**Weekly Calendar**


2/7: Noon report: Red Team (NRR)

2/8: Grand rounds: Ralph A. Giannella, MD: “More Than You Want to Know About Diarrhea” (MSB 5051)

2/9: AHD: Solid Malignancy; Senior Prep: Adrenal/Pituitary

2/10: Noon report: Community Health and Advocacy (NRR)

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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://www.med.uc.edu/intmed/residency/internal-medicine/residency-feedback](http://www.med.uc.edu/intmed/residency/internal-medicine/residency-feedback)
Fecal Immunochemical Testing—the other FIT test

In screening for colorectal cancer, colonoscopy has long been the gold standard, though there were other options, including stool guaiac testing. For many of our Hoxworth patients, they may resist getting colonoscopies, or the lengthy wait for appointments may be a limiting factor. What else can we do? Fecal immunochemical testing (FIT) has better test performance as well as better patient adherence (no diet restrictions and only requires one stool sample!) when compared to the guaiac-based testing. Hoxworth is looking into utilizing this testing strategy for our patients!

Clinic Corner

Early Discharge Project

On of the Quality Improvement Projects that came from the 7NW Improvement Team Meeting is an Early Discharge Project, namely, trying to get patients out of their rooms prior to 11am. The rationale is that, patients who move up from the ED to their rooms after 2pm in the afternoon have longer lengths of stays—makes sense. What does it mean for residents when all discharges happen later in the day? Means that your patients who are being admitted board in the ED (and we all know how difficult that can be), and that we never have open beds for transfers until late (night float feels that pain), and also that your patients get frustrated at a) waiting to be discharged, and b) waiting in the ER for a real bed upstairs. How are we achieving this? We’re using a daily 3pm “Discharge Huddle” to report out patients who we think can go home before 11am. The best patients to target are a) expected to be medically ready in the AM, b) are going home (not SNF), and c) have no pending studies or significant tests that could delay them. Call them out in the huddle, and bring the follow up information the following day. Easy!

**Strategies for success:**

1. Tell the patient they are going home early the next day
2. Tell the patient’s bedside RN and your Care Coordinator
3. Work on the discharge work the day prior to discharge
4. Round on these patients early (while you are waiting for night float, or even before 8am! It should be a quick round if you have already talked to them about their discharge!)
5. Immediately do med rec and discharge summary with your team outside the room (that’s what WOWs are for!)
6. Write discharge order as early as possible and let the bedside RN know
7. Use the Discharge Hospitality Center

Intern Retreat!
Mark your calendars for February 23rd! Coverage provided. Details to come later!

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

Coming soon…
Residency Olympics!

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Last week, Orange team presented a case and led a discussion about the management of increased intracranial pressure. Let’s talk about it!

The cranium is a fixed space that can accommodate 1400 to 1700 mL...AKA not a whole lot. The brain itself comprises 80% of that volume, while the CSF and blood each comprise 10% of that volume. So you can imagine, if the 80% that is brain parenchyma increases in volume, you don’t have a lot of room to spare.

Recall the physiology of the brain’s perfusion. Cerebral perfusion pressure, CPP, equals mean arterial pressure, MAP, minus the intracranial pressure, ICP. So CPP = MAP—ICP.

Knowing this equation helps you remember the hemodynamic changes that accompany increased ICP—remember that when patients have increased ICP, they will become hypertensive (AKA increase their MAP) in order to overcome the increased ICP and maintain CPP!

Side note: You can use this equation to remember how syncope works (remember back to the first AHD??) Ok, so CPP = MAP—ICP, then when the mean arterial pressure drops (from hypovolemia, from pooling of blood in the legs, from bradycardia, etc) then cerebral perfusion pressure drops and then global cerebral hypoperfusion AKA syncope results!

Symptoms of increased ICP include headache and vomiting. On exam you look for papilledema. As ICP increases patients can develop CN VI palsy and fixed/dilated pupil. Cushing’s triad can also be seen which is hypertension, bradycardia, and respiratory depression. Patients can also develop decorticate or decerebrate posturing (BAD BAD BAD!)

