Weekly Calendar
4/24: Noon Report: Community Health and Advocacy
4/25: Noon Report: Orange Team
4/26: Grand rounds: Michael Binder, MD: “The Opioid Addiction Crisis” MSB 7051)
4/27: AHD: Infectious Diarrhea; Senior prep: Inflammatory Bowel Disease
4/28: Morbidity, Mortality, & Improvement (MSB 3051)

Sometimes, on one of the first real Springy days of the year, you just gotta lounge in the sun in your scrubs, right Kantha?

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://www.med.uc.edu/intmed/residency/internal-medicine/residency-feedback](http://www.med.uc.edu/intmed/residency/internal-medicine/residency-feedback)
Clinic Corner  Subclinical Hypothyroidism

Subclinical hypothyroidism is defined as an asymptomatic state with an elevated TSH but a normal serum T4 level. This can be caused by a variety of entities, like iodine containing meds, lithium, cytokines, thyroid infiltration, etc. Typically, patients with TSH levels greater than 10 should be treated with thyroid hormone replacement, and pregnant patients have different considerations for treatment. Who else should be treated? The algorithm below utilizes the patient age to help make the decision, as older patients are more likely to have complications from treatment with levothyroxine. Note that if you choose to observe patients, you should obtain TSH and T4 levels every 6 months until stable (or overt hypothyroidism, in which case you would treat), and then the thyroid profile can be monitored yearly.

For the purposes of this algorithm, convincing symptoms of hypothyroidism are new or worsening fatigue, cold intolerance, and constipation.

Life Planning, Financial and otherwise, for Residents!
When: 4/26, 7:30 to 9 AM
Where: MSB 2001
What: Day 2 will be contract review/ negotiations with Attorney Orly Rumberg.
Breakfast will be served!

Welcome to the World: Evelyn Srinivasan!
Born April 14th at 12:49 AM
6 lbs 2 oz, 19 inches
Mom Beverly evaluates Evelyn at entrustment level 4 for pooping, eating, cuddling, and crying; however Evelyn is only entrustment level 1 for sleeping.
Q. A 76 year old patient with past medical history significant for hypertension, hyperlipidemia, and iron deficiency anemia on PO iron supplementation is admitted for evaluation of abdominal pain. He mentions that he has had decreased bowel movements in the last week, and says that his belly hurts all over, particularly after he eats. His appetite has been poor. A plain radiograph of the abdomen shows a significant stool burden. He has no surgical history other than a right TKA. The patient is admitted for treatment of obstipation with polyethylene glycol and SMOG enemas. He has minimal improvement in his symptoms. Two nights later, a rapid response is called for hypotension and altered mental status. The patient was febrile. The patient is transferred to the MICU where he is intubated for respiratory failure and shock support, a central line is placed for pressor support, he is volume resuscitated and treated for presumptive septic shock. He was started on broad spectrum antibiotics and later blood cultures returned positive for growth of E. coli. CT scan showed a pericholecystic fluid collection. Review of the case showed that the patient developed leukocytosis on the day after admission and complained of specific right upper quadrant pain. The patient is reviewed as part of a SWARM for a missed diagnosis of acute cholecystitis. What cognitive dispositions to respond (biases) contributed to this diagnostic error?

A. Outcome bias  
B. Representiveness restraint  
C. Anchoring bias  
D. Commission bias

A. The correct answer is C, anchoring bias. Biases, or cognitive predispositions to respond, are often underlying diagnostic errors. Oftentimes, we review cases like the above in Morbidity, Mortality, and Improvement conference or in SWARMs, where we are subject to hindsight bias, but it is important to think about the role of bias in decision making in order to best find ways to mitigate our biases. For this patient, the care team anchored on the diagnosis of obstipation and did not adjust their impression despite additional information (worsened RUQ pain and leukocytosis). Similar to this bias is premature closure, accepting a diagnosis before it has been fully confirmed or vetted. Less likely to be biases significant to this case: outcome bias is the bias of “hoping and preparing for the best,” or the tendency to decide on a diagnosis that portends good outcomes than bad (ie diagnosis of poor appetite resulting in weight loss rather than it being from metastatic cancer); commission bias is a cognitive disposition to respond where the tendency is to perform active intervention as the only means of preventing harm ("do something even if its wrong"), and representiveness restraint bias is the bias of “if it walks like a duck and quacks like a duck, it’s a duck” and can result in missing atypical presentations of common diseases (there could be an argument for this bias here but the patient presented rather typically). Having biases does not make us bad doctors or bad people, but it can lead to diagnostic errors, and ways to “de-bias” should be sought out when taking care of patients.
Noon Report Round-up!

