MS-3 Survival Guide:
Tips and Templates for the Student Doctor

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Values and Calculations: Download a medical calculator app to your smartphone! I use MedCalc…

- VS (Temp, HR, BP, RR, O2)
  1. Temp: THERE ARE ONLY 3 OPTIONS!!!
     - Afebrile, or Medicine fever (>100.4), or Surgery fever (>101.4)
  2. HR & BP: please give me a range! Stable or changing from yesterday?
  3. RR: no one cares, unless your O2 is low and/or it’s hypo/hyper and leading to acid/base d/o
  4. O2: Room air - Nasal cannula - How many liters? (For each L, you’re adding about 3% O2 so if I’m on 3L O2, my FiO2 is ~30%) Assisted? (mask, bipap, cpap, vent…settings? Tell me more!)
     - An O2 >92% is fine, less than this, note it! Consider oxygen.

- UOP: amt. of urine in “whatever time”/pts wt in kg/“whatever time” (mL/kg/hr)

- WBC: If your pt has a low white count and/or is at risk for neutropenia, calculate the absolute neutrophil count
  1. ANC=(%segs+%bands)xWBC
  2. What’s that you say, your pt has neutropenic fever???
     - Plan: Cefepime x48 hrs, still fevering?
       - Vanc x5 days, still fevering?
     - Add antifungals!
  3. If the white count is high, why? Look at the differential to see what predominates (neutrophils, lymphocytes, etc)...don’t forget, ADMIN OF ‘ROIDS → increase in white count! So don’t get too excited if you just started your pt on Prednisone yesterday and all of a sudden their WBC jumps.

- Hgb/Hct should be ~1:3 and >7/21 (8/24 for ObGyn and 10/30 in severe conditions)
  1. Transfusing 1U of pRBCs → increase of 1 in Hgb and 3 in Hct! KNOW THIS!
  2. This means that if a pts H/H drops by 1/3, they have likely lost 1 unit of blood

- Plts: Goal of >50 (clot able to be formed), consider transfusing @ <20

- Na: If low, think about volume overload (the 3 “osis-es”); if high, they’re dry!

- K: Know how to replace K if low and what steps to take if high!
  1. HYPOK=10mEq IV → increase in ~0.1 K, give to goal (20-40 at a time), don’t go overboard
     - YOU MUST HAVE ADEQUATE Mg TO REPLETE!!!
     - If you don’t have an Mg level, suggest getting one for this reason, you will look smart
  2. HYPERK=”C BIG K, Die”
     - C=Calcium gluconate (for heart, not actually treating K)
     - B=Bicarb, IG=Insulin/Glucose, K=Kayexalate
     - “Die”=Dialysis (last ditch effort if others aren’t working!)

- Cl/Bicarb: See “acid/base” below…

- BUN/Cr: Calc the GFR! If your pt is on dialysis, Cr is stupid – don’t get excited about it.
  1. Prerenal AKI: BUN/Cr>20, FeNa<1%
  2. Intrinsic AKI: BUN/Cr<15, FeNa>2%
  3. Postrenal AKI: BUN/Cr>15, FeNa>4%

- Ca: “BUT WHAT IS THE ALBUMIN?”
  1. ALWAYS correct Ca for Alb: [0.8x(4-Alb)]+Ca= your corrected Ca level

- Glu: Pt diabetic or been running hypo or hyperglycemic?
  1. Gimme the last 3 glucosees!!!

Scores: The following are also on MedCalc…

- STEMI and NSTEMI: TIMI score
- Pneumonia: CURB-65
- Pleural effusion: Light’s criteria
- Pulmonary embolism: Wells Score (there is also a Wells for DVT)
Pancreatitis: Ranson’s criteria and Apache II score
Liver disease: MELD score
Risk of stroke w/in 1st 2 days of having TIA: ABCD2 score
Risk of stroke in pts w/ A-Fib: CHADS2 score
Stroke: NIH Stroke Scale

### Acid/Base status:
- pH\textsubscript{HCO}_3/CO_2...first, figure out what you are dealing with...also, anion gap?
  1. AG=Na-(Cl+Bicarb)...about 8-12 is normal
  2. If you have a metabolic acidosis WITH an anion gap...think MUDPILES!
  3. Expected CO2 during a metabolic acidosis?\textemdash\textsc{winter’s formula!}

### Indications for emergent dialysis!!! AEI(SLIME)OU!
- A: acidosis (metabolic...so again go back to MUDPILES, etc.)
- E: electrolytes (mainly K)
- I: intoxication
  1. SLIME (salicylates, Li+, isopropanol, Mg-containing laxatives, ethylene glycol)
- O: the “osis-es”...volume overload (from CHF-“cardiosis”, cirrhosis, nephrosis)
- U: uremia (pericarditis, encephalopathy, and/or GI bleed may be present)

### Last thing...TOP CAUSES...YOU WILL BE PIMPED ON THESE THINGS!!!
- Pancreatitis: MCC can be attending dependent...whoopsie!
  1. Gallstones (MC in women)
  2. Alcohol (MC in men)
  3. TGs (>800-1000)
- Small bowel obstruction (SBO):
  1. Adhesions (ask about surgical history, look for abdominal scars!)
  2. Hernia (drop the pants!)
  3. Cancer (fam history, look carefully for signs and symptoms)
- Post-op fever: KNOW THE TIMING!!! Usually happens in the order below...
  1. Atelectasis (MCC day 1), pneumonia (hosp acquired or aspiration), UTI (how long has this foley been in?), PE/DVT, wound infection, line infection (usually >7days post-op)
- Critical limb ischemia...THIS IS AN EMERGENCY!
  1. “6 Ps”: Pain, Pallor, Poikythermia, Paresthesias, Paralysis, Pulselessness

### Good books for studying:
- Step Up 2 Medicine (amazing for shelf)
- Pocket Medicine (amazing for pimps)
- Master the Boards (useful for Step 2)
- UWorld Q-bank
- Watch Emma Ramahi’s reviews!!! [http://som.uthscsa.edu/StudentAffairs/thirdyear.asp](http://som.uthscsa.edu/StudentAffairs/thirdyear.asp)
TRANSPLANT MEDICINE: How to Shine

- Primary team for patients that are awaiting a transplant or are at least a few months post-transplant
- See liver, kidney and lung transplant patients; most commonly cirrhosis, renal failure, and interstitial lung disease
- Schedule:
  - Morning is the same as the other inpatient teams
  - Multidisciplinary meeting at 1pm: resident presents patients to surgeons, pharmacists, consulting services, social workers, etc
    - You need to be there for the meeting, just sit along the wall
  - No call! Accept new patients every day
- For Pre-Transplant patients
  - Cirrhosis: calculate and report MELD score when they come in
    - Hepatic Encephalopathy: check ammonia levels and see if patient is post-TIPPS
      - When obtaining history, ask how much lactulose they have been taking
      - On physical exam, check for asterixis (“please hold your arms straight out in front of you with your hands up like you are stopping traffic”)
  - Renal Failure: report GFR and baseline Cr
  - Lung: look up most recent PFTs
- For Post-Transplant patients
  - Report date of transplant and where it was done if not at UH
  - Usually on Tacrolimus (Prograf) and/or Mycophenolate (Cellcept)
    - Report Prograf levels in the AM
    - These are immunosuppressive drugs so keep that in mind when considering differential!

TEAM-6 (HIV): How to Shine

- For each pt’s one liner make sure to include: when the HIV was diagnosed, the most recent CD4 value and % as well as the most recent viral load and when those values were taken.
  - Ex: “Pt is a 66 yo male diagnosed in March of this year with a CD4 of 200 and 14% on this admission and a viral load of 40,000 back in March.”
- Make sure you also present the drug regimen for each patient. Know the brand name AND the generics…and know how each drug works!
  - Ex: “Pt is currently taking Atripla which is Efavirenz, Emtricitabine and Tenofovir.”
- DRUG S/E! Look this up BEFORE speaking with your pt so you can ask appropriate questions.
- Do NOT be afraid to ask a complete sexual history, drug use history, and psych history!!!
- Do the FULL EXAM! This includes the genital exam, very important!
- Know your opportunistic infections and at which CD4 levels they pop up!
- This page: [http://aidsinfo.nih.gov/guidelines](http://aidsinfo.nih.gov/guidelines) has the “Adult and Adolescent ARV Guidelines” which is all you ever need to know about antiretroviral therapy, and the “Adult and Adolescent OI Prevention and Treatment Guidelines”, which has everything you need to know about the various OIs.
- Lastly, REVIEW YOUR ANTIBIOTICS!!!

PMH
1.
2.
3.
4.
5.

PSH
1.
2.

A/P
1. DDX
   Plan
2. DDX
   Plan
3. DDX
   Plan

Admit Meds
Diet:
IVF:
1. 2.
3.
4.
5.
6.
7.
8. DVT Proph GI proph Prn meds
   Tylenol 650 PO q6 (pain)
   Vicodin _ tab PO q4
   Accuchecks/ISS
   MOM 15 cc PO q4 cont
   Metoclopramide 10 mg IV q6 h
   Temazepam 15 mg PO q8
   Benadryl 25mg PO q8
   Comp 10mg IM/PO naus

To Do

Additional Labs/Pending
1.
2.
3.
4.
5.
6.
7.
8.

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**HPI:** Pt is a 52 yo AA M w/ HIV (CD4 833/39% on 5/2013 and VL<20 on 4/2012) on Atripla (Efavirenz, Emtricitabine and Tenofovir) which he claims to take daily except for the past 3 days. PMH includes chronic HCV, alcohol dependence, and elicit drug use. Pt presented to the ED w/ cc of hallucination after snorting a total of ~5g (~$500) of methamphetamines beginning ~7 days ago while pt was visiting high school friends in Corpus Cristi. Per pt’s partner, pt had not eaten/showered/slept x4 days and continued to have visual hallucinations through Monday to the point where he locked himself in a room for 4 hours. Pt’s partner attempted to calm him down/get him to sleep by giving him 5mg Ambien. Unfortunately pt was unable to fall asleep and continued to hallucinate. Pt claims that ~6 men with guns showed up to his family’s home to kill him Monday evening, however his partner reveals that the pt was hallucinating this event, and states that no one else present at the time witnessed the men with guns. Partner does admit that men may have actually been coming after the pt to collect money (for the methamphetamines) although he does not know if these men are in Corpus Cristi or San Antonio. Of note, pt drinks an average of 12 beers per day and has not had any alcohol since returning to San Antonio on Sunday (05/12/13) and possibly for some days before this as well. This is unclear. Partner reports that pt was shaking over the weekend, especially his feet, but pt experienced no seizures. Of note, pt began having psychiatric issues ~1.5 years ago, including hospitalization for SI in 2012 and has been having episodes of incontinence over the past 1 month. On ROS pt reports acute weight loss of 40-50 lbs although partner says that this has occurred over time, pt also reports cough x6 yrs which he feels has worsened recently. Pt denies fever/sweats, n/v/d/c, CP, SOB, and swelling. *Pt previously incarcerated for burglary (1992-2007).

