Weekly Calendar
8/8: Noon report—Midnight Madness
8/9: Noon report—Purple Team
8/10: Grand Rounds: Charuhas Thakar, MD Proteinuria: Marker and Mediator of Intrinsic Kidney Disease, MSB 5051
8/11: AHD: ACS; Senior Prep: Inflammatory Arthritis
8/12: Noon reports; Intern—Hospitalist 4, Senior-Renal

Downtime cometh...
Not this senior-level downtime (left, with Nedhi, Matt, and Eric's feet) that you see here, but EPIC downtime. Use Read-Only Epic, write paper orders and paper notes, and experience what medicine was like before EMRs existed.
When? August 7th from 2:00am to 4:30am.

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
VA UPDATES

The AOD computer at UH now has a PIV card reader to allow for remote CPRS access! You will still need to have a working PIV card and have your access up to date.

If you have issues using this while at UC, you can call 861-3100 ext 5555 to reach tech support for the VA.

What’s that RACket?

Your intern representatives on the Residency Advisory Committee are Matt Cortese, Natalie Hood, Jeff Miller, and Kory Schrom. Feel free to raise any GME/residency questions/concerns to them!

Reminders from your friendly RAC reps:

- Needle sticks: Proper reporting of blood borne pathogen or exposure is via the Injury/Needle Stick Hotline available 24/7 at 585-8000.
- Hungry? In addition to the silver fridge, there is a Mont Reid Pavilion 4th floor resident lounge with free food and a small gym. Additionally, if you ever feel unsafe, Medical Campus Police will escort you to your car.

<table>
<thead>
<tr>
<th>Population</th>
<th>Men 35 and older</th>
<th>Men 20-35 at increased risk for CHD</th>
<th>Women 45 and older at increased risk for CHD</th>
<th>Women 20-45 and at increased risk for CHD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly recommends screening</td>
<td>Recommends screening</td>
<td>Strongly recommends screening</td>
<td>Recommends screening</td>
</tr>
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What is “increased risk?” Presence of risk factors like DM, personal history of CHD or other cholesterol vessel disease (AAA, PAD, carotid disease), family history of CVD before age 50 in male relatives or age 60 in female relatives, tobacco use, HTN, and obesity (BMI >30).

Clinic Corner

Lipid Screening!

Finding Meaning in Medicine

August 9, 6-8pm
3646 Sandal Lane, Cincinnati
OH 45248
Please see your email for the RSVP
Theme: Gratitude

7NW Interdisciplinary Improvement Team Huddle

Come be part of improving patient care through interdisciplinary teamwork! Great opportunities for QI projects!

EVERY Tuesday at 2pm,
Location: UH 7104 (NRR)

Welcome to the world Erin Morris Binder! Congrats to Elise and Michael for their gorgeous new addition to the family!
Noon Report Round-up!

Pancreatitis...it's not just about lipase! The diagnosis of pancreatitis is made after 2 out of 3 clinical criteria are met: lipase elevated >3 times the upper limit of normal, characteristic findings of pancreatitis on abdominal imaging, and acute onset of severe, persistent, epigastric pain radiating to the back with tenderness on palpation on exam.

**Complications of Acute Pancreatitis**

<table>
<thead>
<tr>
<th>Complication</th>
<th>Causes and Risk Factors for Acute Pancreatitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal compartment syndrome</td>
<td>Choledocholithiasis (40%)</td>
</tr>
<tr>
<td>Acidosis</td>
<td>Chronic alcohol use or abuse (35%)</td>
</tr>
<tr>
<td>Acute renal failure</td>
<td>ERCP (4%)</td>
</tr>
<tr>
<td>ARDS</td>
<td>Medications (2%)</td>
</tr>
<tr>
<td>Ascites</td>
<td>Abdominal Trauma (1.5%)</td>
</tr>
<tr>
<td>Bowel infarction</td>
<td>Other (anatomical abnormalities, autoimmune disorders, hypercalcemia, hypertriglyceridemia, toxins, tumors</td>
</tr>
<tr>
<td>Chronic pancreatitis</td>
<td></td>
</tr>
</tbody>
</table>

The patient presented by Red team had a normal lipase, but described epigastric pain radiating to the back and had CT evidence of acute pancreatitis. Though a positive lipase has a positive LR of 30 (!!) and can therefore have a huge impact on your post-test probability when you get a positive result, it is not necessary for the diagnosis of pancreatitis if you have the clinical and radiographic support.

**Signs and Tests for the Diagnosis of Pancreatitis**

<table>
<thead>
<tr>
<th>SIGN OR TEST</th>
<th>RESULT OR FINDING</th>
<th>LR+</th>
<th>LR-</th>
<th>SENSITIVITY</th>
<th>SPECIFICITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipase level</td>
<td>&gt; 540 U per L (9.0 μkat per L; 3 times the normal level)</td>
<td>30.00</td>
<td>0.03</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Amylase level</td>
<td>&gt; 360 U per L (6.01 μkat per L; 3 times the normal level)</td>
<td>21.00</td>
<td>0.05</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

What is the role of imaging in acute pancreatitis? ACG guidelines suggest that CT or MRI should be reserved for patients in whom the diagnosis is unclear, or in patients who don’t improve within the first 48-72 hours of admission (strong recommendation, low level of evidence). Abdominal ultrasound should be performed in all patients presenting with acute pancreatitis to rule out gallstone pancreatitis (strong recommendation, low level of evidence).
Paracentesis Update!

