Weekly Calendar

3/27: Noon Report: Blue Team
3/29: Grand rounds: Trisha Wise-Draper, MD, PhD: “Immunotherapy and Head and Neck Cancer” (MSB 7051)
3/30: AHD: Endocrine Emergencies; Senior prep: Valvular Heart Disease
3/31: Noon Report: Community Healthy and Advocacy

The Ultrasound Elective has taken off! Scott, Matt, and Nikki are learning the fundamentals of cardiac views under Hellman’s tutelage while Dan provides the anatomy!

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

“Doc, I can’t sleep…”

What is your approach to patients requesting medications for chronic insomnia? The American Academy of Sleep Medicine (AASM) has released new guidelines and consensus statements regarding the diagnosis and treatment of insomnia in adult patients. Psychological and behavioral interventions, like stimulus control therapy, relaxation therapy, and cognitive behavioral therapy for insomnia should be used as the primary intervention for patients with chronic primary or secondary insomnia. Interestingly, although we typically start first with recommendations of good sleep hygiene for patients and all patients with chronic insomnia should follow the rules of good sleep hygiene, there is insufficient evidence to show that sleep hygiene alone is effective for treatment of chronic insomnia, and it should be used in combination with other therapies. For patients in whom initial behavioral intervention has not been effective, short term hypnotic treatment can be considered, in this suggested sequence: benzodiazepine receptor agonists or ramelteon, sedating antidepressants like trazodone or certain TCAs, a combination of the two, and then other sedating medications. OTC antihistamine sleep aids and melatonin are not recommended for the treatment of chronic insomnia due to “relative lack of efficacy and safety data.” Medications should be used at the lowest effective doses and be tapered when able, utilizing cognitive behavioral therapy for insomnia to facilitate the taper.

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.

GRADUATING RESIDENTS:
If you plan on taking the ABIM Boards in August of 2017, the deadline to register is April 15 and the cost is $1,365. Sign up at: https://www.abim.org/ONLINE/DEFAULT.ASPX?TARGET=NEWAPP-18
Q. A 66 year old healthy male with depression and kidney stones is seen in follow up. He wants to discuss some abnormal labs that were noted at a recent visit to urgent care last week, where he presented for symptomatic urolithiasis. He did not have any hydronephrosis on ultrasound at the time and has since passed the stone and no longer has any urinary complaints, but on his discharge paperwork he noted an abnormal value and wants to discuss with you. His only home medications are fluoxetine and Flomax, which he took to pass the stone and is no longer taking. He is entirely asymptomatic and his vital signs and exam are within normal limits. His labs note a serum sodium of 123 and a plasma osmolality of 260. Everything else on his renal panel was in the normal range. You check a renal panel which again shows a serum sodium of 123, and also a urine sodium which is 43 and urine osmolality which is 500. What is your diagnosis?

A. Primary Polydipsia  C. Pseudohyponatremia
B. Beer potomania  D. SIADH

A. The correct answer is D, SIADH. This patient has chronic hyponatremia (>1 week) and is asymptomatic. A systematic approach to hyponatremia includes confirmation of hypotonicity, which this patient has given that his serum osmolality is low, and then determination of volume status, given that this patient has a normal physical exam, he is determined to be euvolemic. At this point, urine sodium and osmolality can lead to the diagnosis. The patient’s inappropriately elevated urine osmolality in the setting of decreased serum osmolality is suggestive of SIADH, as the patient is secreting ADH inappropriately in the setting of euvolemic, leading to the kidney holding onto too much free water and resulting in decreased serum sodium AKA the urine is concentrated like it would be if the patient were volume depleted, but they aren’t, hence the secretion of ADH is inappropriate. This is likely secondary to the patient’s SSRI fluoxetine, a common cause of SIADH. Treatment should include cessation of the offending medication and water restriction. Primary polydipsia will manifest with a maximally dilute urine, as the body’s normal response to increased free water intake should be to have ADH completely turned off and try to get rid of as much free water in the urine as possible, but the intake is beyond what the kidney can do to balance the hypotonicity of the serum. This can’t be pseudohyponatremia, as the patient will have a normal serum osmolality in that case. Beer potomania, or patients on the “tea and toast” diet, are also euvolemic. Their low solute and high water diet decreases solute excretion to the point that the excretion of water is diminished. Like patients with primary polydipsia, they will have a low urine sodium and a low urine osmolality. Urine will be maximally dilute, but patients have low urine volume and so have hyponatremia despite appropriate suppression of ADH. The most important thing to remember about these patients is that they are at high risk of osmotic demyelination. Patients with the highest risk of ODS are those with alcoholism and malnutrition in studies, additionally, it can be easy to overcorrect these patients, as the solute load of normal saline allows for increased solute excretion and water excretion and the serum sodium may rise precipitously. Watch these patients closely for rapid overcorrection!
Purple team presented an HIV positive patient who presented with polyarticular gout. Let’s talk about it!