**PMH:**
- HIV(CD4 833/39% on 5/2013 and VL<20 on 4/2012)
- Chronic Hepatitis C (HCV serotype 1, VL: 7.6 million)
- Alcohol dependence

**PSH:**
- Appy, 1986
- 4 arthroscopic procedures, unknown dates

**FH:**
- Mom- HTN, DM, depression
- Dad-unknown
- Siblings-none

**SH:**
- Lives alone in an apt in SA, has 1 current partner (male), engages in sexual activity w/ both males and females, >300 lifetime partners, previously incarcerated (1992-2007)
- T-1ppd x30 yrs
- E-12 beers daily
- D-hx of IV heroin use (most recent 6 months ago), more recent methamphetamine use (states this is rare)

**MEDS (outpt):** Atripla (Efavirenz, Emtricitabine and Tenofovir)

**PHYSICAL EXAM:**
- VS: T=Afebrile, P=60, R=18, BP=114/69, O2 100% on RA
- GENERAL: A&Ox3(name, location, event, disoriented to time/day/month/year/season)
- HEENT: NCAT, scleral icterus, maxillary adentialis, denture implant seen in L maxillary ridge, ulceration present in same area, no other ulcers identified in oropharynx
- CV: rr no m/r/g auscultated by me (extra heart sound (S3) heard by attending)
- RESP: mild rhtonchi BL lower lung fields, no wheezes/crackles
- ABD: +BS, soft, NT/ND, diffuse 1+edema, somewhat loose skin over abd, mild hepatomegaly, no splenomegaly, appy scar LLQ
- EXT: WWP, no c/c/e
SKIN: small 1mmx1mm white dots on abd, back, and shoulders; tattoos on chest and abdomen (Tupac, Bob Marley?, marijuana leaf, undistinguishable writing), tattoos BL UE and covering entire back as well
GU: circumcised w/ no penile lesions, no drainage expressed, no inguinal lymphadenopathy present

MEDS (inpt):
Atripla (Efavirenz, Emtricitabine, Tenofovir)
Olanzepine (Zyprexa) 10mg QHS
Acetaminophen (Tylenol) 650mg q4h PRN pain
Morphine Sulfate 2mg IV push q4h PRN pain
Enoxaparin (Lovenox) 40mg SC daily

LABS:
CBC: 6.1>12.4/35.5<154 (admit CBC: 7.9>14/40<84)
CHEM: 138/4.9/106/27/26/.8<97 (admit Cr: 1.7)
Ca/Mg/PO4: 9.2/1.9/2.8
Alb: 3.1, Pro: 8.4
AST/ALT: 502/222, AlkPhos: 106, TBili: 2.4
UA: pH6, 1+pro, 1+ketones, 2+bili, 1+blood, RBC1-5, 1+leukocytes, WBC1-5, +nitrites, rare bacteria, 1-5 hyaline casts
Repeat UA: pH6, no pro, no glu, no blood, RBC2, trace ketones, 1+bili, >8 urobili, 1+leukocytes, WBC7, 4 bacteria, 3 hyaline casts
Hep B Core IgM: NR; Hep B Surface Ag: NR; Heb B Surface Ab: 33
Hep A Ab: NR
Hep C VL (01/2009): 7.67 million, Hep C genotype 1
CSF: glucose 66, protein 44
CSF Cell Ct 1: clear, colorless, 230 RBC, total nucleated cell ct<5
CSF Cell Ct 2: clear, colorless, 0 RBC, total nucleated cell ct<5
CSF Gram stain and Cx: No WBCs, No bacteria
CSF India ink and FCx: negative
BCx: 1/2 Gram+ cocci in chains, C/ID to follow

IMAGING:
05/15/13 CT HEAD:
No acute intracranial abnormalities.

05/15/13 KUB:
1. Echogenic liver, suggestive of hepatic steatosis versus fibrosis.
2. Cholelithiasis without other sonographic findings of cholecystitis.
ADDENDUM AFTER STAFF REVIEW: A NONMOBILE STONE IS SEEN IN THE GALLBLADDER NECK.

ASSESSMENT & PLAN: 52 yo AA M w/ HCV coinfection w/ HIV (CD4 833/39% on 5/2013 and VL<20 on 4/2012) on Atripla who has hallucinations x7 days and found to have elevated transaminases this admission.

Hallucinations: Most likely 2/2 to methamphetamine use complicated by possible alcohol withdrawal and Ambien intoxication. As this pt has HIV, we must also consider TB, Syphilis, HSV, Toxo, Crypto, Histo, and Coccidioides.
--BCx
--SCx
--UCx
--Viral swab of oral lesion
--LP: Get cell count, AFB Cx and stain, VDRL, RPR, Fungal Cx, Cryptococcal ag, Histo ag, Toxoplasmosis ag, Toxo/HSV PCR, Coccidioides serologies
--Psych consult
--MRI W/WO
--Continue Atripla (Efavirenz, Emtricitabine, Tenofovir)
--VL pending

Possible bacteremia: BCx shows Gram+ cocci in chains, C/ID to follow
--Empiric tx w/ Vanc x1 day
--F/u on Cx results

Elevated transaminases: HCV+, AST/ALT 502/222 w/ TBili 2.4, DBili 0.9, Indirect 1.5;
H/H on admit 14/40, now 12.4/35.5
--Abd US: Steatosis vs Fibrosis
--Hep A, Hep B panel normal
--Peripheral smear for possible hemolysis

Substance abuse: Admits to alcohol use daily and intermittent illicit drug use
--Counseling on outpt basis (psych at FAACTS clinic)

Dispo: FULL CODE
**HPI:** Patient is a _____ year-old M/F with a history of ________________________________________

Presents with:

**O/N events:**

Vitals: Tc_____  Tm_____  HR_____  BP_____/_____  R_____  O2 _____on_____  I/O _____/_____

**PHYSICAL EXAM:**

GEN:
HEENT:
RESP:
CV:
ABD:
EXT:
NEURO:

**LABS:**

- MCV _____

- Ca _____ Mg _____ PO₄ _____

**IMAGING:**

**A/P:** Patient is a _____ year-old who presents with _____________________________

1)  
   •  
   •  
   •  

2)  
   •  
   •  
   •  

3)  
   •  
   •  
   •  

4)  
   •  
   •  
   •  

5)  
   •  
   •  
   •  

6)  
   •  
   •  
   •  

MEDICINE: PROGRESS NOTE (SOAP FORMAT) WRITE-UP EXAMPLE

S: No acute events o/n. This AM pt sedated, responds to voice but not to commands, unable to open eyes.

O: VS: T=Afebrile, P=80s, R=15-20, BP=137/86-153/107, O2 100% on NC
DRIPS: none
UOP: 3,200 mL=1.2mL/kg/hr
PHYSICAL EXAM:
   GENERAL: sedated, sitting up in bed, unable to open eyes but squeezes eyes shut in response to my attempt to open them/shine light in them
   HEENT: NCAT, non-icteric sclera, 1mm pupils BL, UTA reactivity, conjugate gaze
   CV: rrr no m/r/g auscultated (difficult to hear as pt has loud tracheal breath sounds)
   RESP: diffuse ronchi BL, loud tracheal breath sounds
   ABD: +BS, soft, obese, 1+ pitting edema throughout lower abdomen
   EXT: See below...
   -WWP
   -Trace pitting edema of R hand, 2+ pitting edema of R forearm
   -No edema of L hand, 1+ pitting edema of L forearm
   -3-4+ edema on dependent aspect of BL thighs
   -3+BLLLE pitting edema
   -Mild skin mottling on BL feet (more near great toe)
   -Bx site C/D/I, wound packed, bandage in place, no warmth/erythema/edema, no serosanginous drainage
   -INGUINAL lymphadenopathy non-visible at this point

MEDS:
Acetaminophen (Tylenol) 650mg q6h PRN fever/pain - HOLD
Allopurinol 300mg daily
ASA 81mg daily
Atorvastatin 10mg QHS - HOLD
Azithromycin 1,200mg weekly
Filgrastim (Neupogen) 480mcg daily
Folate 1mg daily
Furosemide (Lasix) 40mg IV BID
Heparin 5,000U q8h SC
Metoprolol 50mg BID
Micafungin 100mg daily
Olanzapine 10mg BID
Ondansetron 4mg q4h PRN n/v
Ranitidine 150mg BID
Thiamine 100mg daily
Valacyclovir 500mg BID
Truvada (Emtricitabine/Tenofovir) + Raltegravir - HOLD
Vancomycin 1g IVPB BID - HOLD
CHEMO: Intrathecal Methotrexate

LABS:
CBC: 0.6>7.7/24.4<101➔0.3>7.2/22.2<59 (ANC: 204)
CHEM: 149/4.1/118/20/46/1.6<112➔149/3.9/117/21/46/1.7<193
Ca/Mg/PO4: 7.4(8.9)/1.8/2.4➔7.3(9)/1.7/2.3
Alb: 2.1➔1.9, Pro: 5.7➔5.5
AST/ALT: 2049/818➔1673/816, AlkPhos: 243➔323, TBili: 3.4, DBili: 2.5
LDH: 1371➔1111, Uric acid: 4.8 (stable), Lactic acid (5/19/13): 3.2
Vanc level: 21.0
Ammonia<25, CK 156 (WNL), urine myoglobin: negative
TSH: 1.227
BNP>5,000
Lingual bx site wound cx: Coag-neg Staph. and Enterococcus
5/17 BCx 1/2 NGTD
   Cath tip (PICC) NGTD
   CSF Cx negative at 72 hours, AFB negative, Fungal Cx negative
5/16 Sputum Cx many leuc
   Cath tip (Quinton) >15 colonies of CNS
   Blod Cx x2 NGTD
5/14/13 BCx (PICC): +yeast
   BCx (periph): NGTD
5/15/13 BCx (L. AC): NGTD
   BCx (R arm CVC): NGTD
5/16/13 SCx: mod G+ clusters, few G+ rods, budding yest w/ pseudo-hyphae

IMAGING:

5/22/13 CXR:
1. Worsening mixed interstitial/air space opacity, differential diagnosis includes pulmonary edema and/or multifocal pneumonia.
2. Left retrocardiac opacity (atelectasis and/or pneumonia), unchanged.
3. Life-support devices satisfactorily positioned, without visualization of the distal end of the orogastric tube.

5/21/13 RUQ SONO:
FINDINGS:
Liver is normal in size and demonstrates increased echogenicity. A 2.0 x 1.7 cm echogenic lesion is again noted in the right hepatic lobe.
Gallbladder is normal and its wall measures 4 mm in thickness. No gallstones are seen. Negative sonographic Murphy's sign was reported by the ultrasound technologist. The common bile duct measures 2 mm and there is no biliary dilatation. Pancreas is partially seen and is normal.
The right kidney is normal in echogenicity and measures 9.6 cm in length. No stone or hydronephrosis is seen.
Visualized portions of aorta and inferior vena cava are normal.
IMPRESSION:
1. Echogenic liver consistent with hepatic steatosis or fibrosis.
2. Indeterminate 2-cm echogenic lesion in the right hepatic lobe.

5/20/13 ECHO:
There is moderate RAE, LAE and RVE, also mild LVE. LV shows normal wall thickness and severe regional wall motion abnormalities as depicted below. Global function is moderately to severely depressed (EF 35% by biplane method but by visual inspection is 25-30%). There is severe diastolic dysfunction. Heart valves are structurally normal with mild MR and TR. Estimated PASP is 50 mmHg c/w moderate pulmonary hypertension. CVP is elevated at 15 mmHg. No previous study available for comparison.

5/20/13 KUB:
Poor visualization of the nasogastric tube; suspect that the tube's tip is located within the distal esophagus or gastroesophageal junction. Tube advancement or replacement is recommended to obtain optimal positioning. This finding and recommendation were discussed with Kanapa Kornsawad, M.D. on May 20, 2013 at 11:43 a.m..

5/14/13 MRI BRAIN:
Two small nonenhancing foci of T2/FLAIR hyperintensity within the left middle and left inferior frontal gyri. This finding is nonspecific but could relate to a prior insult/remote infarction.

