suit to keep. www.cincinnatigorillarun.com.

**Cinci-Cart-Ic Race**, noon, Fountain Square, Fifth and Vine streets, Downtown. Teams of 5 race through 5-mile course while physically attached to shopping carts. www.myfountainsquare.com.

**Cincinnati Opening Day Art Event**, 7-11 p.m., The BLDG, 30 W. Pike St., Covington. www.bldgrefuge.com.


**Zoo Blooms**, 10 a.m.-5 p.m. daily, Cincinnati Zoo and Botanical Garden, 3400 Vine St., Avondale. Features largest tulip display in Midwest. www.cincinnatizoo.org.

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**TRIVIA**

What drug causes this urinary crystal?

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**SHOUT OUTS!!!**

- to Dorothy Jung and Sarma Singam for being awesome
- to Jeremy Sorkin for senior reporting on short notice
- to our AODs: Steve Gannon, Steve Bohinc, and Jess Scott for helping out with admissions during busy long-calls
- to Danielle Clark and Steve Cogorno for being VA ward seniors this month