Weekly Calendar

5/15: Noon Report: Blue Team
5/16: Noon Report: Purple Team
5/17: Grand rounds: Leonard Calabrese, DO: “Evolving Strategies in the Diagnosis and Management of Spondyloarthritis” (MSB 7051)
5/18: AHD: Heme/Onc Emergencies; Senior prep: Patient Safety
5/19: Noon Report: Intern-Hosp 2; Senior-Renal

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

Beats by Gabre. Photo cred to Javy Baez.
Clinic Corner COPD: 2017 GOLD Guidelines

The WHO estimates that 65 million people have moderate to severe COPD and that 3 million people (3% of all deaths globally) died of COPD in 2005. It is even higher prevalence in low income countries, however there is a significant burden of COPD in the US. States with the highest COPD-related death rates are clustered along the Ohio and Mississippi rivers (aka our neck of the woods). The direct cost of COPD in the US is estimated to be about $32 million, with an additional $20 million in indirect costs.

We see these patients all the time in clinic. The big take homes from the new guidelines are to consider the diagnosis in any patients with dyspnea, chronic cough or sputum production, and/or risk factors for the development of COPD. Also to get these patients vaccinated for flu and pneumonia! See figures.

Resident Appreciation Lunch
Where: Back of the UCMC Cafeteria
When: Next Tuesday, May 16, 11:00 AM - 1:00 PM
There won’t be any food at noon report, so be sure to grab your lunch beforehand!

Finding Meaning in Medicine
When: May 23, 6-8pm
Where: Hosted by Whitney Whititis (2016 Residency Grad)
Theme: Martyrdom
RSVP: https://goo.gl/forms/EgNKjdiI9XixVkcM2
Q. You are seeing a 76 year old female in your clinic for pre-operative risk assessment. She is having an elective total knee replacement after failure of conservative therapy with physical therapy, NSAIDs, corticosteroid injection, and even tramadol. She is otherwise healthy, with no history of diabetes, coronary artery disease, chronic kidney disease, stroke, or hypertension. Last year she was diagnosed with aortic stenosis after an echo was ordered for a murmur heard during her yearly physical. The echo showed an LVEF of 65% and severe aortic stenosis with a valve area of 1cm² and mean gradient was 41. She denies any chest pain, shortness of breath, syncope or presyncope. EKG obtained at her last visit was normal without q waves, and an exercise stress test from the time of her diagnosis of aortic stenosis last year was normal. She gardens and plays with her young grandchildren regularly and never has any symptoms. Neither she nor anyone in her family has ever had problems with anesthesia, she is a lifelong nonsmoker, and she has not had any issues with bleeding after procedures or after childbirth. What do you recommend?

A. Proceed to surgery with no further consultation  
B. Proceed to surgery with anesthesia consultation  
C. Dobutamine stress echo  
D. Defer the surgery until after aortic valve replacement

A. The correct answer is B, proceed to surgery with anesthesia consultation. This patient has a calculated RCRI of 0 and her risk of a cardiac event peri-operative risk is low using that system of risk assessment. Her known history of severe asymptomatic aortic stenosis, though not in the RCRI, does denote some additional cardiac risk—the risk of mortality in patients with severe AS who are having intermediate or higher risk surgery (including orthopedic procedures) is estimated to be 6-10%, but may be lower in patients with asymptomatic disease and with a lack of other risk factors, like this patient (mortality rates estimated 1-3%). The 2014 AHA/ACC guidelines support that patients with asymptomatic severe AS undergoing noncardiac surgery may proceed with the appropriate intraoperative monitoring (which may include right heart catheter or intraoperative TEE), which is why this patient should have an anesthesia consult. This question highlights that while RCRI is important, it isn’t the only part of the pre-operative evaluation. Patients should also be asked about personal or family history of anesthetic problems, including malignant hyperthermia, pulmonary diseases, and bleeding issues. Of note, patients with severe AS may be at increased risk of intra- and post-op bleeding, due to acquired von Willebrand syndrome (the same pathophysiology of Heyde syndrome!)

**Sodium Bicarbonate Shortage!**

We have a critical shortage of sodium bicarb syringes—there is a supply of about 200 syringes in the central pharmacy and, of course, an additional supply in the crash carts.

What can you do to mitigate use of bicarb for your patients? Here are some strategies.