5/14/13 MRI LIVER:
Please note this study was degraded to motion artifact. An 2.5-cm lesion within hepatic segment 7 with possible rim enhancement concerning for metastasis. Recommend short interval follow-up.
5/14/13 MRI LUMBAR SPINE:
1. No evidence of metastatic disease of the lumbar spine.
2. Multilevel lumbar spondylosis, as described above.

5/12/13 CT HEAD:
No acute intracranial abnormality.

5/13 MUGA: septal hypokinesis with EF 41%

4/29/13 CT Chest:
1. No evidence of intrathoracic metastatic disease.
2. Coronary artery calcifications.
3. Left upper lobe, lingula and bibasilar subsegmental atelectasis.
4. Partially visualized soft tissue density encasing the celiac trunk, described in detail in on prior CT of the abdomen and pelvis.

4/24/13 CT ABD/PELVIS: Extensive infiltrative soft tissue density mass throughout the abdomen (primarily retroperitoneum) and extending into the pelvis, presacral region and left inguinal region in addition to a right hepatic mass. Differential considerations include retroperitoneal sarcoma, lymphoma and metastatic disease. The left inguinal lymphadenopathy would be amenable to ultrasound-guided biopsy.

**ASSESSMENT & PLAN:** 60 yo M w/ HIV/AIDS (dx Mar 2013, CD4: 49/5%, VL: 98), CAD s/p CABG, HTN, HLP and DM who was recently found to have CD10+ Burkitt’s lymphoma and w/ “hyper-Warburgism” on this admission as well as Tumor Lysis Syndrome w/ initiation of chemotherapy.

AMS/Agitation: Pt may have AMS 2/2 electrolyte abnormalities and/or may be experiencing ICU delirium. Ammonia, TSH, RPR, B12, LP, CT, and MRI all unremarkable. Folate 3.2 on 05/03/13 but pt has been supplemented w/ folate since admission. EEG showed diffuse slowing 2/2 moderate-severe encephalopathy of non-specific origin.
--Reduce Olanzapine to just 10mg QHS, plan to taper off
--Continue aspiration precautions
--HSV, JC pending

Elevated LFTs: Appear to be downtrending, AST/ALT: 2049/818→1673/816, AlkPhos: 243→323, TBili: 3.4, DBili: 2.5
Most likely causes are toxic agents/medications (pt on allopurinol, HAART, IT MTX, and atorvastatin), and hypotension/CHF related cause such as ischemia (i.e. shock liver) or congestion.
--Ammonia<25, CK WNL, urine myoglobin negative
--CMV, EBV, HSV pending
--Switch Fluconazole to Micafungin 100mg daily
--HOLD HAART
--HOLD Atorvastatin
--Continue to follow daily LFTs

Hypernatremia: Na still at 149, likely 2/2 third spacing w/ water deficit between 2-4L (3.5 L per renal).
--Give D5W 200cc/hr x24 hrs (per renal rec)
--DC Saline (per renal rec)
--Na checks q6h
--Continue Lasix 40mg BID
--Follow BMPs

Candidemia: Pt found to have yeast in SCx, UCx, and BCx of PICC line. C/ID showed Candida albicans
--Switch Fluconazole to Micafungin 100mg daily

Line infection: Quinton cath w/ CNS
--HOLD Vanc as level is 21.0
--Get Vanc level at 4 AM and restart as needed
--Leave HD cath in in case of emergent HD as pt will begin chemo again soon (per renal rec)
Linguinal SSTI: Cx showed CNS and amp/vanc susceptible enterococcus
--Continue wound care
--See above for Vanc changes

HIV/AIDS: Dx Mar 2013; CD4 of 49/5% on 04/01/13, VL 98 on 5/6/13; HLAB5701 negative
--HOLD Truvada (Emtricitabine/Tenofovir) + Raltegravir
--HOLD PCP and Toxo PPX w/ Bactrim 1TAB daily
--Continue MAC PPX w/ Azithromycin 1,200mg weekly
--New VL pending

Burkitt’s lymphoma: CD10+ lymphoma likely 2/2 HIV. Pt recently completed a round of EPOCH and is receiving IT MTX. BM bx report states that, “the location of the small lymphoid aggregate is worrisome; however, involvement by lymphoma cannot be established. A repeat bone marrow may be useful if clinically indicated.”
--Continue Allopurinol 300mg daily for TLS ppx
--TLS labs BID
--Keep nephrology in the loop as pt may need emergent CRRT (if TLS)
--IT MTX today (heme-onc)

CAD s/p CABG, HTN, HLP, GERD, Chronic anemia, and Ppx:
--MICU continues to manage for now
--Diastolic HTN 2/2 increased catecholamines on alpha-receptors as pt is on beta-blocker?

Dispo: Full-code
- Suggest discussing code status w/ family at their next visit
MEDICINE: PROGRESS NOTE PRESENTATION EXAMPLE

First give a brief reminder of who the person is:

“Ok, so this is Mr. H, our 37 year old male with nephrotic syndrome”

Then, subjective: Always include the first line. Report any patient complaints or new symptoms, adding pertinent positives or negatives to the complaint, then add information about results from changes in management done the day before, or changes in symptoms from the day before.

“No acute events overnight. This morning, the patient is complaining of increased swelling in his L arm after his IV was replaced. He denies any pain or redness at the area. He denies any fevers or chills overnight. He is also complaining of some redness in his vision that is new and a period of about 5 minutes where is vision went completely black but then returned to normal. He denies the experience of “a curtain being pulled down” or any pain associated with the event. He reports his cough has improved from yesterday with the Tylenol with codeine. He says he is urinating well and no longer feels he has to strain. Overall, he feels better and that his total body swelling has decreased.”

Next, Objective: Start with vitals, then physical exam, then labs, then imaging/other tests.

“Patient was afebrile overnight, heart rate ranged from 80-96, blood pressure remains elevated, ranging from 145/88 to 174/91, and he is satting well on room air. Total fluid intake was 1.5L, total output was 4L with a net out of 2.5L. ”

Physical exam should be brief, targeting only key areas, and focusing on changes.

“On physical exam, patient remains edematous, however, level of edema is now 3+ just above the knees, sacral edema is not appreciated, and periorbital edema has resolved. The left arm does appear to be more swollen than the right, from the elbow distally to the fingertips. Peripheral IV is in place in the left antecubital fossa, dated yesterday. The site is non-erythematous, non-tender, and there is no increased edema at the IV site compared to the rest of the arm. Lungs sound more clear than yesterday, still with some appreciable crackles in the lung bases bilaterally.”

Labs, again should be brief and focus on abnormal numbers, changes, and trends.

“In his labs for today, his potassium dropped slightly to 3.1, BUN and Cr remain elevated, but are stable. Hemoglobin and hematocrit are decreased, but stable. Last three glucoses were 200, 150, and 130. 24 hour urine protein came back as 10g. SPEP and UPEP have been ordered but are pending.”

For the images/other tests section, read the impression and/or final report. If none are given, you can give your opinion if you are relatively confident.

“Bilateral hip Xrays were ordered yesterday because the nephrologist noted the patient’s gait appeared abnormal and he was concerned for avascular necrosis of the femoral head. The final read hasn’t come back yet, but on my review this morning, I didn’t appreciate any abnormality. Patient also had an echo done yesterday which showed an estimated ejection fraction of 55-60%, no wall motion abnormalities, and mild mitral regurgitation.”

Finally, assessment and plan. This is where you will improve the most your third year, so don’t worry about getting it right your first day or even your first semester. You will also be interrupted a lot during this section with new information the resident got during rounds you didn’t know about, or just the team thinking out loud. Come up with a couple things at least to show you are thinking about the information you have gathered.

The assessment is your one liner.

“So this is Mr. H, our 37 year old with a past medical history of uncontrolled diabetes, type 2 and hypertension who presents with nephrotic syndrome and vision loss.”
Your plan should be problem based on medicine. Start with new problems and the most acute issues. Ask your residents for help on the plans before rounds. They will give you advice, but sometimes forget to offer it first because they are busy.

“Problem number one would be his new vision complaints. Patient has already been seen by optho on Monday and they performed photocoagulation on his R eye, which is his only good eye, and they set him up for a follow up appointment next month as an outpatient. His symptoms are probably related to his diabetic retinopathy but may be a complication of the photocoagulation. We should probably call optho again and have them re-examine his eye. We will also continue the regimen of drops they recommended for pain and pressure control. We will consult OT to help him with ADLs with his decreased vision.

His next problem is the new swelling in his L arm after the IV was replaced. Based on physical exam, it doesn’t appear to be infected, so we aren’t worried about cellulitis or thrombophlebitis. We should have the nurse check the IV today and replace it in his R arm. We will put a new nurses order to no longer place IVs in his L arm as he might be considered for dialysis for long term management and since he is R handed, we will need to protect his nondominant arm.

Next would be his nephrotic syndrome. The patient is improving symptomatically with the diuresis and continues to have large net urine output. Renal is on board and recommends to continue diuresing him with Lasix 80mg iv bid as he still has a large amount of edema. We will also continue Lisinopril 20mg bid and Trental 400mg daily to prevent additional protein loss through the urine. Patient noted he felt like he was being given a lot of different juices and teas with his meals, so we will place a fluid restriction of 1.5 L in his diet order.

His next problem is his hypertension. His blood pressure remains elevated since admission. Due to his Utox being positive for cocaine, we avoided Beta-blockers and started a calcium channel blocker. Renal recommended increasing nifedipine to 90mg daily.

Next would be his chronic kidney disease. His BUN and Cr remain stable since admission, and he is still Voiding well. Again, renal is on board and they recommend obtaining venous mapping and consulting vascular surgery for placement of an AV fistula as patient will most likely need dialysis for long term management.

Next is his diabetes. He is currently only on insulin sliding scale, requiring only 5 units in the past 24 hours. His sugars have been well controlled since admission, so we can continue with that with plans for continuing his outpatient regimen on discharge as his hemoglobin A1c on admission was 6.8.

He also has a microcytic anemic with an H&H of 8.2 and 24.6 and an MCV of 82. This has been stable since admission. Patient remains asymptomatic with no complaints of fatigue, dizziness, or lightheadedness. The anemia is most likely secondary to his chronic kidney disease, however, we will order iron studies to make sure it is not a reversible cause.”

At the end of your presentation include the following: prophylaxis measures, code status, and disposition. Prophylaxis includes for DVT (lovenox, SCDs, heparin, early ambulation), aspiration (dysphagia ground diet, protonix), etc. Disposition is where their care will be continued and where they will go when they are discharged.

“He is on heparin 5000 units twice daily for DVT prophylaxis due to his poor kidney function. We are avoiding SCDs due to his edema. He is full code and his disposition will be continued diuresis in house with discharge to home.”
NEUROLOGY: How to Shine

**PRACTICE YOUR NEURO EXAM!**
- This exam is long and complicated but each part is very important. You can't just say "4/5 strength on the left"...you really need to know each muscle you are testing because patterns lead to diagnoses and if you can find a pattern (even if you can't recognize what it means) your resident/attending will be impressed :)
- Be sure to ask the 4 orientation questions 1st (even if it seems silly, you cannot report A&Ox4 if you don't!): 1. Tell me your name. 2. Where are we? 3. What is today? Date? Month? Year? Season? 4. Do you remember why you came to the hospital? Why are you here?
- Next I usually ask a few more questions...What is this object? What color is it? Who is the president? Do you remember your first job? Or...where did you go to high school?
- Make sure you are paying attention to the patient's speech this entire time!
- **REVIEW YOUR CRANIAL NERVES!!!** Please know each nerve and what it does BEFORE you start!
  - CN1: olfactory
  - CN2: optic
  - CN3: oculomotor
  - CN4: trochlear
  - CN5: trigeminal
  - CN6: abducens
  - CN7: facial
  - CN8: vestibulo-cochlear
  - CN9: glossopharyngeal
  - CN10: vagus
  - CN11: spinal accessory
  - CN12: hypoglossal
- Last but not least, please do not forget to do a good general physical exam on your patients. I'm all for you recognizing that your patient has 1mm pupil in one eye and 2mm pupil in the other but what about that giant butt abscess that ya missed because you didn't undress the patient and flip em over?!?
  1. Never forget your basics! Every patient deserves a heart and lung exam.

