Weekly Calendar

2/20: Noon report: GI team (NRR)

2/21: Noon report: Purple team (NRR)

2/22: Grand rounds: Justin Held, MD: “Delirium and Dementia” (MSB 5051)

2/23: Intern Retreat! (no AHD) Senior prep: Toxicology (NRR)

2/24: Morbidity, Mortality, & Improvement: Danielle Weber (MSB 3051)

Olympics Opening Ceremony (immediately following)

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
Clinic Corner

What do you know about PCOS?

Polycystic ovary syndrome is an important cause of menstrual irregularity and infertility, hyperandrogenism, and metabolic dysfunction and is one of the most common endocrine disorders in women. The pathogenesis is not entirely understood, but is thought to be a combination of both genetic and environmental factors.

The Rotterdam criteria require 2/3 for diagnosis: evidence of excess androgen (hirsutism or a hirsutism equivalent—like inflammatory acne vulgaris that doesn’t respond to topical therapies), dysfunctional ovulatory pattern (oligomenorrhea or amenorrhea, or even excessive uterine bleeding), and polycystic ovaries. Work-up should include TSH, testosterone (free and total) levels, and prolactin, as well as transvaginal ultrasound.

Management includes lifestyle changes like diet, exercise, and weight loss. Medication therapies include OCPs to improve menstrual irregularities and acne, spironolactone to improve hirsutism, and metformin for metabolic abnormalities associated with PCOS.

This is important to keep in mind as a diagnosis in our clinic, as we have had an influx of younger patients!

Joint Commission Site Visit Reminders—TOP TEN

1. Check your inbox and complete all outstanding verbal and phone orders!
2. All PRN orders must have an indication, and if multiple drugs are ordered for the same condition, there must be parameters of when to give what med
3. All nonviolent restraint orders must be signed by a physician every calendar day
4. Use alcohol gel before and after each patient contact.
5. Make sure to log out of the EMR terminals if you are walking away from them, this includes WOWs in the hall on rounds. Don’t leave your list on your WOW when you walk in a patient room!
6. No food, drink or personal belongings at nurse stations or in patient care areas – Don’t bring your coffee on rounds
7. Wear your badge, face forward and visible at shoulder height
9. Know the location of your specific departments yellow emergency binder (this are behind the HUC at the Nurses’ station).
10. Know what the Codes are and how to respond (check on your badge!)

GLOBAL HEALTH!

Categorical and Med Peds PGY1s—
If you are interested in going abroad in 2018, please contact Caroline Lee at: leecn@ucmail.uc.edu.

Cody shows us how to take a “fatigue mitigating nap” prior to the start of long call!
Blue team presented a case that included work up for possible neurosyphilis. Let’s talk about it!

Syphilis is an infection with multiple types of manifestations in different stages (the Great Imitator) and is caused by the spirochete Treponema pallidum. T. pallidum can’t be seen on normal microscopy and also can’t be cultured, so its diagnosis relies on serological or other testing.

How do you screen for syphilis? The recommendations have recently changed. It is now recommended that the screening test be with a treponemal test (fluorescent treponemal antibody absorbed test/FTA-ABS, T.Pallidum passive particle agglutination/TP-PA, various enzyme immunoassays/EIAs, and other treponemal immunoassays, rather than with a nontreponemal test, namely, the Rapid Plasma Reagin or RPR test. Remember however that if a patient has EVER had syphilis (with or without treatment), their treponemal test will remain positive, so it is important to ask your patients about a history of syphilis infection and treatment prior to ordering a screening test. If they have had syphilis before, then you order an RPR to determine if there is repeat infection.

