Weekly Calendar

11/7: Noon report: Yellow team
11/8: Noon report: Renal team (MSB 5051)
11/10: AHD: Defense of the Measures; Senior Prep: Heart Failure
11/11: Noon report: GI team (MSB 5051)

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

Last week at the Difficult Patient AHD, Reza had the perfect “stunned intern look” when Owen acted as the patient with the difficult medication reconciliation, on both warfarin, Coumadin, ASA 81 mg, and ASA 325 mg.
The Pediatrics residents at Children’s challenge us to a friendly game of flag football!

**When:** Saturday, November 5 at 4pm  
**Where:** Football field at Madisonville Recreation Center (5312 Stewart Avenue)

**Why:** Because it’s football season!

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**11th Annual Residency Party!**
Dr. Warm and his family are hosting the annual Fall residency party at his home this Friday, November 4th, at 7pm.

We are celebrating the changeover of the Long Block, our fabulous interns, the return of the 3rd year residents to the wards, recruiting kick-off, and the start of the fall party season.

Friends, family, kids -- everyone is welcome!

The ‘band’ will go on at about 9 PM. (You are in the band).

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**QI/PS Corner**

Incident reports are an integral part of the process of quality improvement and help us ensure the highest quality of care for our patients, delivered in the safest environment we can. Residents are incredibly important for that process, and we want to a) encourage you to continue submitting as many incident reports as necessary and b) remind you about what kind of information should be submitted in an incident report. Incident reports are a place to provide as much OBJECTIVE and DETAILED data about an event (near miss, adverse event whether preventable or not) as possible. Incident reports are not the place for your personal interpretations, assumptions, or for opinions, and especially not for venting frustrations or finger-pointing. Patients are safest in a culture of accountability, not a culture of blame.

At both the VAMC and UCMC, there are committees specifically organized to review EVERY incident report, and get to the bottom of whatever issue is at the ROOT of your submission. After that review process takes place, appropriate action is taken, even if you don’t hear about it directly (that’s not really allowed). Unfortunately, if the editorial content is included in incident reporting, it gets in the way of its purpose, which is to improve the safety and quality of the care we provide, and the system in which we provide it.

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**VA UPDATES**

Radiology will have a CT technologist in house covering the weekends, Saturday and Sunday from 7am to 7pm. You may reach this individual through Vocera, “Call CAT Scan Tech.” This begins this Sunday, November 6th! This is a huge improvement in care for our Veterans!
Noon Report Round-up!

Orange team presented an interesting case of compartment syndrome after IV extravasation. Let's talk about it!

Medications can be described as a vesicant or an irritant, and some are both. Vesicants cause mucosal pain, irritation, and blistering. Irritants produce local inflammation, pain, tightness, without necrosis. Irritants extravasating = not great, and can still have detrimental effects, but the extravasation of vesicants can be very dangerous! Google “vesicant extravasation,” but be prepared. Pictured below is a patient’s arm after extravasation of TPN.

Medications that can increase the risk of extravasation include anticoagulants and antiplatelets, which can exacerbate extravasation or cause compartmental injury by increasing local bleeding, vasodilators, hormone therapy and steroids (for their vasodilating properties), analgesics, and IV antibiotics.

Non-cytotoxic drugs that are vesicants that we use commonly include: diazepam, digoxin, nafcillin, nitroglycerine, phenytoin, and tetracyclines! Total parenteral nutrition is also a vesicant. When in doubt about what to do after an IV medication extravasation, consult with pharmacy, because some medication extravasations have substance-specific treatment.