**Come prepared! ALWAYS have a stethoscope (that's for your resident/attending bc they never have theirs), have like 5 pens in your pocket for the same reason, have a pen light, reflex hammer, large tuning fork, something to test sensation with (cotton swab, safety pin, etc), and try to bring an ophthalmoscope if you have one or know someone who does. Obviously don't go buy one for a 3 week rotation...but try to find one.**

**Know how to take a seizure history!!!** Attached you will find a seizure history template.

**Review anatomy and neuro-radiology!** Make sure you know the Circle of Willis please! And the following...
- CT: a series of X-rays, used for bleed, stroke, mass, calcifications; bone=bright white
  1. HypoDENSE→infarction, edema (note: tumors may have surrounding edema)
  2. Hyperdense→calcifications, bleed
  3. CT angio indicated when you need to look at vessels (anatomy, clots, leaks, etc.)
- MRI T1: CSF/water is dark, fat and white matter is white, grey matter is grey
- MRI T2: CSF/water is bright, fat and white matter is darker (so grey matter is lighter than white here)
- MRI T2/FLAIR (fluid attenuation inversion recovery): uses a pulse sequence technique that nulls fluids so CSF is dark, BUT white matter is still darker than grey matter…this is why you cannot use the CSF alone to judge what type of MRI you’re seeing! AKA just knowing “WWII” is not that helpful here.
  1. Note: lesions on MRI are described as hypo or hyperINTENSE (not dense, like CTs)

**Good books for studying:**
- Pocket Medicine (read the neuro section before you start your rotation)
- Step Up 2 Medicine (amazing for the midterm-read this at least twice before the midterm!)
- UWorld Q-bank
### Physical Exam

<table>
<thead>
<tr>
<th>HEENT:</th>
<th>CVS/neck:</th>
<th>Lungs:</th>
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Mental Status:
- AAOx4;
- language fn and comprehension;
- memory;
- concentration and attention.

CN 2: OD____, OS____ visual fields, no papilledema
CN 3, 4, 6: PERRLA, EOMI, No nystagmus
CN 5: facial sensation (V1-V3)
CN 7: facial expression, no nasolabial fold flattening
CN 8: hearing, no lateralization
CN 9, 10: palate elevation
CN 11: trapezius______, sternocleidomastoid______
CN 12: no tongue deviation, no fasciculations

Motor:
- Tone/Bulk

Strength
- Right
- Left

Deltoids
- Triceps
- Biceps
- Wrist Fl
- Wrist Ex
- Intrinsic
- Hip Flex
- Knee Fl
- Knee Ex
- Dorsiflex
- Plantarflex
- DRIFT

Sensory:
- Light Touch
- Temp
- Vibration
- Pin Prick

Reflexes: Bic | Tric | BR | KJ | AJ | Babinski
- Right
- Left

Coordination:
- finger-to-nose, fine motor coordination, rapid
  alternating movements
- heel to shin, rhomberg

Gait: normal______, Tiptoe, Heel, tandem

### Lab Exam

| Question/CC: | LH/RH |

### PMH/PSH

#### Baseline Activity:

Consult from:
- Resident:
- Attending:

| Baseline Wt: | Cr: | Diet: |

### Allergy/Rxn:

| Father: | Mother: |

#### General:
- Wt Loss, Fever, Chills

#### CV:
- CP, Palpitations

#### Pulm:
- SOB, Cough

#### GI:
- N, V, D

#### GU:
- dysuria

#### Endo:
- Polyuria, Polydipsia

#### Skin:
- Rash

#### Heme:
- Bruises

#### MS:
- Aches, Pains

#### Psych:
- SI, HI

#### Neuro:

| Social Hx | Tob: |

| Home: | EtOH: |

| Occ: | Drugs: |

| Sex: | CODE STATUS |
HPI:

ROS:
Gen: no loss or gain of weight, no fatigue, no fevers, chills, night sweats
Eyes: no recent changes in vision, no blurred vision or diplopia; wears corrective lenses
Ears: no recent changes in hearing, no tinnitus
Nose: no nosebleeds
Mouth: no bleeding gums, sore throat
Allergies: no congestion
Neck: no pain or stiffness
Resp: no SOB, no cough
CV: no palpitations, no chest pain
GI: no changes in appetite, no dysphagia, no n/v, no abdominal pain, no diarrhea, no constipation, no BRBPR or melena
GU: no dysuria
Neuro: as per HPI
Skin: no rashes
MSK: no joint pain
Heme: no easy bruising, no bleeding

PMH:

PSH:

FH:

SH:
Lives with:
Smoking:
EtOH:
Illicit drugs:

ALLG: NKDA

MEDS:

PHYSICAL EXAM:
VS:
GEN: NAD, appears stated age, good personal hygiene
HEENT: NC/AT, MMM, oropharynx clear
CV: regular rhythm, no m/r/g, no peripheral edema
RESP: breathing regular and unlabored, CTAB
ABD: soft, NT/ND, +BS
EXT: WWP, no c/c/e

Mental Status:
alert & oriented x4, repetition intact, speech is spontaneous and fluent
comprehension and naming intact, object recognition normal, recent and remote memory intact

Cranial Nerves:

CN2: optic discs? OD/OS? visual fields full to confrontation?
CN3,4,6: PERRLA, EOMI, no nystagmus, ptosis?
CN5: sensation V1, V2, V3 intact to light touch BL?
CN7: facial expressions intact bilaterally, no weakness of facial musculature observed?

CN8: hearing grossly intact (Weber, Rinne)?

CN9,10: palate elevation symmetrical, no hoarseness of voice

CN11: trapezius and sternocleidomastoid 5/5 strength BL

CN12: no tongue deviation, no fasiculations

Motor:
Normal bulk and tone, no involuntary movements, no rigidity or spasticity, no fix, no pronator drift, able to stand on heels and toes

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<thead>
<tr>
<th>Strength</th>
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<td>Plantarflex</td>
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Sensation:
intact b/l to light touch, pinprick, proprioception, vibration and temp

Reflexes:
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<th>BR</th>
<th>Bic</th>
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<td>Right</td>
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Cerebellar:
intact finger-to-nose, heel-to-shin, and rapid alternating movements

Gait:
Normal physiologic gait with no ataxia, normal tip toe walk, heel walk, and tandem walk

PHYSICAL EXAM (SEDATED Patient):
VS:

Gen: NAD, intubated
HEENT: NC/AT, MMM, oropharynx clear
CV: regular rhythm, no m/r/g, no peripheral edema
RESP: breathing regular and unlabored, CTAB
ABD: soft, NT/ND, +BS
EXT: WWP, no c/c/e

MS: opens eyes spontaneously to voice or noxious stimulation, does not answer questions or follow commands
CN: optic discs not visualized, PERRL, +oculocephalic maneuver, no nystagmus, +corneal reflex, face appears symmetric
Motor: Flaccid tone, normal bulk, no involuntary movements, no rigidity or spasticity
Strength: moves all 4 extremities spontaneously
Sensation: withdraws to noxious stimuli
Reflexes:
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<th>BR</th>
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Cerebellar/Gait: unable to assess
Labs: PLEASE DO NOT FORGET TO TREND YOUR LABS! They are meaningless w/out the prior day’s values to compare to.

CBC – WBC>Hgb/Hct<Plts

Chem – Na/K/Cl/Bicarb/BUN/Cr<Glu

**Imaging:**

A/P:

1. 
2. 
   etc…

PPx:

Dispo: FULL code?

---

**For seizure patients make sure to:** Discussed with patient that by Texas law, pt is not to drive until he has gone 6 months free of any loss of awareness or seizure. Also advised patient not to be alone around open flame, standing water, heights or heavy machinery. Also advised patient to refrain from any activity during which loss of consciousness could lead to harm to himself or others.

**If your pt has ICH, suggest the following in your plan:**
- Admit to neuro stroke for obs
- Neurochecks q2h
- If changes in neuro exam, then stat CT head and notify NSG
- Normothermic, Normotensive – prn labetalol for SBP >160
- Avoid anticoagulation and antiplatelets
- Trauma surgery to clear c-collar.
- Bedside dysphagia screen

**If your pt has had a CVA, suggest the following in your plan:**
- Admit to Neuro stroke
- Neurochecks q2h x4 h, then q4h
- Telemetry
- Liberalize BP up to 220/110, prn labetalol
- MRI brain
- MRA head and neck
- TTE with bubble study
- FLP, HgbA1c
- Pending bedside dysphagia screen
- ASA 325 mg daily
- PT/OT/Speech/Rehab consults
HPI:
Pt is a 62 yo RHF w/ h/o seizures, HTN, angina, CVA, chronic migraines and panic attacks who was brought to the UH ED by Airlife after pressing her Life Alert button due to a fall. Pt reports that she woke up stuck in between her bed and her nightstand and was unable to get up on her own due to weakness of both right and left arms and legs, which has since resolved. The last thing she remembers is sitting on her bed. The patient does not remember falling and does not know how long she was unconscious. Pt reports urinary incontinence but denies fecal incontinence and tongue biting. Baseline activity = L sided weakness s/p CVA 2006. Pt states that her first seizure occurred on Sept. 26, 2012 at her daughter’s birthday party where she got into a fight with family members. She describes her seizures as beginning with a “sinking spell” in which she feels that her BP is unchanged but her HR is decreased, followed by a fall in which she experiences LOC. Per pt, she has never experienced a grand mal seizure. Her last seizure occurred Feb. 23, 2013 at her great granddaughter’s birthday party where she got into a fight with family members once again. Pt cannot tell us how many seizures she has had since these episodes began. She sees Dr. Mehendale and has had a 72-hour EEG within the last 4 months – results unknown at this time.

