Weekly Calendar

12/5: Noon report: GI team (NRR)
12/6: Noon report: Renal Team (MSB 5051)
12/7: Medical Grand Rounds: Robert Neel, MD: “Peripheral Neuropathy” (MSB 5051)
12/8: AHD: Meningitis; Senior Prep: Solid Malignancy
12/9: Noon Report: Blue Team (MSB 5051)

Our residents are known for the compassionate care that they provide to our patients at the VA. In return, they get the warm, fuzzy feeling from having served the population that served the country, and occasionally can hitch a ride on a VA-issued scooter.

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
STI screening in clinic is an important and often overlooked part of primary care. We think to screen patients upon their request, or test in the case of symptoms, but otherwise, are you doing the appropriate STI screening for your patients? As our clinic population has become younger, this is definitely something you need to think about!

How do you screen? HIV is a blood test, using HIV 1 and 2 Abs and p24 Ag. To screen for gonorrhea and chlamydia, we use a nucleic acid amplification test (NAAT) for screening. For males, the preferred specimen is a urine sample (urethral swabs may be less sensitive and equally specific to urine). For women, do you need to be a speculum exam in order to test? NO! Self-collected vaginal swabs are the specimen of choice for NAAT, and are as sensitive and specific as cervical swabs. What about syphilis? The right screening test depends on the situation. The CDC still recommends non-treponemal test (AKA, RPR) as the screening method of choice, however, RPR is a labor intensive lab. A good strategy for a Foxworth clinic patient who has never had syphilis before, is to test with a treponemal test. Trepia is more sensitive, but less specific. Its also more expensive, but less labor intensive (and that’s worth it for a big lab like ours). Remember, treponemal tests will always be positive in anyone who has ever had syphilis, so a nontreponemal test (RPR) would be the right choice for that patient.

Many of the most ill patients at UCMC languish in the ED waiting for a bed upstairs. Many of the most well patients at UCMC languish on the floor awaiting a promised discharge. We get negative feedback from both groups of patients regarding their unexpected wait. We also know that adjusted length of stay increases by more than 0.5 days when a patient is admitted to the floor after 1PM compared to before 1PM. We have partnered with the Inpatient Progression Traction Team and 7 Northwest to attempt to improve throughput, patient care and patient satisfaction.

The Ultimate Goal: Safely discharge all medically ready patients who qualify for early discharge before 11 AM.

Breaking Down the Problem: There are an average of 41 discharges from 7NW weekly, and an average of 1 per week leaves the unit before 11 AM. We are excluding the 30% of patients who are discharging to a facility, and also will exclude patients who have a pending discharge dependent study (which we estimate to be about 25%), as well as exclude patients who are not eligible for the Discharge Hospitality Center (about one third). This leaves 14 patients per week that we would like to target: patients who are going home, with no major studies pending, and who are eligible for the DHC.

We set a goal of discharging 30% of all patients from 7NW by 11 AM by 1/1/2017. That is about 12 of those 41 original patients. That’s close to our target population!

Early success shows us that discharge prior to 11 AM requires: Targeting a patient the day before discharge and sharing this targeted patient at the 3 PM huddle. Doing the pre-work early, seeing the targeted patient very early, if not first, in the day (can the senior at attending see the patient quickly before night float presentations? Why not!) and finishing up paperwork immediately after seeing the patient (even as a team!), and then writing the discharge order immediately after completing paperwork (remember to let the bedside RN know!) It helps to put in the discharge order comments that the patient is eligible for the DHC, and again, communicate directly with the patient and the nurse!

What does the 3 PM Huddle entail? It occurs daily at 3 PM in the noon report room and MUST have attendance of all faculty hospitalists, team leaders, and nursing leadership. Simply state who your target for the next day is, and then this information should be shared by nursing with pharmacy and care coordination as appropriate so that preparations for early discharge can be made. This is also an opportunity to follow up on those from the day who you thought could be DB11s (discharges before 11am) and find what happened—what went well, and what didn’t—in order to document the barriers to early discharge so that we can make overall improvements in this process.
Noon Report Round-up!

Steve Cogorno presented a very interesting case of extrapulmonary blastomycoses. Let’s talk about it!

