Weekly Calendar

12/19: Morbidity, Mortality, & Improvement: MSB 3051
12/20: Noon report: Heme/Onc (NRR)
12/21: No Grand Rounds today
12/22: No AHD or senior prep today
12/23: Noon Report: Purple Team (NRR)

Chris Johns and Javy Baez doing a chest pain rule out on Santa while on Cards 6S...seriously, look at that guy and tell me he doesn’t have risk factors! He eats millions of cookies and smokes a pipe!

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
7NW Interdisciplinary Improvement Team Huddle
Come be part of improving patient care through interdisciplinary teamwork!
**EVERY** Tuesday at 2pm Location: UH 7104 (NRR)

The VA teams have been all practicing their Code Blue and Rapid Response simulations while at the VA. This is a great opportunity for R3s to freshen up those skills and for our interns to get ready to be team leaders (it happens sooner than you think!) Thanks to the current VA residents for going all-in during their training this month!

In working on the processes surrounding patients with uncontrolled Diabetes in our clinic, the Long Block team discovered that, on average, 10 patients per day were leaving without appointments. This has been less since the end of November. There was no standard work regarding how to communicate follow-up appointments to patients. Some residents were writing it on the AVS, but sometimes our patients fold that up and put it in their bags/purses, leave it in the bathroom, or lose it. We do have a best practice on how to do this—see to the right. Everyone (including non-Long Block residents) should be using this process! Carla at the front desk will track our progress, and we can see if we are improving our appointment rates!

Thanks to our very own Nabeela for spreading Holiday cheer at the Associates Holiday breakfast on Tuesday morning!

**VA UPDATES**

**Clinic Corner**

Use the preset buttons if you know that you will be available at a given time. Use the wrench to set your own buttons.

Write a note to check-out if you need an exact date and time, or if you need to communicate something to them. This will NOT print on AVS, but is visible to the check out desk.

Click the Follow-up tab in Navigation
Noon Report Round-up!

Green team, led by Hilary Miller, presented an interesting case of a skin rash. Let’s talk about it!

The diagnosis of erythroderma is made clinically. Patients present with diffuse and generalized erythema over 90% body surface area. The major diagnostic dilemma occurs in determining the etiology of the erythrodermic reaction. In this patient, it may have been related to the administration of systemic corticosteroids, which is known to cause an erythroderma in patients with underlying psoriasis. A quick withdrawal of steroids can also do this. It is important to always consider the diagnosis of Sezary Syndrome, which is a subtype of cutaneous T cell lymphoma. Blood smears can show presence of Sezary cells in patients with erythroderma, but counts of less than 10% can be found in erythrodermas of multiple etiologies. To the right is a Sezary cell, which has cerebriform nuclei. More than 20% of Sezary cells is suggestive of Sezary syndrome.

Remember, although erythroderma is not SJS or TEN, it is still on a similar spectrum of disorders and these patients can be quite sick. Though it is rare, it has mortality rates ranging from 4-64%. Patients presenting with erythroderma should have symptomatic treatment for their pruritis, nutritional support, management of fluids and electrolytes, and be maintained in a warm environment, as they are susceptible to hypothermia. They should be treated with low potency steroids for the face and body folds, and mid-potency steroids for other body areas. Monitor for bacterial infections of the skin, particularly staph aureus, including MRSA.
**Christmas Tree Photo Contest!**

Send us your best resident and staff (extra bonus points for full Team pics!) in front of the many hospital lobby Christmas Trees! Per resident request, we will also accept photos in front of home Christmas trees. Winners to be featured in next week’s ‘SCOOP. Deadline 12/22, 11:59pm.

Categories include: Most Festive, Most Ridiculous, Best Hair (to beat out Thomas), Most Likely to be your Mom’s actual Christmas Card, and Most Likely to make it into Dr. Warm’s Recruiting Presentation. Text or email submissions to Caitlin, 513-203-1861

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**BOARD REVIEW WITH THE CHIEFS:**

Q: You are seeing a 34 year old woman as a new patient appointment. She was referred to you by GYN/ONC to establish care with a PCP. She had a recent hysterectomy for endometrial cancer, and has no other pertinent past medical history. She has a family history of colon cancer in her sister and mother (sister diagnosed at 50 years old and mother diagnosed at 49 years of age) and her maternal grandfather was diagnosed with rectal cancer at age 68 years old. What recommendations would you make with regards to colon cancer screening for this patient?

A. Screening colonoscopy at age 50  
B. Screening colonoscopy at age 39  
C. Screening colonoscopy now  
D. Screening colonoscopy at age 40

A. The correct answer is C, screening colonoscopy now. This patient likely has Lynch syndrome, or hereditary nonpolyposis colorectal cancer (HNPPC). She meets criteria for this per Amsterdam II criteria which include: “(1) three or more relatives with an HNPCC–associated cancer (including colorectal, endometrial, ovarian, urothelial, gastric, brain, small bowel, hepatobiliary, or skin), (2) two successive generations of relatives affected, (3) one affected relative a first-degree relative to two other affected relatives, and (4) one cancer diagnosed before age 50 years.” For patients who meet the above criteria for HNPCC, or who have had genetic testing for HNPCC and are positive, should have screening colonoscopy starting at age 25 years old, every 1-2 years, or starting 2-5 years earlier than the youngest age at which a person in their family was diagnosed with cancer, if they were under 25 years old. Screening starting at age 50 years old is acceptable for those patients at average risk. Patients who should be screened starting at age 40 years old are patients who have first degree relatives, 60 years old or older, with colorectal cancer or adenomatous polyps. For patients who have had first degree relatives diagnosed with colorectal cancer or adenomatous polyps before age 60, colonoscopy should begin at either 40 years old or 10 years before the earliest case in their first degree relatives.

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Weekend to-do!

Friday: Merry Splifffmas with Afroman, 7 p.m., Madison Theater, 730 Madison Ave., Covington. With C the Gray, Sundae Drives, Day Needs Night, Where It's At and Bvrebones. $20, $15 advance. cincyticket.com.


Straight On: Tribute to Heart, 8:30 p.m., Bogart’s. $15, $13 advance. www.bogarts.com.


SHOUT OUTS!!!

- To Sarma Singam for taking “great care of patients” overnight, from a ward attending. He especially wanted to thank Sarma for giving him a call overnight when one of his patients had an unexpected seizure and was transferred to the NSICU.
- To Kelly Grannan and Wes Dutton, for caring for a really sick patient last week.
- To Scott Merriman and Dan Tim for their graciousness while being jeopardized to cover for sick colleagues. Thank you both!
- To Marc Guerini, for “braving the cold to help a fellow resident change a tire after an interview dinner, and to Scott Merriman for ‘supervising.’”
- To Hilary Miller and Bo Franklin for their awesome noon reports this week!
- To Kantha Medepalli, Parm Mavi, Dorothy Jung, and Javy Baez for being understanding with schedule changes in the CVICU. You make a chief’s job much easier!
- To Julie Broderick-Gomez, Tyler Derr, Bri Rizik, Sarah Weiskittel, Rachel John, David Young, Weixia Guo, and Sean Maloney for coming to 100% of AHDs that they are eligible for!
- To all our hardworking residents who are being incredible while the hospital is so busy. You guys are truly amazing! You make us proud every day.

Guess the applicant
Pictionary clue!

Congrats to Elliott Welford and Keith Luckett for correctly guessing Takutsubo Cardiomyopathy from the above applicant Pictionary clue!