ROS:
-Gen: + subjective f/c over past 2 days, denies recent weight loss
-HEENT: + new vertical diplopia when fatigued; denies new changes in hearing, nosebleeds, bleeding gums and sore throat
-CV: denies chest pain, palpitations
-Pulm: denies SOB, cough
-GI: + constipation, no n/v/d
-GU: denies dysuria
-Endo: denies polyuria, polydipsia
-Skin: + painful rash under L breast that appeared 4 days ago
-Heme: denies any new bruising
-MS: denies any new aches/pains
-Neuro: + migraine w/in last 2 weeks, denies trouble swallowing, see HPI for more

PMH:
-Seizure d/o (diagnosed 2012)
-HTN
-Angina
-CVA (2006)
-Chronic back pain
-Chronic migraines
-Panic attacks

PSH:
-Growth removed from L lateral neck

FH:
-Parent w/ CVA
-Daughter w/ seizure disorder (onset in mid-20s), pt describes daughter’s seizures as falls w/ LOC

SH:
-Pt lives alone in Centerville, TX; has a caretaker; unemployed
-Tobacco: 2 ppd
-EtOH: denies
-Drugs: denies

ALLG: Latex
MEDS:
- Aspirin 81mg qday
- Amlodipine 10mg qday
- Gabapentin 300mg QID
- Soma 350mg TID
- Topamax 100mg QAM, 200mg QPM
- Phenergan
- Norco

PHYSICAL EXAM:
VS: BP 104/64, HR 55, RR 20

HEENT: NCAT, mmm, non-icteral sclera
CV/neck: rrr, no m/r/g, no carotid bruits
Resp: CTAB, no w/c/r

Mental Status:
AAOx4; repetition, speech, lang fn and comprehension, memory, concentration and attention intact

Cranial Nerves:
CN2: visual fields full to confrontation
CN3,4,6: PERRLA, EOMI, no nystagmus; R partial ptosis
CN5: sensation V1, V2, V3 intact to light touch on R, decreased on L
CN7: facial expressions intact bilaterally
CN8: hearing decreased on L side compared to R (pt reports this is not new)
CN9,10: palate elevation symmetrical, no hoarseness of voice
CN11: trapezius and sternocleidomastoid 5/5 strength BL
CN12: no tongue deviation, no fasiculations

Motor:
Tone/Bulk: Tone decreased on L, bulk equal bilaterally (no hypertrophy or atrophy)
Strength: Note +L drift

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Sensory: Decreased light touch, temp, vibration, pinprick on L face, arm, leg
Reflexes: 2+BL (all), neg Babinski
Coordination: dysmetria w/ FTN, HTS and rapid alternating movements on Left
Gait: N/A (pt in wheelchair)
Meningeal signs: N/A

LABS:
-CHEM: 136/3.2/104/23/4/.05/99; 9.0/2.2/3.9
-Glu 139 on admission, 108 this AM
IMAGING:
- CT head = calcification on falx cerebri indicating past calcified meningioma
- CTA = no acute intracranial abnormality; Note: 6mm thyroid nodule and 9 mm nodule at R medial apex (possibly residua of remote infection)

**A/P: NOTE THIS PLAN IS NO BUENO, SHOULD HAVE A PROBLEM LIST!**
62 yo RHF w/ h/o seizures, HTN, angina, CVA, chronic migraines and panic attacks who presents s/p fall precipitated by aura and associated w/ LOC and urinary incontinence. Physical exam consistent w/ h/o L sided weakness s/p CVA 2006 and significant for dysmetria w/ FTN, HTS and rapid alternating movements on left. Differential diagnosis includes syncopal episode, seizure (focal progressing to generalized vs psychogenic) and TIA/CVA.

- Admit for obs, place pt on telemetry
- Check orthostatic BPs to r/o syncopal episode
- EEG and MRI to work up seizure vs TIA/CVA
- Increase pt’s Topamax from 100mg QAM, 200mg QPM to 200mg BID
- Pt f/u w/ PCP regarding thyroid and lung nodules seen on CTA
S: No acute events o/n. Asleep on exam this AM. Pt responds to pain but is not spontaneously opening eyes or responding to commands. Unable to obtain ROS.

O: VS: T=97.5, P=102, R=23, BP=86/56, O2 99% on 2L NC
INS/OUTS: UOP 2.9mL/kg/hr

PHYSICAL EXAM:
   GENERAL: UTA orientation as pt is asleep and not easily arousable; withdraws to pain (sternal rub), decorticate posturing w/ little spontaneous movement
   HEENT: NCAT, no JVD, non-icteric sclera, no carotid bruits auscultated
   CV: tachycardic w/ regular rhythm; no m/r/g
   RESP: BL upper airway rhonchi; no wheezes/crackles auscultated
   ABD: +BS, soft, NT/ND
   EXT: WWP, no c/c/e
   NEURO: limited due to sedation…
   CN: face symmetric, eyes conjugate, tongue w/ fasiculations
   MOTOR: increased tone in upper and lower extremities, diffuse atrophy in upper and lower extremities, mild intermittent fasiculations in left UE, decorticate posturing throughout (most prominent in BLLE, esp feet)
   SENSATION: withdraws to pain
   REFLEXES: 3+ UE reflexes, no UE clonus, +Hoffman’s BL; UTA LE reflexes due to posturing
   CEREBELLAR/GAIT: UTA gait as pt is not ambulatory

MEDS:
1) ALBUTEROL SOLN, INHL  1 VIAL INHL Q4H PRN
2) ALPRAZOLAM TAB  0.5MG PO BID PRN anxiety
3) CEFEPIME INJ, PWDR CEFEPIME 1 GM in D5W IVPB Q8H
4) CLINDAMYCIN 600MG/50ML D5W IV INFUSE Q8H
5) DONEPEZIL TAB  5MG PO DAILY
6) ENOXAPARIN INJ  40MG/0.4ML SC DAILY
7) HYDROCODONE 5MG/ACETAMINOPHEN 325MG Q6H PRN pain
8) IPRATROPIUM SOLN, INHL  1 VIAL ORAL INHL Q4H PRN
9) LEVOTHYROXINE TAB  0.125MG PO DAILY
10) LORAZEPAM INJ  2MG/1ML IV AS DIRECTED PRN
11) MEMANTINE TAB  10MG PO BID
12) PREGABALIN CAP, ORAL  100MG PO QHS (BEDTIME)
13) RANITIDINE TAB  150MG PO BID
14) SERTRALINE TAB  200MG PO DAILY
15) SOD CHLORIDE  0.9% BAG INJ in NS 1000 ML 30 ml/hr IV

LABS:
   CHEM: 136/3.2/104/23/4/.05/99
   Ca/Mg/PO4: 9.0/2.2/3.9
   B12>1,500
   HIV pending
   RPR pending
   BCx, UCx, clean catch: all NGTD (prelim report)
   SCx pending

IMAGING:

04/23/13 CXR Impression:

1. Minimal bibasilar atelectasis.
04/23/13 CT Chest Impression:

1. No pulmonary embolism evident on this exam, which is slightly limited due to respiratory motion.
2. Bronchial wall thickening with intraluminal debris and lung parenchymal nodular/tree-in-bud opacities in a predominantly lower lobe distribution compatible with bronchopneumonia. There is also bibasilar atelectasis, although superimposed infection is not excluded.

04/25/13 MRI Report:

STUDY: Noncontrast and contrast enhanced Brain MRI

HISTORY: Evaluation of progressive dementia; progressive dementia, dysphasia, now with respiratory weakness, in the differentials are ALS versus dementia.

COMPARISON: CT head without contrast from 09/06/2012

FINDINGS: A 1.1 x 1.1 cm lesion is seen arising to the left of the falx cerebri at the vertex with a dural tail, appearing slightly hypointense on T1 and T2-weighted images, and showing enhancement, consistent with a meningioma.

There is parenchymal atrophy, which appears more prominent in the frontotemporal lobes, with associated ex vacuo dilation of the ventricular system.

T2/FLAIR hyperintensity along the prefrontal white matter likely represent chronic microvascular ischemic changes. Hypodensities in the bilateral basal ganglia on T1 and FLAIR images show no surrounding gliosis, and may represent prominent perivascular spaces.

There is no extraaxial collection or midline shift. There is no abnormal restricted diffusion. T2 gradient sequences reveal no remote hemorrhage. Posterior fossa structures appear normal. The dominant normal intracranial flow voids are seen.

The orbital soft tissues, soft tissues immediately underneath the skull base appear grossly normal. No significant abnormality is seen of the visualized paranasal sinuses and within the temporal bones.

Impression:

1. Brain parenchymal atrophy, greater than expected for the patient's age. Questionable disproportionate involvement of the frontotemporal lobes raises concern for frontotemporal lobar degeneration.
2. 1.1 cm left parafalcine meningioma at the vertex.
3. Chronic macrovascular ischemic changes.

ASSESSMENT & PLAN: 58 yo F w/ PMH hypothyroidism, depression, and CLBP since early 20s w/ worsening progressive dementia associated w/ dysarthria, dysphagia, weakness, and weight loss who is currently admitted w/ dx of aspiration PNA and is being worked up for “ALS plus”.
Pneumonia: Likely aspiration 2/2 pt’s worsening dysphagia. CXR shows bibasilar atelectasis, CT chest shows bronchial wall thickening with intraluminal debris and lung parenchymal nodular/tree-in-bud opacities in a predominantly lower lobe distribution compatible with bronchopneumonia. Pt appears to be improving after administration of abx. Procalcitonin was negative. Deescalate abx pending cultures.
--Cefepime 1G q8h x8 days (pt on day 4/8)
--Clindamycin 600MG q8h x8 days (pt on day 3/8)
--Continue NC at 2L
--Recommend Bipap o/n
--Aspiration precautions
--Cultures pending

Dysphagia: Likely 2/2 neurodegenerative process.
--Aspiration precautions
--Per speech consult: pt able to tolerate thin liquid diet
--Video Fluoroscopic Swallow Study recommended
--Pt scheduled to Speech Swallow Clinic on 5/16 @ 1415
--Pt will be followed by speech pathology during inpatient stay.

Dementia NOS/Neurodegenerative d/o NOS:
-Likely to be ALS w/ associated frontotemporal dementia (“ALS plus”). Pt has “clinically definite” ALS based on the following positive World Federation of Neurology ALS criteria: UMN and LMN signs in bulbar region (tongue fasiculations, dysphagia), cervical region (UE atrophy and RUE fasiculations w/ increased tone, hyperreflexia and +Hoffman’s in UE), and lumbosaceral (atrophy as well as increased tone and decortic posturing in LE). The patient also has the following common complications of ALS: progressive inability to perform ADLs, deterioration of ambulation, aspiration pneumonia, and respiratory insufficiency. Although dementia is rarely associated w/ ALS, when it has been reported it is often of the frontotemporal type which is consistent w/ the findings on this patient’s recent MRI.
-A less likely dx to consider is adult-onset/late-onset Tay Sachs (LOTS) dz as pt is of Polish descent, although not Jewish, and displays the following characteristics: clumsiness and muscle weakness in the legs, evidence of mental health problems (dx depression), gradual loss of skills (cane to walker to wheelchair), and speech and swallowing difficulties. Unfortunately, you will not find a cherry-red spot on the macula in pts w/ LOTS. Dementia has been listed as a possible symptom in pts with Tay-Sachs.
-Lastly, I would consider multisystem atrophy in my differential as this often presents w/ an akinetic rigidity in movement, problems w/ balance, and incontinence which is interesting as this pt first presented in September of 2009 w/ cc of LE weakness, multiple falls and urinary incontinence. It may also be noted that a percentage of MSA pts will also have cognitive decline. MRI in pts with MSA can be totally normal but if not, expected MRI findings in MSA are as follows: Atrophy of cerebellum and brainstem in OPCA and striatonigral degeneration (SND), No vascular damage, No multi-infarct pattern in brainNo other lesions, Hyperintensity in the pons, peduncles, and cerebellum on T2-weighted and proton density–weighted MRI scans. You may also see slitlike hyperintensity on T2-weighted and proton density–weighted MRI scans; a cruciform hyperintensity in the pons on T2-weighted MRI, known as the hot cross bun sign. While this is diagnostically helpful, it is not specific to MSA.