The pilot project went very well, and we appreciate everyone who participated! The pilot was the last step in validating a unique assessment tool that we developed to help define procedural competency. We are very excited to announce that the permanent Cincinnati abdominal mannequin has arrived and we will be ready to begin training shortly! Your overall training package will include an online component as well as 1-on-1 training in the simulation lab with faculty. Please look for emails from Dana Sall and the chiefs in the next few weeks for instructions on how to access the online material and when your personal training session is. Thanks for your continued dedication to this project!
Q: A 71 yo AAM with h/o DM2 and HTN is admitted to the ICU with fever, productive cough, and shortness of breath for the last 3 days. He neither smokes nor drinks, and his only medications are metformin and amlodipine. On exam, he is febrile to 101.3F, HR 120 bpm, rr 30/min, and initial BP was 70/50 mmHg, which improved to 97/61 mmHg after 2L fluid bolus. His initial O2 sat on room air is 84% and improves to 96% with supplemental O2 via venti-mask, FiO2 40%. On exam, he has decreased breath sounds on the right lower lung base with crackles bilaterally, R>L. His heart exam is notable only for tachycardia. The remainder of his exam, including mental status, is unremarkable. His labs are notable for leukocytosis with left shift and bandemia, thrombocytopenia to 80k, his renal panel is normal, and CXR shows a RLL consolidation. Blood cultures were obtained. He is diagnosed with pneumonia and antibiotic therapy is started. What additional studies are most appropriate for this patient?

A: The answer is C, sputum culture. This patient meets criteria for severe CAP with 3 minor criteria present, including rr>30, hypotension requiring aggressive resuscitation, and thrombocytopenia. In addition, his degree of hypoxemia is telling you that this patient is SICK. His CURB65 score is 3 (rr, age, and BP) indicating a 14% 30-day mortality. For patients with severe CAP, ICU admission is appropriate. In patients with severe CAP requiring ICU treatment, sputum cultures are indicated. Pro-calcitonin would not help guide your management here, as you are already very suspicious for bacterial pneumonia. CRP would also not change management or guide therapy, and is not indicated. CT chest with contrast would be used to detect a pulmonary embolism, and while this patient has tachycardia, tachypnea, and hypoxia, his symptoms are much better explained by bacterial pneumonia and a CT with contrast is not indicated at this time. CT chest without contrast may show complications such as pleural effusion or empyema, cavitary lesions, or hilar lymphadenopathy, and could be performed to look for those complications if the patient does not improve despite antibiotic therapy.

Fatigue Mitigation

FOUND: Stay Awake caffeine pills in the resident room! Though these are only about equal to 2 cups of coffee from ABP, remember what happened to Jessie Spano?

We want to remind you about resources for sleepiness and fatigue. ALL residents have 24/7 access to call rooms. Go to the first floor of Mont Reid at ANY TIME to get a call room if you need this. You may also get taxi vouchers (for home and back to work) at ANY time from the main lobby desk or at the UC Health Security Office in the ED lobby. Up to 6,000 fatal crashes each year may be caused by drowsy drivers. Please keep yourself and others safe!
**Weekend to-do!**

**Friday:** The Claudettes, 10 p.m., MOTR Pub, www.motrpub.com.

**Saturday:** Lumenocity, 2, 3:40, and 9:40 p.m. Saturday, 2, 3:40, 8 and 9:40 p.m. Sunday, Taft Theatre. Live illuminated concert experience. $12-$20. lumenocity2016.com.

Milford Street Eats Festival, 3-10 p.m., Chamber Drive, 701 Chamber Drive, Milford. Over 20 food trucks and music from Four on the Floor and Buzz Bin. Local breweries include Madtree, Old Firehouse and Mt. Carmel. www.milfordstreeteats.com.

Northside Summer Market, 9 a.m.-3 p.m. (Yard sale and art market) and 11 a.m.-7 p.m. (Beer garden and entertainment), Northside Summer Market, 1662 Hoffner Street, Northside. Combines community-wide yard sale with art market, including fine artists and crafters. Beer garden and food. www.northsidesummermarket.com.

**Sunday:** Art on Vine, noon-6 p.m., Fountain Square. Up to 40 local artists displaying and selling fine arts and handmade goods. www.artonvinecincy.com.

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**TRIVIA**

First correct answer wins a $5 Starbucks gift card!

Congrats to Jesse Rhodes for diagnosing acute mesenteric ischemia! The presence of pneumatosis intestinalis should lead you here. Clinical triad of elderly, atrial fibrillation, and pain out of proportion to exam. Bloody stools are uncommon until late in the presentation.

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**SHOUT OUTS!!!**

- To Eric Niespodzany for his “wonderful bedside manner” and for being a “true human blessing” to the family of a critically ill patient in the MICU. Thank you for your dedication to patient care!
- To Geoff Motz for sending “lots of info” on a critically ill VA patient to the resident caring for that patient in the UH MICU, and to Joe Cooley (again!) for helping provide CPRS information to UH residents taking care of VA patients while admitted at UC. Thank you both for taking time out from your day to help both your colleagues and patients!
- To Sarah Weiskittel from a VA patient, for "being more than a doctor, being a human that truly cares and making [him] feel like a person that had value." Thank you for your kindness!
- To Steve Bohinc for taking on another resident’s clinic schedule with no questions asked. Thank you for your flexibility and willingness to help!
- To Alan Hyslop for being ‘da real MVP! And to Alan and Sean Maloney for cleaning up the GI room!