To the left is a picture of a patient with a “cold abscess” secondary to mycobacterial tuberculosis. Cold abscesses are called such as they do not have the intense signs and symptoms of inflammation that accompany typical abscesses. They can be misdiagnosed as lipomas due to their subcutaneous locations and that they don’t present as hot, red, tender, or indurated masses.

Interestingly, patients with Job Syndrome, or hyperimmunoglobulin E syndrome, may have cold abscesses from bacteria like Staph aureus, which typically cause regular ole hot abscesses in other patients.

Cold abscesses can be caused by tuberculosis most commonly, other mycobacteria, and also fungi like blastomyces, as well as actinomycosis and leprosy.

These can be misdiagnosed as soft tumors, lipomas, cysts, or pyogenic abscesses.

Blastomycosis is the disease caused by blastomyces, a dimorphic fungi. The areas in which this fungus is endemic is in the Midwest, southeastern, and south central US, as well as the Canadian provinces that border the Great Lakes.

Exposure is typically through inhaled conida, but primary cutaneous blastomycosis can be spread through dog bite.

Disease can range from subclinical or asymptomatic (this occurs in at least 50% of patients infected), to acute and chronic pneumonia (pulmonary blastomycosis is the most common manifestation and mimics community acquired pneumonia), but 25-40% of patients will also develop extrapulmonary infection, like this patient. Extrapulmonary manifestations include cutaneous disease, osteoarticular, genitourinary, and CNS disease (rarely EXCEPT in immunocompromised patients—as many as 40% of AIDS patients with blastomycosis have CNS disease, being either mass lesions of meningeal involvement). Disseminated blasto is more likely to occur in the immunosuppressed, including patients with organ transplant and HIV.

<table>
<thead>
<tr>
<th>Manifestation</th>
<th>Preferred treatment</th>
<th>Class</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Moderately severe to severe pulmonary</td>
<td>Lipid AmB, 3-6 mg/kg per day, or deoxycholate AmB, 0.7-1 mg/kg per day, for 4-6 weeks, followed by intracranial, 200 mg bid for 6-12 months</td>
<td>A-I</td>
<td>The entire course of therapy can be given with deoxycholate AmB to a total of 2 g; however, most clinicians prefer to use step-down intracranial therapy after the patient’s condition improves. The lipid formulations of AmB have fewer adverse effects.</td>
</tr>
<tr>
<td>M to moderate pulmonary</td>
<td>Itraconazole, 200 mg once or twice per day for 6-12 months</td>
<td>A-I</td>
<td>The entire course of therapy can be given with deoxycholate AmB to a total of 2 g; however, most clinicians prefer to use step-down intracranial therapy after the patient’s condition improves. The lipid formulations of AmB have fewer adverse effects. Treat osteoarticular disease for 12 months.</td>
</tr>
<tr>
<td>M to moderate disseminated</td>
<td>Lipid AmB, 3-6 mg/kg per day, or deoxycholate AmB, 0.7-1 mg/kg per day, for 4-6 weeks, followed by intracranial, 200 mg bid for 12 months</td>
<td>A-II</td>
<td>TREAT OSTEARTICULAR DISEASE FOR 12 MONTHS.</td>
</tr>
<tr>
<td>CNS disease</td>
<td>Itraconazole, 200 mg once or twice per day for 6-12 months</td>
<td>A-II</td>
<td>Step-down therapy can be with fluconazole, 800 mg per day, Itraconazole, 200 mg 2-3 times per day, or voriconazole, 200-400 mg twice per day. Longer treatment may be required for immunosuppressed patients.</td>
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<tr>
<td>Immunosuppressed patients</td>
<td>Lipid AmB, 3-6 mg/kg per day, or deoxycholate AmB, 0.7-1 mg/kg per day, for 4-6 weeks, followed by intracranial, 200 mg bid for 12 months</td>
<td>A-I</td>
<td>Lifelong suppressive treatment may be required if immunosuppression cannot be reversed.</td>
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Q: A 56 year old female presents to the ED after failure to improve with outpatient therapy for community acquired pneumonia. She was diagnosed 3 days prior in her PCP’s office after she presented with shortness of breath, chills, and fever, with crackles on exam over the lower lung fields on the left. Chest radiograph at that time showed an infiltrate in the left lower lobe. She was deemed to be stable for outpatient treatment and was given a prescription for moxifloxacin, which she has been taking. Her only other medical problems are chronic low back pain for which she takes ibuprofen and cyclobenzaprine, as well as insomnia which has been responsive to amitriptyline.