--Possible diagnostic tests to order are as follows…
   --Anti-ganglioside MI antibody testing to r/o ALS
   --Hexosaminidase A testing to r/o LOTS
   --Alpha synuclein immunochemistry showing GCIs that are ubiquitin-positive, tau-positive, and alpha-synuclein–positive oligodendroglial inclusions (on histology) to r/o MSA

Hypothyroidism: TSH 1.5 (WNL)
--Continue Levothyroxine 0.125mg daily

DVT PPX
--Lovenox 40mg SC INJ daily

Dispo
--Pt is full code
--Plan to DC to home w/ husband after resolution of PNA and pending neuro evaluation
--Consider having SW discuss future care options w/ husband
SURGERY: How to Shine

■ In the OR
  o Be there EARLY!!!
  o The scrub tech will make or break your surgery experience; be nice to them always, say please, thank you, sir, ma’am, etc, put your hands where they tell you to, don’t touch anything unless told to touch it!
  o Act like you are supposed to be there. Walk in, introduce yourself, ask where you can pull gloves, pull them before anyone scrubs in, and open them and hand them to the tech unless they tell you to drop it on their field.
  o Scrub when your resident does and scrub for just a little bit longer than they do
  o Know your anatomy for when you get asked questions
  o Read about the case before and have 1-2 questions to ask either about the procedure, the patient, why they are doing something, but …
  o Don’t ask questions when you see a lot of blood or when they are doing something very delicate like sewing onto a beating heart
  o At the beginning of the week ask someone for the case list so you know what to prepare for!

■ During rounds
  o Be there EARLY!!!
  o Know about your patients and their social history, past medical hx, drug history, family history, etc. these are often things the residents don’t have time or attention to ask
  o Know all the numbers and details for post-op days 1 and maybe 2. After that, they want to know:
    ▪ 1.) pain control, 2.) how are they eating? 3.) are they pooping yet? 4.) can they go home?
  o Know what lines they have in (ex: right peripheral iv, L IJ central line)
  o For plans you can always add pull foley, d/c central line (if they don’t need it), transition to po pain control, consult PT/OT, the little things that get them moving out of the ICU, out of the hospital, and going home

■ On Trauma Call
  o Buy trauma shears (you can find cheap ones on amazon.com)
  o Be aggressive by knowing what you are supposed to do:
    ▪ fill out the four pager,
    ▪ cut clothes off,
    ▪ check for distal pulses,
    ▪ check for dorsiflexion and plantarflexion of feet,
    ▪ when they roll the patient, check their back, run your fingers down their spine to check for any deformity or point tenderness
    ▪ roll the bed to the CT scanner and back to the trauma bay
  o Always have gloves on
  o Remember to go back and fill out labs on the four pager
  o Volunteer to do procedures like arterial lines, venous blood gases, starting IVs. Don’t be offended if they say no, or if they give you one or two tries before taking over, these are emergency cases after all!

■ Good books for studying:
  o NMS Surgery Casebook
  o Surgical Recall
  o Netters…KNOW YOUR ANATOMY!!!
S

Overnight events:
Pain & pain meds:
PO: UOP: BMs: Ambulatory:

nausea fever dizziness muscle weakness sensation
vomiting chills swelling myalgia headache
diarrhea chest pain claudication numbness syncope
constipation SOB rest pain palpitations vision loss

O

Tm HR RR BP PO2
Ins: Outs: Drains:

GEN: A0x3, NAD
HEENT: no JVD, PERRLA, oral mucosa without lesions, no carotid bruits
CV: RRR, no m/r/g
RESP: CTAB, no wheezing/rhonchi/crackles
ABD: soft, NT/ND, + BS, no palpable masses, organomegaly, no abdominal bruits
UE: WWP, palpable radial pulse, good capillary refill, m. strength 5/5
LE: WWP, m. strength 5/5, 2+ DTRs, sensation intact, dressing C/D/I

Labs: Imaging:

A/P

Problem/Plan:
1.)

2.)

3.)

4.)

5.)

Prophylaxis:
Code Status:
Overnight events:

Neuro:
Pt alert and oriented x4, moving all extremities well. Pain well/not well controlled on ___(pain meds and doses)____, currently rated as ______/10.

CV:
Chest pain? On exam, heart sounds regular rate and rhythm, no S3/S4, murmurs, rubs or gallops. HR range: ____________
BP range: ____________ MAP range: _____ CVP: ________ CO: _________

Chest tube output:

Drips:

Cardiac Meds:

Resp:
SOB, cough, dyspnea? Exam: lungs sound clear to auscultation bilaterally.

Vent settings:

Meds:

CXR:

FEN/GI:

Ca: ____ Mg: __ PO4: _________

Meds:

KUB:

Diet:

GU:
Foley in place?
In: ___________ Out: __________ Net: __________ UOP: ___________

Endo:
Last 3 glucomes:

Diabetes regimen

Ext/Skin:
Exam: warm and well perfused, dressing in place/ wound appears clean, dry, and intact

Heme/Id:

Tmax:
Antibiotics (dose, day ___out of ______)

Lines in place:

Prophylaxis:

A/P

___ yo M/F s/p ___________________________ due to _____________________ on POD# ___

NEURO:
CV:
RESP:
FEN/GI:
GU/RENAL:
HEME:
ID:
ENDO:
MSK:

Code status:
OB/GYN: How to Shine…PLEASE FOLLOW THE TEMPLATES PROVIDED IN THE PACKET!!!

■ OB morning rounds:
  o Please make an effort to understand TPAL correctly (create some scenarios where there were twins or where a child died so that when this actually happens you’ll be correctly reporting this mom’s Gs and Ps)
  o When looking up the mom in the morning, look up the baby too!
    1. They’ll be named: Baby Boy/Baby Girl and then their mom’s last name, i.e. Baby Boy Ramirez
  o Ask EVERY question on the template, do NOT be too shy to ask about BM/flatus
  o Please know if your pt has a foley in, if so, look at the urine and make sure it’s normal
  o Know the EBL from the delivery
    1. >500cc SVD and >1,000cc c/s is considered post-partum hemorrhage
    2. Know your pts H/H, OB likes a goal of >8/24 (if your pt’s H/H is <8/24, consider transfusing…how much? 1U pRBC → increase of 1/3 on the H/H)
  o Know what happened…was this mom pre-eclamptic or eclamptic?
    1. If so, what’s her Mg level? How are her reflexes?
      • Hyporeflexia is a sign of Mg toxicity!
  o Does she have DM? Last 3 glucoses please!
  o HTN? BP range please!
  o Has it been 48 hours? → Remove c/s bandage…do this quickly! “One motion, right off!” - Seinfeld

■ OB clinic:
  o If you do/ask nothing else…2 THINGS AND 4 QUESTIONS!!!
    1. Fundal height (from the pubic symphisis to the top of the uterus)
      • Before 20-24 weeks, it’s probably below the umbilicus
      • After this, the cm should correspond to the weeks +/- 2
      • Toward the end of the preg (around 36-38 weeks), it is normal for the cm to decrease as the baby is descending at this point
    2. Fetal heart tones
      • Please know that you may not hear this before 12 weeks, please do not lie and make up a heart rate, you will look dumb
    3. Is your baby moving? Esta moviendo su bebe?
    4. Any vaginal bleeding? Sangre por la vagina?
    5. Any vaginal fluids/fluid loss? Ha salido flujo por la vagina?
    6. Have you had contractions? Ha sentido contracciones?
      • When did they start? Cuando empezaron? How often are they happening? Cuanta tiene en una hora? How long do they last? Cuanto tiempo duran? What do they feel like? Como sienten?
  o Memorize the “baby book” and know what the moms need at each visit (based on weeks gestation)
  o Look for the template for Dr. Kost when on gyn onc clinic!!! IMPORTANT!!!

■ OB triage: You can scrub in that morning and then use Avagard the rest of the day (speedy)
  o DO NOT FORGET the psych/abuse screen!!!

■ Good books for studying: Case Files,Blueprints, UWORLD Q-bank
  o For Case Files: Read what you’re on! AKA when you’re on OB, only read the OB stuff and then read the GYN stuff when you get to GYN…sounds obvious but some people just read the book in order…
SUBJECTIVE

- Pain: Líquido o sangre por la vagina? Puede comer?
- Lochia: Con vómitos?
- Tolerating PO: Pasa popó?
- Nausea/vomiting: Pasa flato o gas?
- Urinating: Dolor de cabeza?
- HA: Con vértigo?
- Light headed: Palpitations?
- Other: Mareo?


SOB: Falta de aire?
- RuQ pain: Dolor de la panza?
- Vision Changes: Otros síntomas?

Falta de aire? Dolor de la panza? Otros síntomas?

Ambulatory: Breast bottle


OBJECTIVE

Vital Signs:
- T: _______ HR: _______ RR: _______ BP: _______ Pain Scale: _______

I/O: _______/_______ net: _______ Foley?

HEENT: NC/AT

Heart: RRR no r/m/g flow murmur

Lung: CTAB no c/w/r

Abd: + BS appropriatelly tender uterus @ umbilicus/_____ cm below umbilicus

POD #1: dressing intact

POD #2: dressing removed and wound is c/d/i, serosanguineous, erythematosus

Ext: no c/c/e Homan’s sign: _______

ASSESSMENT

_____ yo female who is now a G____ P_______ (TPAL) is doing ______ PPD/POD #_______ s/p NSVD/c-section secondary to _______________ on _______ at _______.

1. Labs
   - Blood type: _______  Antibody: _______  Rubella: _______
   - HBsAg: _______  HIV: _______  PAP: _______
   - GC: _______  RPR: _______
   - Chlamydia: _______  GBS: _______ (first dose of abx: _______)
   - Pre/Post Hct: _______/_______

2. Baby
   - Male  Female
   - Gestational Age: _______
   - APGAR: _______
   - BW: _______

3. Medical Issues
   - GDM under poor/moderate/good control (Last 3 glucoses, insulin regimen)
   - Postpartum hemorrhage- asymptomatic (EBL)
   - Pre-eclampsia (overnight BP range)
   - Other: __________________________
S: No acute events overnight. Pt has no complaints this morning. Pain well controlled with ______. Tolerating a low residue/regular diet without nausea or vomiting. Foley in place draining clear yellow urine. Voiding without difficulty, Foley removed yesterday. Ambulating without difficulty. _____ flatus, _____ BM. Minimal lochia. Denies headache, vision changes, dizziness, RUQ pain, palpitations, and SOB. Patient is breast and bottle feeding infant without difficulty and desires _____ for contraception.

O:
VS: Tm Tc HR BP RR O2
I/O:

PHYSICAL EXAM:
GEN: AAOx3, NAD
HEENT: NCAT
CV: RRR, no m/r/g, flow murmur
RESP: CTAB, no rales, ronchi
ABD: +BS, appropriately tender/ non-tender to palpation, uterus @ umbilicus, dressing c/d/I OR dressing removed and wound is c/d/i
EXT: no c/c/e, negative Homan’s

LABS:
Pull in prenatal labs
Any relevant labs since delivery

A/P: _____ yo now G____P____ s/p ______ c/s or NSVD or pre-term c-section, etc. secondary to ______ at ______ weeks on _____ date at _____ time. POD/PPD # ______. Skin incision closed with ______. Mother and baby doing well.

