**Weekly Calendar**

**5/22:** Noon Report: Red Team

**5/23:** Noon Report: Orange Team

**5/24:** Grand rounds: Richard Becker, MD: “What’s New in Cardiology: Honoring the Legacy of Johnson McGuire” (MSB 7051)

**5/25:** AHD: Patient Safety; **Senior prep:** Issues in the Geriatric Population

**5/26:** Morbidity, Mortality, & Improvement MSB 3051

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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)

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From the Archives: A picture of Suchin, Sarma, Sarah, Danny, Matt, and Danielle from their intern year, at one of the last AHDs of 2014-15 academic year. Today, they are all a little bit older and a lot bit wiser.
Clinic Corner

ACP Guidelines Update: Low Back Pain

Recommendations:

1. Most acute or subacute back pain improves over time regardless of treatment, so choose nonpharmacologic treatment first. Examples: superficial heat, massage, acupuncture, spinal manipulation (all low level of evidence EXCEPT for heat, which has moderate evidence). If you go down the pharmacologic route, pick NSAIDs (moderate quality).

2. For chronic low back pain, initial treatment is nonpharmacologic (these are also low or moderate quality evidence, but strong recommendation). Examples: exercise, rehabilitation, stress reduction, tai chi, CBT, spinal manipulation, and others. Consider sending them to the pain group visits!

3. For patients with chronic low back pain and inadequate response to the above therapies, can consider pharmacologic therapy with NSAIDs (first line), or tramadol or duloxetine as second line.

4. Opioids should only be considered in patients who have failed everything above, and if benefits outweigh risks.

TL; DR = non-med treatment first, then NSAIDs. Opioids last line of therapy.

VA UPDATES

Big things are happening at the VA!

1. The VA is moving to a Q5 call schedule in June! This will increase support for daytime admissions.

2. They are working toward developing a dedicated observation unit, an NOD run admission algorithm, and increasing hospitalist staffing to have more support for daytime admissions that should be fully active by November.

3. The VA is now providing resident nutrition, with sandwiches, yogurt, pasta, cheese sticks, etc in the fridge in the resident room. Please give Thomas your feedback so we can continue to improve the selection and quality of the food provided.

Thank you all for the hard work you do caring for our Veterans!

REMINDERS!

R3s and R4s—please RSVP to Joan if you are planning on attending Graduation!

ALL—please complete the word cloud for our graduating residents, this is a really nice way to say farewell!

Finding Meaning in Medicine

When: May 23, 6-8pm
Where: Hosted by Whitney Whitis (2016 Residency Grad)
Theme: Martyrdom
RSVP: https://goo.gl/forms/EgNKjdiI9XixVkcM2
Q. A 64 year old female with a history of recently diagnosed adenocarcinoma of the lung, not yet on treatment, is being admitted to the medicine service for evaluation of anemia. She presented with shortness of breath and swelling of her right thigh. She denies trauma to the area, hasn’t taken any long car trips, and has no history of clotting or bleeding disorders. She is afebrile, BP is 116/76 mmHg, HR 96 bpm, respiratory rate is 16/min and her oxygen saturation is 96% on room air. Her exam reveals clear lung sounds, no murmur, her right thigh is swollen and her distal pulses are intact, and her arms and legs show multiple ecchymoses. Basic metabolic panel is unremarkable. Complete blood count is normal except for a hemoglobin of 7.2, a previous lab value is 10.5. A CTPA obtained in the ED is high quality and negative for a pulmonary embolism and shows her known adenocarcinoma. A bedside venous Doppler performed in the ED is negative for deep venous thrombosis. A CT of the right hip and thigh is performed and shows a large intramuscular hematoma. She is admitted for further work-up and management. You order coagulation studies and aPTT is prolonged is 87 seconds, PT is normal at 11 seconds. You order a mixing study that shows an aPTT of 45 seconds after a 1:1 mix with normal plasma. What diagnosis do you suspect?

A. Interference with tests secondary to being on heparin  
B. Antiphospholipid syndrome  
C. Factor deficiency  
D. Factor inhibitor

A. The correct answer is D, factor inhibitor. Specifically, this presentation is concerning for an acquired factor VIII inhibitor, or acquired hemophilia A. Factor VIII is the most common factor to have an autoantibody directed against its activity, though this is quite rare (1.3 to 1.5 cases per million population per year). Most patients with this will be above 50 and there is an association with malignancy, so this patient fits that disease script. Patients present with bleeding and prolonged aPTTs and normal PTs. Soft tissue bleeding is the most common and it is less likely than hereditary hemophilia to have spontaneous hemarthroses. The mixing study indicates the presence of an inhibitor—remember that if the mixing study corrects the PTT, there is a factor deficiency, therefore you can rule out C as an answer, as this did not correct. Patients with antiphospholipid syndrome will have prolonged aPTTs, but these patients present with clots rather than bleeding (remember that this is one of the causes of both venous and arterial clotting). Patients on heparin therapy will have prolonged PTTs (did you ever think about why we call them hPTTs? Its just so...). Patients with factor VIII inhibitors are treated with factor VIII. However, the next step performed should be a Bethesda titer, in which serial dilutions of the patient’s plasma are incubated with normal plasma and then the factor VIII activity is measured—the higher the Bethesda titer (AKA the greater the dilution required to allow for factor activity) shows the presence of a strong inhibitor. Patients with high Bethesda titers (>5 Bethesda units) should be treated with recombinant factor VIIa (allows for clotting independent of factor VIII), whereas patients with low Bethesda titers may be treated with factor VIII.