On presentation to the ED, her temperature is 101.2F, heart rate is 112 bpm, blood pressure is 134/83 mmHg, respiratory rate is 18 and her O2 saturation is 94% on room air. Her exam is only notable for mild increase in respiratory effort and pulmonary exam is consistent with diagnosis of left lower lobe pneumonia. Chest radiograph shows a stable infiltrate and laboratory studies are within normal limits, except for leukocytosis to 14,000. EKG is shown as below. What medication changes, if any, would you make?

A. Continue current medications without changes
B. Discontinue moxifloxacin
C. Discontinue amitriptyline
D. Discontinue moxifloxacin, amitriptyline, and cyclobenzaprine

A. The answer is D, discontinue moxifloxacin, amitriptyline, and cyclobenzaprine. This patient has a prolonged QT interval, likely due to being on multiple medications that prolong the QT interval. Fluoroquinolones are well known to prolong the QT, as are TCAs, like amitriptyline. Remember Dr. Warm's point during noon report this week, that cyclobenzaprine is molecularly related to TCAs, and therefore can result in the same cardiac side effects, including prolonged QT, particularly when combined with TCAs and other medications that prolong the QT. Prolonged QT puts patients at the risk for Torsades de Pointes, so her medical therapy must be adjusted in order to decrease her risk of this life threatening arrhythmia.
**Weekend to-do!**

**Friday:** Ohio National's Victorian Holiday Village, 6-8:30 p.m. Friday, 5-8:30 p.m. Saturday, Ohio National Financial Services, One Financial Way, Montgomery. View enchanting victorian houses decorated in holiday scenes with thousands of lights. Bring nonperishable food item (no glass containers) for Freestore Foodbank. Free. bit.ly/1czcSnt.


**Saturday:** Holiday Market, 8 a.m.-4 p.m. Saturday, 10 a.m.-4 p.m. Sunday, Findlay Market, 1801 Race St., Over-the-Rhine. Craft cocktails and beer, live entertainment and holiday music, baked goods, arts and fine crafts, jewelry and more, all from local vendors. Free. www.findlaymarket.org.

Macy's Downtown Dazzle, 5:45 p.m., Fountain Square, Fifth and Vine streets, Downtown. Santa rappels down the side of the 525 Vine Building office tower to the Macy’s rooftop at Fountain Square to kick off holiday fireworks display. Free. www.downtowncincinnati.com.


**Sunday:** Showcase of Arts, noon-5 p.m., Woman’s Art Club Cultural Center, 6980 Cambridge Ave., Mariemont. The Barn. Ornaments, jewelry, soaps, ceramics, paper creations, paintings, stained glass and more. Free. www.artatthebarn.org.

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**SHOUT OUTS!!!**

- To **Calvin Feng** for being “a rock star and an efficient admitting/discharging machine at the VA. He can GSD!” From a thankful senior resident.
- To **Anna Yan** and **Steve Cogorno** for their stellar noon reports this week!
- To **Sarah Weiskittel**, **Sean Maloney**, **Matt Cortese**, and **Brian Shaw** for their awesome EKG reading during AHD this week! Ten points for Gryffindor!
- To **Emerlee Andersen** for helping out a co-intern with a schedule need!
- To the **Chronic Pain Group Visit group** for their earning of a $30,000 grant from the Care Delivery Innovation competition! Congratulations!
- To future Categorical Chief Residents, **Bo Franklin**, **Elyse Harris**, **Greg Wigger**, and **Elliott Welford**, as well as Med-Peds Chief **Brian May**. Congratulations!

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**TRIVIA**

First correct answer wins a $5 Starbucks gift card!

Guess the applicant's Pictionary clue!

**Congrats to Nedhi Patel (AGAIN!) for recognizing Queen Anne’s sign, or sign of Hertoghe, which is the thinning of the outer third of the eyebrows and is most commonly associated with hypothyroidism.**