1. PPD # ______
   - UOP _____ since _____ (ONLY IF FOLEY)
   - Pre/ Post Hct: _______ (EBL _____)

2. Post partum – Rh ____, Rubella ____ , GBS ____ (Abx ____ first dose at ____), Chlamydia ____ , GC ____, HIV ____ , RPR ____ , HBsAg ____ , 1 hour glucose testing ______

3. OTHER PROBLEMS (PPH, HTN, chorio (last fever!), etc.)

PLAN:
- Continue postpartum care – 1st time mom, c-sections, teenage mom, breast feeding for 1st time all stay 48 hours
- Discontinue Foley
- Advance diet as tolerated
- Continue _____ for pain control
- Pelvic rest for 6 weeks
- Rx given/ to be given (CHECK CHART!) for Norco, Motrin, FeSO4, Surfak, and PNV
- Rh ____ ; no further action needed/RhoGam given ______
- Glucose testing ____ ; no action needed/ follow up in clinic for 2 hour GTT
- Rubella ______ ; no further action/ MMR
- Follow up in 6 weeks for post partum check
- Anticipate discharge home tomorrow/ today
- _____ for contraception; pt breast and bottle feeding
Name: 
MRN: 
CC: 
HPI: ______ y/o G_____P_______

ROS: 
N/V Abd Pain Diarrhea Constipation
Fever/Chills Dysuria VB Other: _____________________

OBHx: (TPAL, SVD vs C/S &why)

GYNHx: 
Pap: Abnl Pap: Mam: Abnl Mam:

STDs (disease/year/tx):
Birth Control: LMP: ___/___/___

Last intercourse/no of partners:
Age at menarche:
Usual menstrual cycle: ____ days ____bleeding days

PMH: 
FH: 
Uterine CA
Ovarian CA
Breast CA
Cervical CA
Colon CA

PSH:

SH: T ____ E ____ D____

ALLG:

MEDS:

Vitals: T: ____ HR: ____ RR: ____ BP: _________ Height:_______ Weight:_____

PHYSICAL EXAM:

HEENT:
Heart:
Lung:
Abd:
Ext:

LABS:
Know your AMSIT!!!

Really know the diagnostic criteria for depression, schizophrenia (vs. schizoaffective vs. schizotypal, vs. schizoid), bipolar disorder, PTSD

Ask orientation every day!! They might fool you into thinking they are aware of where they are, by seeming normal, but they might think they are in a hospital…on a spaceship
  o If they don’t know the date, ask what month, if they don’t know the month, ask what year; if they don’t know that, ask what season or the weather outside
  o You lose your orientation in the order of: time, place, person
  o Oriented x4 means you know why you are in the hospital

Ask SI/HI every day!!!

Know details about their drinking and drug history. Don’t be satisfied when they say 4 drinks a day- of what (beer vs. wine vs. liquor), how much (12 oz, 24 oz, 32 oz, 1 shot, 1 double shot, 1 24 oz bottle of wine vs. 1 L bottle of wine). Know how much of a drug they have been doing, for how long, have they ever tried quitting?

Know when their last drink was! Important for symptoms of detox – you have to worry about seizures for up to 72 hours

Have they ever tried rehab before? How many times? Why didn’t it work? Why are the motivated to do it now?

Know a good social history- who do they live with, abuse at home, boyfriend/girlfriend, social support, religion, kids, pets

Suicide is a scary, sensitive topic, but ask details. How long have they felt this way? Did they have a plan? (cutting wrists vs. stepping out into traffic vs. shooting themselves) What stopped them? Why?

Good books for studying:
  o Your Psychopath syllabus from 2nd year
  o Lange Psych questions
  o First Aid for Psychiatry
  o UWorld Qbank
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Mental Status Exam
www.medfools.com - Thanks rauls@ucla.edu

General appearance & behavior:
  Dress/grooming
  Cooperativeness
  Eye contact
  Psychomotor agitation/retardation
  Attitude
  Bizarre mannerism/gestures/facial expressions

Language: Native language/fluency

Mood (how pt. feels):
  Dysphoric, euthymic, euphoric, hostile

Affect (observed emotional state):
  Expansive, labile, normal, constricted, flat
  Appropriateness

Thought Process (organization of thought):
  Speech: speed, volume, clarity
  Circumstantial, tangential, linear, flight of ideas, “word salad”

Thought Content:
  Hallucinations (AH/VH)
  Delusions (persecution, grandiose, erotomanic, somatic)
  Suicidal/homicidal ideation (SI/HI)
  Derealization/depersonalization

Cognitive:
  Level of consciousness: Alert/drowsy/stuporous
  Orientation: Person, place, date, situation (A+O x 4)
  Concentration: 1) Spell “world” backwards
                  2) Serial 7’s or 3’s
                  3) Months of year backwards
  Memory: 1) Immediate: Instant recall of 3 objects/digit span
           2) Short term: Recall of 3 objects in 5 minutes
           3) Long term: Ask about pts past hx
  General fund of knowledge: 1) Current/past president
                             2) Historical events (9/11)
  Abstract thinking: Similarities/ Proverbs

Judgement:
  Based on pt’s recent behavior: Is pt meeting social/family obligations
  Solutions to hypothetical situations (found stamped envelope…)

Insight: Pts understanding of his/her illness, need for treatment

Impulse control: Based on observation
Psych Inpatient Progress Note

Date/Time
MS3 PN-Psychiatry
S) 34 yo HM admitted for…(e.g. major depression w/ psychosis)
   Pt. quote/ pt. subjective report of how he/she is doing, symptoms, feelings.
   Events since previous day, observations by staff (e.g. not taking meds, not sleeping, was restrained…)
O) Mental status exam
Meds: Current meds
Labs: New labs (e.g. Lith/Valproate levels, WBC’s…)
A) Axis I/ Axis II/ Axis III/ Axis IV/ Axis V
   Any documentation for continued hospitalization (SI/HI, med refusal…)
P) Continue current med/management…
   Day 8 of 14 day hold.
   Conservatorship/reise hearing scheduled….

Global Affect Scale

100-91 Superior fnxng, no sympt.
90-81 Good functioning, absent/minimal sympt.
80-71 Transient sympt/ expectable rxns to stressors
70-61 Mild sympt.
60-51 Moderate sympt.
50-41 Serious sympt., impaired fnxng
40-31 Impaired reality testing, major impairment in funxn/judge.
30-21 Behavior considerably influenced by delusions/hallucination, inability to fnxn in almost all areas
20-11 Some danger harming self/others, grossly impaired comm.
10-1 Persistent danger of severely hurting self/others, suicidal act
0 Inadequate information

www.medfools.com - Thanks rauls@ucla.edu
CC: "I don't think people should take stimulants." The patient is brought in by police on Emergency Detention.

**HPI:** Pt is a 32 yo male with a hx of paranoid schizophrenia diagnosed in 2000 with decompensation in the context of lapse of medication compliance. Per pts mother, she contacted police because she was concerned about his safety. Pt was a long-time patient of Dr. C in Telemedicine, which was closed 4-6 weeks ago. Since then, pt has not taken medications, and has voiced plans for suicide. Mother also reports that pt has auditory hallucinations which command him to hurt himself, and the voices seem to be escalating. Per record, pt has been vegetarian for 10 years, and per mother, recently became vegan, has not been eating adequately, and recently lost 50 pounds. Pt also suffers from Gilbert's Syndrome, which was diagnosed in 2006, and continues to have hyperbilirubinemia. In PES interview, pt endorses mother's report, but denies that voices are commanding him to hurt himself, rather stating that they are "friendly" and "the word of God." Pt reports that he has no plan to kill himself. He does report in the PES that he has recently been fasting for 3 months on just water and vitamins, and is now ready to eat.

On initial evaluation pt reports feeling "happy". He requests to go back to sleep as he has been tired and has not slept much. He goes on to tell MD about the voices he has been hearing for a few weeks since he stopped taking his medication. He reports that the voices are actually "rational projections" which help him connect psychically with other people who also have the ability. He denies that the hallucinations are commanding him to kill or hurt himself or others. He reports that he feels that he needs his medications again because there is a current "overload of different channels" and he feels "overwhelmed with the voices.” He had done well on medications in the past, but stopped taking them because he feels that people "shouldn't be on stimulants." Pt with loose associations, tangentiality, thought broadcasting, thought insertion, ideas of reference, and neologisms and hyper-religiosity during interview.

After admission, pt became agitated when he did not receive his vegetarian tray that he requested. He became disruptive and angry, knocking pictures off walls and talking to himself. Pt was given Haldol 5mg Ativan 2mg and Benadryl 50mg IM, and calmed after a few minutes.

Per chart review, pt has had several hospitalizations, beginning in 9/2006 when pt had suicidal ideation and police was called. During that visit, pt was consulted by medicine for jaundice and scleral icterus, who determined that hyperbilirubinemia and abnormal labs were consistent with Gilbert's syndrome. Pt was floridly psychotic endorsing AH, VH, SI, insomnia, ideas of reference, thought insertion, difficulty concentrating, and was displaying illogical ideas, tangential/circumstantial thought, flight of ideas, paranoid, thought. Pt was started on Risperdal for his psychotic symptoms and improved. Pt was again admitted to 7th floor on 10/18/06 with similar symptoms and medication non-compliance. Pt had been on risperdal 1mg QAM and 3mg QHS, so was increased to Risperdal 2mg QAM and 3mg QHS. Pt felt risperdal made him too sedated, so Haldol 5mg QHS was given, and suggested to give Haldol dec. Pt was discharged on 10/20/12 with dose of Haldol Dec 100mg IM. He was also discharged with follow up with medicine for Gilbert's. Pt was again seen in the PES on 1/28/06 for suicidal ideation and anxiety expressed to his mother as well as paranoia that people were out to get him, in the context of medication non-compliance. Pt denied AVH at this time. Pt was to follow up with outpt provider Dr. B. Pt was again seen as inpatient in Feb 2008 brought in by his mother for worsening paranoia and auditory hallucinations, in addition to treatment non compliance with telecare. At this time, pt was restarted on Zyprexa 20mg daily and Topamax 50mg daily as he had been on this as an outpatient. Pt was also asked to follow up with telecare Dr. B. Pt was again seen in PES on 4/18/2012 for auditory hallucinations referred from crisis center. Pt with command hallucinations he reports caused him to become depressed. Mother was also concerned about pt "not eating right" as he had been a vegetarian and now became more focused on his diet only eating very limited types of foods. Pt on zyprexa 20mg at this time, took medications and denied SI/HI/AVH while in the PES.

**PPsychHx:**
Past Hospitalizations (date/location): States he has been hospitalized 7 times including at UH.

Past Psychiatric Medications: Risperdal and Zyprexa.

Past Psychiatric Diagnoses: Schizophrenia.

Outpatient Treatment (clinic/provider): Dr. C. Previous Suicide Attempts (how many, when, means used, hospitalized?): denies.
PMH: Gilbert’s syndrome

MEDS:
- **Topamax 50 mg oral tablet**: 1 tab(s) orally 2 times a day x 30 days, Active, 60, None
- **Olanzapine 20 mg oral tablet**: 1 tab(s) orally once a day (at bedtime) x 30 days, Active, 30, None

FamPsychHx:
- **Family Psychiatric History**: mother with depression

ALLG:
- **PENICILLIN**

SH:
- **Patient lives**: Alone in apartment in SA. Performs all ADLs, mother helps with finances
- **Employment**: Disabled, receives disability check
- **Physical Activity**: Sedentary Lifestyle
- **Tobacco Use or Exposure**: 1ppd x 6 years, recently quit
- **Alcohol Use**: Occasional 12 oz beer
- **Illicit Drug Use**: Denies

Development / Social History:
Development history: (incl. delays, educational history, medical history, employment history, family relationships) Pt raised by mother. Only child. Placed in Special education in elem school, went through 11th grade, dropped out. Never married, no children.