When we think of gout, we often think of an acute, monoarticular, inflammatory arthritis. Patients present with severe pain, redness, warmth, and swelling of the affected joint with associated disability—patients will tell you that they can’t bear weight on the affected joint. As we approached this case in noon report, residents astutely began to question what tissue was involved, as the patient presented with a complaint of “swelling.” The signs of inflammation can extend beyond the joint involved and may even be mistaken as cellulitis, and dactylitis can be present.

Acute polyarticular gout is the initial presentation of gout in less than 20% of patients with gout. This type of presentation is more common later in the disease process, and may be more frequent of a presentation of hyperuricemia in patients with myeloid or lymphoproliferative disorders, as well as in patients who are on cyclosporine or tacrolimus for immunosuppression after organ transplant.

There is an association between HIV and hyperuricemia, and uric acid levels can also increase with protease inhibitors, and particularly with patients with medication regimens utilizing ritonavir boosting (like this patient). Hyperuricemia does not always result in gout, but it is a risk factor for its development. Additional risk factors include obesity, hypertension, hyperlipidemia, ischemic cardiovascular disease, diabetes, chronic kidney disease, alcohol consumption, dietary factors (diets high in protein), and medications that alter urate balance (like PIs, cyclosporine, tacrolimus, etc).

Treatment of gout always sounds simple, but in patients with many comorbidities (like all of the conditions that put them at risk for gout) may have contraindications to standard initial therapies. For patients with an acute gout attack, NSAID therapy is utilized first. If NSAIDs are contraindicated (renal insufficiency, heart failure, PUD, anticoagulation), then colchicine should be considered. If colchicine is contraindicated (as it is in patients who are on protease inhibitors—they are strong Cytochrome P450 3A4 inhibitors and can result in severe colchicine toxicity, including GI symptoms, neuropathy, rhabdo, cytopenias, etc), then either systemic or directed steroids should be used for treatment. For patients with monoarticular involvement, intraarticular steroids can be administered. However, for this patient with multiple joint involvement, systemic steroids were used for treatment.
Weekend to-do!

**Friday:** A Raisin in the Sun, 7:30 p.m. Friday-Saturday, 2 p.m. Sunday, Cincinnati Shakespeare Company. Story of working class family in 1950s Chicago. When unexpected financial windfall gives them opportunity for better life, conflicts and pressures threaten to shatter their opportunity at American dream. Through April 15. $22-$39. www.cincyshakes.com.


**Saturday:** Braxton Block Party, noon-11 p.m., Braxton Brewing, 27 W. Seventh St., Covington. Tappings throughout day. Food trucks. Four live music acts and DJ. www.braxtonbrewing.com.

All the Roads Home, 8 p.m. Saturday, 7 p.m. Sunday, Playhouse in the Park. In the 1950s, teenager Madeleine runs away to New York with hopes of becoming a dancer. Through April 23. www.cincyplay.com.

**Sunday:** Pop-Up Festival, 5-9 p.m., Leapin Lizard Gallery, 726 Main St., Covington. Features women in arts musical, visual, dance and culinary arts. Portion of proceeds go to local women-focused Cincinnati charity. Ages 21 and up. Free.

SHOUT OUTS!!!

- To **Dan Tim**, who was erroneously congratulated as “Can Tim” for the Trivia answer last week, and never even complained. Sorry!
- To **Scott Merriman**, **Megan Caroway**, **Nedhi Patel**, **Greg Wigger**, **Jane Neiheisel**, **Eric Niespodzany**, and **Elyse Harris**, for their help with coverage needs. You guys are the best and your help is much appreciated!
- To Rising Rising Chiefs **Greg Wigger**, **Elyse Harris**, **Elliott Welford**, and **Bo Franklin** for providing coverage for next year’s chiefs while they are at APDIM! And to **Tim Reed**, **Javy Baez**, **Rita Schlanger**, and **Danielle Clark** for learning everything they could at “chief camp!”
- To **Natalie Hood** and **Syeda Ahmad** for “being the best babies a momma could ask for,” from a clearly loving senior.
- To **Rita Schlanger** and **Weixia Guo** on Blue team, for getting some early discharges in this month! Great work!
- To **Ned Palmer**, for providing some in-the-moment jeopardy coverage for a sick co-resident...when he wasn’t even on jeopardy!
- To **Jeff Miller** for being a “cross-cover stand out extraordinaire” while on night float! From a thankful Hospitalist.
- To **Greg Wigger** for “teaching medical students how to communicate errors like a boss,” from a chief.
- To **Tim Reed** and **Ben Shearer**, for the outstanding care they provided to a Veteran while at the busy VA. The Vet stated that they and the other 6th floor staff, “were all so professional and efficient in everything they did or said and followed through with all tests they did or they were going to have performed or had done.” Thanks to Tim and Ben, and to all our residents who rotate at the VA, for taking such great care of our veterans in a resource-limited setting.

First correct answer wins a $5 Starbucks gift card!

What are you looking at?
What is your diagnosis?

TRIVIA

Congrats to Patricio Alzamora for diagnosing Glucagonoma presenting with diarrhea, hyperglycemia, and necrotizing migratory erythema as seen above!