Sodium acetate is an alternative therapy, the dosing is slightly different, see this table from the Journal of Medical Toxicology. If you have a patient with a toxidrome or overdose that is treated by sodium bicarbonate, please consult poison control and pharmacy for help with sodium acetate dosing.
VA team 4 did a great noon report about a patient who presented with abdominal pain and weight loss, who was found to have an SMA dissection and likely underlying collagen vascular disease. Let’s talk about it!

Noon Report Round-up!

This 38 year old patient presented with weight loss and abdominal pain. The initial differential included etiologies like chronic pancreatitis, pancreatic cancer, and SMA syndrome (pictured below, because you maybe forgot about it). Interestingly, this patient had a superior mesenteric artery dissection on imaging, as well as an internal iliac artery dissection. On further questioning, the patient had hypermobility of joints, hyperflexibility of skin, and pes planus (flat foot), and there was concern for the patient having Ehlers-Danlos syndrome.

Patients who present with SMA dissection are typically in the fifth and sixth decades of life, and men are more commonly affected than women. Typical risk factors for atherosclerosis (the cause of most other dissections) like hypertension, smoking, and hyperlipidemia usually don’t play a role in SMA dissections.

Some patients are asymptomatic and the dissection may be found incidentally on imaging. Symptomatic patients complain of pain (often directly from the dissection) or from poor perfusion due to the dissection, which results in intestinal ischemia, and abdominal pain. Patients may also have nausea, vomiting, and diarrhea.

The diagnosis is typically made with CTA of the abdomen. Most patients will not develop intestinal gangrene, however it is possible, and if patients have evidence of that, or peritonitis, or free air in the abdomen, they should be taken to the OR for surgical exploration. For patients who are symptomatic but without evidence of intestinal ischemia, they should be placed on bowel rest, have supportive care with electrolyte management, and be started on anticoagulation, typically aspirin and heparin followed by a vitamin K antagonist. Blood pressure control should also be a goal of therapy, and usually this is achieved with beta blockers.

Above are the different classifications of mesenteric dissections, depending on flow in the false lumen. The picture on the right is of a patient with intestinal ischemia related to an acute mesenteric arterial occlusion and shows bowel that is no longer viable and would need to be resected. This picture is also why I’m not a surgeon (gross).
Weekend to-do!


Crafts and Crafts, 5:30-7:30 p.m., Krohn Conservatory. See Majestic Monarchs and enjoy sampling craft beers, music and time to shop at the Krohn Street Market. Adults only. $15, $12 pre-register. Includes 2 beer tickets. krohn.cincyregister.com/crafts.

**Saturday:** Asian Food Fest, noon-9 p.m. Saturday-Sunday, Washington Park. Over 30 Asian restaurants and food trucks, performances and dances. Free admission. www.asianfoodfest.org.

Loveland Food Truck Rally, 3-10 p.m., Shoppers Haven Mall, 675 Loveland Madeira Road, Loveland. Food trucks, children's play area with inflatables, carnival games, face painting, live music and entertainment. Beverages include craft beer, wine, soda and water. Parking available at primary school across street. Free admission, food prices $5-$7. www.lmrchamberalliance.org.

**Sunday:** Mother's Day! Call your moms!

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What is your diagnosis?

**TRIVIA**

- First correct answer wins a $5 Starbucks gift card!

What is your diagnosis?

Congrats to Weixia Guo for identifying Cullen's sign, or periumbilical bruising, which indicates acute hemorrhagic pancreatitis. This can also be an indicated of intraperitoneal bleeding.

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**SHOUT OUTS!!!**

- To Brian Shaw for “killing it in clinic with good workups, differentials, and keeping things concise and organized like a pro.”
- To Medhavi Bole and Andrea Portocarrero for an amazing noon report at the VA!
- To Leila Borders for creating a geriatrics assessment for the AOD service! Awesome job!
- To Rita Schlanger and Jen Leddon for their amazing job at the VA this week with a very challenging group of patients! And Rita gave a special shout out to Jen specifically for “going above and beyond” for her patients. Great job!
- To Lauryn Benninger, who deserves a “ol’ shout out” for coming in on a day off to have a family meeting for one of her patients…”and for buying the hungry night MICU team breakfast bacon.” Bacon and a dedication to patient care—doesn’t get much better than that! Thank you Lauryn, and thank you Brian May for your sweet recognition of a coworker!
- To Danny Peters, for always being flexible and understanding!
- Congratulations to the entire Hoxworth Resident Clinic team for their recognition and certification as a Patient Centered Medical Home!