Tips from Interpreting Services

1. Interpreting Services are a tool to connect with your patient—when you are talking to the patient via an interpreter, make sure to look at the patient and talk to them (say “you,” not “ask him”).
2. The interpreter is obligated to repeat what you are saying exactly, but they are trained to ask for a rephrase or ask you to repeat your question if they feel that the patient doesn’t understand what you are trying to say.
3. There is someone on call for Interpreting at all times. They may not be able to speak the language you need and may need to use an agency, or will recommend the interpreter video or phone. Regardless, it is helpful to call them so that they know the patient is here or being admitted.
4. When you have a patient on your service who’s preferred language is something other than English, please make sure to connect with Interpreting Services. It is helpful to have a pre-session with the Interpreter beforehand, and you can also negotiate a good time to round on the patient or have sensitive discussions.
5. The use of a family member to provide interpreting is discouraged, and if they are going to be used, you still need to go through Interpreting Services in order to get a signed waiver.
6. Their number is 476-5682, please don’t hesitate to call them!
Blue team presented a case of a young patient who presented with shortness of breath and was found to have tuberculosis. Let’s talk about it!

Tuberculosis has a fascinating history (if you’re into that sort of thing). To the left, patients relax at the Stannington Sanitorium, which looks pretty nice until you remember that everyone was essentially dying of TB because they were only being treated with fresh mountain air. To the right, the painting “La miseria” by Cristobal Rojas, a Venezuelan impressionist painter, showing the less romantic view of living with TB.

A CXR consistent with reactivated TB, showing a cavitary lesion in the right apical segment of the lung. Symptoms include cough, dyspnea, weight loss, and fatigue. Fever and night sweats might only be in half of patients, and hemoptysis in a quarter of patients.

What about LTBI, or latent TB? Remember that screening with tuberculin skin testing or quantiferon gold is to identify patients with LTBI (you will diagnose active disease with AFB sputa). Diagnosing and treating LTBI is important for 2 reasons: from a public health standpoint, it is second in priority to treating active TB, and from an individual standpoint, testing for LTBI is important to identify those who are at increased risk of developing active TB infection, in order for them to be treated prior to that.

What test to use to identify LTBI? The two choices are quantigeron gold (interferon gamma release assay, or IGRA) or a tuberculin skin test, TST. Times when IGRA is preferred over TST are for patients who have low to intermediate risk of progression of LTBI to active TB, patients who are unlikely to return to have a TST read, and people who have had history of the BCG vaccine. TST is ok if the IGRA is too expensive or isn’t available. People with high risk of progression of LTBI to active disease, either test is ok.
Weekend to-do!

Friday: MainStrasse Village Maifest, 5-11:30 p.m. Friday, noon-11:30 p.m. Saturday, noon-9 p.m. Sunday, MainStrasse Village, Main Street, Covington. Arts and crafts booths, children’s rides, family-oriented activities, German heritage themes, food and village showcase shops. www.mainstrasse.org.


Sunday: Cincinnati May Festival, 8 p.m., Cathedral Basilica of the Assumption, 1140 Madison Ave., Covington. This year's performance spans four centuries, from joyful music by Palestrina, Handl and Viadana, to heartfelt work by Mendelssohn and Brahms, to Bach's profound message of hope. $35. Reservations required. www.mayfestival.com.

⭐ To Ashwin Jain, for going “above and beyond his duties as an intern. He never leaves his work to be passed on to another resident. He always offers to help out his co-interns, by taking on an admission even if he is not on call to help ease the stress of his team. He is able to timely recognize critically ill patients and act swiftly and responsibly! Most importantly, he does all of the above with a calm and cool demeanor! He has a great attitude and respectable work ethic, warranting a shout out before he leaves for Boston!” Thank you Ashwin and good luck to you!

⭐ To Ashley Cattran for her “constant baked goods and giggles!”

⭐ To Tyler Derr for being incredibly helpful with a schedule change for a co-resident!

⭐ To Saagar Sanghvi, who received a video shout out (via a pulmonary fellow) from a VA MICU patient whom he cared for. You clearly made a difference for this Veteran, thank you!

⭐ To Reza Ghoorkhanian and Weixia Guo for being flexible and helping one another out on 6S!

⭐ To Eric Niespodzany for helping out a fellow resident with a ride home!

SHOUT OUTS!!!

What is this?
Name 3 diseases associated with this.

TRIVIA

First correct answer wins a $5 Starbucks gift card!

What is this?

Congrats to Erin Connolly for recognizing the diagnosis of acute promyelocytic leukemia based on this blood smear.