Acute management of elevated ICP:

1. Positioning—elevate the head of the bed and avoidance of excessive flexion
2. Hyperventilation- goal pCO2 of 26-30
3. Avoid fever and hypotension
4. Hypertonic saline* (more effective than mannitol)


*Including 23.4% saline (also known as “bullets”). This can be used through a central line as a bolus of 15 ml or 30 ml slow IV push. You may see this done in the NSICU while on neuro or as AOD.
Q. A 63 year old male with medical history of type II diabetes mellitus, poorly controlled, on insulin, and complicated by diabetic retinopathy and neuropathy, is being seen for follow-up on post-operative day 5 after trans-metatarsal amputation of the left foot for diabetic foot osteomyelitis. Intraoperative cultures grew MRSA. The bone biopsy showed acute osteomyelitis and bone margins did not show active inflammation. The patient was discharged with a PICC and has been on vancomycin since surgery, with appropriate trough levels. The wound bed on exam appears uninfected. What do you recommend?

A. 4-6 weeks of vancomycin  
B. 2 weeks of TMP-SMX  
C. Repeat debridement with more proximal resection  
D. No additional antibiotics

A. The correct answer is D, no additional antibiotics. This patient had diabetic foot osteomyelitis, without mention of cellulitis, and had a proximal resection with bone margins being free of disease, meaning that all infected and necrotic bone was removed. In these cases, antibiotic therapy can be continued for 2-5 days per IDSA guidelines for the treatment of diabetic foot infections. If the patient had necrotic bone remaining, or if the bone margins were positive for acute osteomyelitis, then antibiotic duration should be continued, for 4-6 weeks. TMP-SMX can be considered as a treatment for MRSA given its high bioavailability, however 2 weeks duration after a proximal resection would not be necessary.

AHD Jeopardy Winners were the Mantis Shrimps! The best way to learn is to TEST, TEST, TEST—so if you’ve not been hitting up some Osmosis questions, you really should be! Make a pledge to do a certain number of questions per week and stick to it!
**Weekend to-do!**


Winterwetterbraten Keg Tapping and Pig Roast, 6-9 p.m., Mecklenburg Gardens, 302 E. University Ave., Corryville. Ticket price includes keg tapping of Riegeles Speziator, stein hoist competition, live music, pig roast and German sausage buffet dinner. $25. Reservations recommended. bit.ly/2jNJ0iU.

**Saturday:** Underground Community: How Blacks Settled in Historic Glendale, 11 a.m.-3 p.m., Glendale Heritage Museum, 44 Village Square, Glendale. Exhibit chronicles black families who arrived in Glendale before 1855. Free.

**Sunday:** Big Game Party, 4 p.m., Fifty West Brewing Company, 7668 Wooster Pike. Includes buffet and 2 Fifty West brews of choice. $35. Reservations required. fiftywestbrew.com.

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**SHOUT OUTS!!!**

- To Geoff Motz for “being a rock star on Geriatrics!”
- To Zulma Swank for covering short call for a sick co-resident last week!
- To the Renal team Kristine Dematta, Connie Fu, and Sarah Weiskittel, for taking lots of medicine overflow patients last week! You are the bomb!
- To Patricio Alzamora, for covering a jeopardy shift. And chiefly apologies for forgetting to include you last week!
- To Elyse Harris, “for manually disimpacting a patient for 3 hours” who was sent over from clinic for a direct admission. Daaaaaaaammn Gina!
- To Danny Peters, Alan Hyslop, and Jackie Janecek for being super understanding and helping out an intern in need. From a very grateful co-resident.
- To Scott Merriman, for accommodating several patients in clinic this week, even when he wasn’t scheduled. He’s back at it with a string of shout-outs, too!
- To our very own Liz Bauke, for donating all the recruitment snacks to our residents! Come see the “Snack Box” in the Chief’s office! Snacks were also taken to the VA!
- To Ashwin Jain and Jason Wei for their stellar job on 6S! From a thankful senior. And to Michael Sabbah, for his constructive ideas about 6S!

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**What’s going on here?**

TRIVIA

First correct answer wins a $5 Starbucks gift card!

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**What’s going on here?**

**TRIVIA**

Congrats to Greg Wigger for seeing a widened mediastinum and ordering a CTA for aortic dissection!