BOARD REVIEW WITH THE CHIEFS:

Q: A 53 year old male is admitted to the MICU with septic shock secondary to community acquired pneumonia. His course has been complicated by acute respiratory distress syndrome requiring intubation and mechanical ventilation. On hospital day 2, his lactic acid has cleared and he no longer requires vasopressors to maintain perfusing mean arterial pressures. He is on ceftriaxone, azithromycin, fentanyl, with PRN midazolam for sedation, as well as maintenance intravenous fluids with normal saline at 100 mL/hr. He was initially fluid resuscitated for his septic shock and has a positive fluid balance of 7.2L. You are evaluating him for oliguria which has developed over the last 12 hours. On exam, he is afebrile, blood pressure is 98/58 mmHg, pulse is 87 bpm, and respiratory rate is 24/min. O2 saturation is 90% on FiO2 of 50% and PEEP of 18. He has required an increase in PEEP over the last 24 hours to maintain oxygenation. On exam, his skin is warm, there is pitting edema of his extremities, and his estimated CVP is 17. Labs show a creatinine of 2.2 (prior baseline 1), and ABG with pH 7.3, pCO2 50, and pO2 87. Chest radiograph shows bilateral infiltrates, increased from prior, with development of bilateral pleural effusions. What is your next step in treatment?

A. Start hydrocortisone  C. Administer albumin
B. Discontinue IV fluid  D. Start dobutamine

A. The answer is B, discontinue IV fluid. This patient has been adequately volume resuscitated (normal lactate, no longer on pressors), and is now showing signs of volume overload, with elevated CVP, pleural effusions, and need for increased PEEP to maintain oxygenation. Additional volume will likely worsen his hypoxemia. Albumin has no advantage over crystalloid and would not be preferred for this patient, even if he were volume down. Hydrocortisone would be a consideration if the patient had persistent shock despite fluid resuscitation and pressors. Dobutamine or other inotropic support should be considered in septic shock, as sepsis can lead to decreased myocardial function, however this patient has perfusing MAPs and, though he is volume overloaded, it is the result of preload rather than pump, and so inotropes are not necessary. This patient should be given a trial of diuresis to improve his oxygenation and fluid balance.
**Weekend to-do!**

**Friday:** Dr. Warm’s Annual Residency Party! Friday, 7pm, 11/4/16 7 PM, 3413 Burch Avenue Cincinnati Ohio 45208. To celebrate the changeover of the longblock, our fabulous interns, the return of the 3rd year residents to the wards, recruiting kick-off, and the start of the fall party season! Family and friends are welcome.


The Second City’s Holidazed & Confused Revue, 8 p.m. Saturday, 7 p.m. Sunday, Playhouse in the Park, 962 Mount Adams Circle, Eden Park. Seasonal sketches as riotous send-up of Christmas, Hanukkah, Kwanzaa and everything in-between. $30 and up. www.cinciplay.com.

**Sunday:** Don We Now Our Gay Apparel Family Christmas Photo Shoot and Bazaar, 12:30-4 p.m., Echo Church, 1301 E. McMillan, East Walnut Hills. Support work of local nonprofit that empowers Christians, LGBT+ and same-sex attracted individuals to step towards loving one another boldly. Photos, cookie decorating, wreaths. Donations accepted. tinyurl.com/photos4LGBT.


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**SHOUT OUTS!!!**

- To **Elyse Harris** for getting a STEMI patient at the VA to the cath lab in less than 15 minutes. Incredible!
- To **Javier Baez, Rita Schlanger,** and **Danielle Clark** for being so helpful and gracious while covering for colleagues for various reasons—you guys are awesome!
- To the R3s who are back at it on the wards and doing great!
- To the long blockers who are settling in to their new roles!
- To **Betsy Larder** for her commitment to the “DB-11” project, AKA discharging patients before 11am! She is doing awesome and we appreciate it!
- To **Scott Merriman** and **Elliott Welford,** who hung out with our applicants in the Mark Brown Library this afternoon! We love showing off our awesome residents to the applicants!
- To **Kyle Hines** and **Alicia Caldwell** for their great noon report today! Thanks for the great case!

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**TRIVIA**

What is this sign called?
What disease (or diseases) is it classically associated with?

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Congrats to Kelly Laipply for recognizing pulmonary artery organized thrombus removed during pulmonary thromboendarterectomy! This is a treatment for Chronic Thromboembolic pulmonary hypertension (CTEPH).