In patients with an unknown history of syphilis and you are concerned for the possibility of neurosyphilis due to the presence of symptoms, keep in mind that an RPR may be nonreactive, but that the treponemal tests will be positive. On CSF examination, a positive VDRL is confirmatory, but a negative VDRL does not exclude the disease. If the VDRL is nonreactive, treatment for neurosyphilis should occur if CSF WBC is >5 OR if protein is >45.
Q. A 63 year old female is referred to your office for evaluation by the anesthesia pre-operative clinic for a total knee replacement, after she was noted to have elevated potassium on routine laboratory studies. The sample was not hemolyzed. In your preparation for her appointment, you reviewed her labs and note that she has had elevated potassium on her renal panels in the last 9 months. Her past medical history is significant for diabetes mellitus which is complicated by neuropathy and mild non-proliferative retinopathy, as well as hypertension and osteoarthritis. Her medications include insulin, atorvastatin, aspirin, Tylenol, and amlodipine. On exam, her vital signs are T 98.7F, HR 83 bpm, BP 137/74 mmHg, and respirations are 14/min with normal O2 saturations. She is obese, foot exam is consistent with neuropathy, and her right knee is swollen with a moderate effusion and crepitus is present. The remainder of her exam is within normal limits. You review her most recent renal panel, which shows a sodium of 139, potassium of 5.5, bicarb of 20, chloride of 107, phosphorus of 4.3, glucose of 156, and creatinine of 1.4. Her urine pH is 5.0. What is the most likely etiology of her hyperkalemia?

A. Medications—she must be on Lisinopril but it isn’t on her med list.  C. Type I RTA
B. Renal failure
D. Type IV RTA

A. The correct answer is D, Type IV RTA. Type IV RTA is a result of aldosterone deficiency or resistance, and is a distal, hyperkalemic RTA. Patients with this will have hyperkalemia and a non-gapped metabolic acidosis. This can be caused by medications, including heparin, ACE inhibitors, NSAIDs, and calcineurin inhibitors, but is commonly caused by diabetic nephropathy leading to a hyporeninemic hypoaldosteronism. This is secondary to a defect in the conversion of the precursor prorenin to active renin. A type I RTA is a hypokalemic RTA, with a defect in urine acidification in the distal tubule and impaired excretion of hydrogen ions. Renal failure causes hyperkalemia and a metabolic acidosis however it is more likely to be an increased anion gap acidosis.

Residency Olympics will soon be upon us...start training!
Last year, the Orange Iguanas took the Gold...who will it be this year?
Opening Ceremonies will take place in MSB 3051 on Friday, at 1pm. See you there!
**Weekend to-do!**

**Friday:** **Cincy Winter Beerfest,** 7:30-11 p.m. Friday, 1:30-4:30 and 7:30-11 p.m. Saturday, Duke Energy Convention Center, 525 Elm St., Downtown. More than 350 craft beers. Ages 21 and up. Early admission ticket entry at 6:30 p.m. $45-$95; $20 designated driver. www.cincybeerfest.com.


**Saturday:** **UC Men’s Basketball,** noon, Fifth Third Arena, University of Cincinnati, University Heights. vs. Tulsa. $10. www.gobearcats.com.


**Brink Brewing Co. Grand Opening,** noon, Brink Brewing Co., 5905 Hamilton Ave., College Hill. Free.

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**SHOUT OUTS!!!**

- To **Avanti Jakatdar, Kelly Grannan,** and **Reza Ghoorkhanian** for being flexible with a schedule flub. Thank you guys!
- To **Ned Palmer** and **Cody Lee** for covering their co-residents so that they could go interview for jobs! Thanks!
- To **Jess Fuller** for arranging her schedule to be able to do a great noon report!
- To **Bri Rizik** for taking on a difficult patient case and making a diagnosis! Great job!
- To **Scott Merriman,** for seeing many acutes and a new patient in clinic and “deserves a shout out!” Thanks Scott! Is Scott maxed out on shout outs yet?
- To **Yellow Team Jon Janiczek** and **Gene Novikov** for discharging a patient to a SNF as a DB11 (discharge before 11!) Great job guys!
- To all the residents providing coverage for intern retreat. Your interns and chiefs thank you!

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**TRIVIA**

What is your diagnosis (be specific). What is your next step?

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First correct answer wins a $5 Starbucks

Congrats to Patricio Alzamora who diagnosed PJP on this BAL! In a hypoxemic patient (PaO2 <70 or AA gradient >35), you should start steroids in addition to Bactrim.