In senior report today, Javy discussed a patient who presented with abdominal pain and a pleural effusion. Let’s talk about it!

When working up a pleural effusion, getting a fluid sample by thoracentesis is crucial. Thoracenteses are indicated in patients who present with a new pleural effusion, however in patients who present with uncomplicated heart failure, it can be deferred.

The patient presented in noon report had a pancreaticopleural fistula as a result of acute on chronic pancreatitis. This is a relatively rare complication in patients with pancreatitis, but the most common etiology of pancreaticopleural fistulas (PPF) is chronic alcoholic pancreatitis.

Patients may present with dyspnea, cough, and chest pain. The diagnosis is made after pleural fluid analysis reveals an exudative effusion (see Light’s criteria to the right) with an elevated pleural amylase (often greater than 1000). ERCP will be diagnostic in these cases, as contrast extravasation can be seen in real time. Patients should be managed with NPO status and jejunal enteral feeds. Octreotide has a theoretical benefit in decreasing fistula output and decreasing the time to closure of the fistula, however a meta-analysis did not reveal a change in fistula closure rates. ERCP can be therapeutic with pancreatic stent placement that promotes internal drainage of pancreatic secretions. If failure with medical management or endoscopic management, the patient can be considered for surgery (pancreaticojejunostomy, partial pancreatic resection, fistulojejunostomy).

As part of the VA Wards Experience Improvement project, Thomas and Owen are trialing a “Vocera Freeze,” in order to have protected time where teams can be contacted via Vocera messages only, or by page if something is more urgent. The goal is to prevent interruptions during rounding times and educational times.

Additionally, Dr. Hochhausler has been working on getting healthy food in the fridge provided for residents while rotating on the wards at the VA!

VA UPDATES
Weekend to-do!

**Friday:** **Earth Day Celebration,** 10 a.m.-2 p.m., Krohn Conservatory. First 300 visitors receive free tree seedling. $7, $4 ages 5-17, free ages 4 and under.

**MainStrasse Village Ladies Night,** 6-10 p.m., MainStrasse Village. Ladies enjoy night on town with retail, food and service specials from MainStrasse businesses. Pick up passport at retail location to get details on how to get registered to win gift basket. Free. www.mainstrasse.org.

**Saturday:** **FC Cincinnati Soccer,** 7 p.m., Nippert Stadium. v. Louisville City FC. $30, $20, $12, $10. wwwfccincinnati.com.


**Sunday:** **Mainstrasse Village Bazaar,** 9 a.m.-3 p.m., MainStrasse Village. Antiques and collectibles available for sale along MainStrasse's Promenade. www.mainstrasse.org.

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First correct answer wins a $5 Starbucks gift card!

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The owner of this hand was on vacation in New England and went fishing with his drinking buddies, and cut his hand while boning a fish. What could be the explanation?

**TRIVIA**

Congrats to Joe Cooley, who coolly diagnosed primary sclerosing cholangitis based on the beading shown on cholangiogram.

**SHOUT OUTS!!!**

- To Brian May, Dan Tim, Patricio Alzamora, Marc Guerini, and Erin Connolly for their stellar jeopardy and volunteer coverage they are providing! Thank you!
- To Yasmin Hassoun for being a great senior at the VA this week!
- To Cody Lee, Weixia Guo, Steven Thebaud, and Cathy Nguyen for being a flexible 6S team! Thanks!
- To Danny Peters and Eejung Kim for taking care of sick Veterans during busy nights on VA night float!
- To Alan Hyslop for preventing a rapid response and “not looking scared,” like the soon-to-be-senior that he is!