Mental Status Exam:
- **Appearance**: Appears stated age, thin body habitus. Pt appropriately dressed with good hygiene. Speech spontaneous and appropriate, easily understood and of avg rate and rhythm. He maintains eye contact, is cooperative with examiner, alert and attentive, with neither increased nor decreased psychomotor activity.
- **Mood**: “Happy”, with congruent, expansive affect
- **Sensorium**: Orientedx4. Concentration good, memory grossly intact
- **Intelligence**: Avg, based on fund of information and vocabulary
- **Thought**: Coherent, illogical, not goal directed. Tangential/circumstantial with loose associations, tangentiality, thought broadcasting, thought insertion, ideas of reference, neologisms and hyper-religiosity. Denies SI/HI
- **Judgment**: severely impaired
- **Insight**: Limited

ASSESSMENT/PLAN:

**Axis I**: Chronic paranoid schizophrenia, MD episode, Panic d/o NOS
**Axis II**: none
**Axis III**: Gilbert’s Syndrome
**Axis IV**: Problems with access to health care services, Other psychosocial and environmental problems, Chronic mental illness
**Axis V**: 30-21: Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home or friends).
Suicide Assessment:
A. Current ideation Denies.
   1. Wish to Live Moderately to strong.
   2. Wish to Die None.

B. Reasons for Living/Dying For living outweigh for dying.

C. Desire to Make Active Suicide Attempt None.

D. Passive Suicidal Attempt Would take precautions to save life.

Total Score: 0.

Clinician Rating For Suicide:
D. Clinician’s Rating of the level of concern about potential suicidal behavior: Lowest concern (no prior or current concern about suicidal behavior).

E. Safety Plan: Pt agrees to inform staff of SI.

Initial Assessment:
Pt is a 32 yo male with a hx of paranoid schizophrenia with decompensation in the context of lapse of medication compliance. Pt would benefit from restart of Olanzapine 20mg daily for psychotic symptoms. Will draw fasting lipids and fasting glucose tomorrow, given pt is on atypical antipsychotic. Pt will also have lab for PTH and Phos level, as hyperparathyroidism can present with psychosis given pt elevated Ca++. Pt to continue on vegetarian diet per request, but nutrition will be consulted for rec on nutritional supplements, as patient's diet does not appear to be sufficient to maintain adequate nutrition. We will also speak with mother for collateral info. Pt should benefit from re-establishment of psychiatric care since Telemedicine has been closed, and we will discuss this with social work. Pt may also benefit from long acting injectable neuroleptic, such as Risperdal Consta, given hx of med noncompliance. Medicine will be consulted for hyperbilirubinemia, as well as hypercalcemia. Bone density testing may be helpful in the future to evaluate pt for osteoporosis given elevated serum calcium.

Initial Treatment Plan:
Initial Treatment Plan:  
1. Continue pt on Olanzapine 20mg Daily  
2. Consult medicine for Gilbert's and hyperCa++ 
3. Consult nutrition for nutritional concerns. 
4. Consider starting long acting injectable neuroleptic for med adherence 
5. Continue to monitor pt for SI/AVH 
6. Encourage participation in groups and activities 
7. Obtain further collateral info from mother 
8. Order PTH level as hyperparathyroidism may be cause of hypercalcemia
PEDIATRICS: How to Shine

- **Nursery**
  - Know your newborn VS: HR 120-160, RR 40-60, BP 65/50
  - Be aggressive to get deliveries! Residents will take note of your interest, your evals will be better!
  - APGAR score! You will be asked to calculate this in the delivery room/OR!
    - Score at 1 min=represents conditions DURING labor/delivery; indicates need for resuscitation
    - Score at 5 min=represents effectiveness of resuscitation efforts; prognostic of survival
    - A LOW APGAR score is NOT predictive of CP
  - TTN more common in c/s babies (benign condition seen in term infants)
  - RDS more common in premies (look at lethicin:sphingomyelin ratio!)
  - HYPERBILIRUBINEMIA!!!
    - <24 hours of life=pathologic! Requires evaluation!
    - Indirect=unconjugated
      - Transient hyperbili peaks at 2-3 days of life, ~60% of newborns, ~80% of preemies
    - Direct=conjugated: Requires evaluation!
  - Duchenne-Erb C5-C6 (lose axillary n., musculocutaneous n.)
  - Klumpke C7-T1 (lose ulnar n., also often assoc w/ Horner’s)
  - Sepsis??? Early (GBS, E. coli, Listeria) vs Late (Coag neg staph, E. coli, GBS)
    - Either way: IVF, Cx, Abx (Amp, Gent, Cefotaxime)
  - Know the Ballard score
  - Know all the benefits of breastfeeding! Breast is best!! Any time you can incorporate that into your plan/management you will get brownie points 😊
  - The babies aren’t always in the nursery, don’t be afraid to go to the mom’s room and examine the baby in there…make sure you know how to introduce yourself to the mom in Spanish!

- **NICU**
  - Fill out the NICU template!!!
  - Calculate the kcals/kg/day based on their formula
  - Know neonatal jaundice, apnea of prematurity, gastroschisis vs. omphalocele, Necrotizing enterocolitis, Intraventricular hemorrhage, neonatal opiate syndrome, the benefits and detriments of giving them O2
  - You often won’t get to physically examine the baby due to limited “touch time” but you can report on their activity level, how their breathing looks (are they using accessory muscles?), their skin color, any noticeable rashes,
  - Know if the bili light is on or not
  - Talk to the nurses!

- **Inpatient wards**
  - Talk to the parents and to the kid to get the history
  - Know their primary care physician- be a rock star and get their phone and fax numbers!
  - Know the levels of management of asthma
  - You can do a full physical exam on the child while they are sleeping!! Most of them are really heavy sleepers, just pull back the blankets and let them keep laying there. There is no need to wake up a sick 4 year old at 5 am.
  - Know the immunizations they have had and what they are missing
  - Ask about sick contacts- school, daycare, siblings at school
  - Ask if this has happened before, you may find a pattern of illness suggestive of some underlying process
  - Pay attention to fevers and whether or not they were on Tylenol; need to be afebrile for 24 hours before going home

- **Good books for studying:**
  - Pretest, Case Files
HEENT: NCA T, A/F 1x1cm (ant. Fontanelle)
E: PERRL(A), EOMI, conjunctiva moist, RR++
E: TM movement- clear and mobile
N: Polyps, discharge
T: erythema, exudate, moist, tooth develop
(20 baby teeth – 1st at 6month, then 1/month)
Neck: soft, supple, LAD, thyromegaly?
Chest: symmetric, CTA, retractions?
CV: RRR, nl S1S2 without m,r,g, femoral pulse full and equal
Abd: BS+, NT, -masses, -organomegaly
GU: nl ext genitalia, descended testes?
Back: CVA tenderness? Scoliosis?
Ext: c/c/e
Skin: rash, birthmarks, perfusion
Neuro: Grossly intact
Mental status-alert, motor-tone, bulk, mass, sensory-touch, pain,
vibration, proprioception, cerebellar-tremor, DTR
Development:gross/fine motor, language, problem solving

LABS/STUDIES:
A/P: Problem #1, 2, 3
A.1) What do you think is causing problem
2) Why? – consistent, inconsistent features w/ HPI, PMHx, PE, LABs
3) Differential
P. 1) What are you going to do? W/U
2) Tx further

Congenital
Infectious
Neoplastic
Vascular/Anatomic
Metabolic
Idiopathic/Iatrogenic
Toxic

Pocket Peds H&P Card
CC: “quote from historian”
ID: Identify info, reason for admit from MD perspective
Historian: (reliability, vague?)
Referring MD: __________ Phone #

HPI: This is a __yo (m/f) in USGH until X days prior to admission
when…. 2 day PTA…. Day PTA…. pertinent (+/-)…b/c of ___ pt
admitted to 4NE to…)
or birthHx: Pt was ____lb product of a __wk gestation born by NSVD
(C-section for ___) to a ___yo GXPxAbx following an uncomplicated
pregnacy w/Appgars of __/

PMHx: 1. Hosp/illness
2. SurgHx
3. Meds -- mg PO/IV BID (x mg/kg/day)
4. Allergies
5. Immunization IUTD (Hep B?, varicella?)
6. Birth Hx- as above, unremarkable
7. Development- failure to thrive, abuse, Gross Motor,
   Fine motor, language, problem solving
8. Feeding Hx
9. Menstrual Hx

FamHx: Fam Tree
SIHx: Live with? Parents profession, smoker,
   (esp. when abuse, failure to thrive)
ROS: Difficulty seeing/hearing, pain, easy bruising? “non contributory
   except for…”

PE: 1)General: Interactive, active, happy, smiling, well appearing
   - irritable but consolable - irritable and unconsolable
   - toxic (mental status changes, perfusion changes)
2) Vitals: Temp, HR, RR, BP
3) Growth Wt (%), Ht(%), Head circ if < 3yo (%) [present as 50th%ile of X age when hugely above/below nl]
<table>
<thead>
<tr>
<th>NICU Progress Note</th>
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<tbody>
<tr>
<td><strong>PATIENT NAME:</strong></td>
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<td><strong>Birth Hx:</strong></td>
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<td><strong>Interval Hx:</strong></td>
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<td>Date:</td>
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<td>O/N Events:</td>
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<td><strong>Problem List:</strong></td>
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<td><strong>VENT R:</strong></td>
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<td>Oscillator A:</td>
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<td>Babygram:</td>
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<tr>
<td>A&amp;P:</td>
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<td><strong>RESPIRATORY</strong></td>
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<td>Lines/Fluid:</td>
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<td>Meds:</td>
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<td><strong>CARDS</strong></td>
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<td><strong>FEN/GI</strong></td>
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<td>Diet:</td>
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<td>Chem:</td>
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<td><strong>HEME</strong></td>
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<td>UTox:</td>
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<tr>
<td>Plan:</td>
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<tr>
<td><strong>Notes/Comments:</strong></td>
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</tbody>
</table>

**Notes/Comments:**
FAMILY: How to Shine

- Ask all of your patients a personal question: How are their kids? How is work going? Are they following the Spurs in the playoffs?... If time allows, feel free to present this information in the subjective part of your presentation, it shows that you care about more than just the medical part of their care. If clinic is rushed that day, only present the most pertinent findings.
- Ask about compliance with medications and details about how they take them: Did they actually fill the prescription from last time? Any side effects? Do they take them as prescribed or only when they remember/feel symptoms/can afford it?
- When managing diabetes you need to know: if they check their sugars, what time of day (am, pre-meal, post-meal etc.), when their sugars are high or low, what their medications are, what their insulin regimen is, what their diet is like... if they say they eat salad, ask what they put on it! A bowl of ranch and cheese is NOT following diet recs.
- Again, ask everyone about diet and exercise!
- Know the guidelines for diagnosis and management of hypertension, diabetes, and dyslipidemia backwards and forwards!!! Most of these can be found on Up To Date or the AAFP website.

**Good books for studying:**
- Case Files (NOTE: There are two editions, questions will be pulled from BOTH editions for your weekly quizzes, these questions will be EXACTLY the same as those in this book. MEMORIZE THEM!)
- AAFP questions online (good for the shelf, esp bc UWorld doesn’t have a family section)
Syo M/F here today for nausea, vomiting, diarrhea, constipation, fever, chills, chest pain, palpitations, SOB, cough, dysuria, frequency, urgency, swelling, claudication, muscle weakness, myalgia, numbness, tingling, headache, syncope, vision changes, bleeding/clotting, SIGECAPS, weight loss.

PMH/PSH:

MEDS:

FH:
stroke  MI  bleeding/clotting d/o  CA
HTN  DM  dyslipidemia

SH:
Tobacco:  EtOH:  Drugs:

Last visits:
Dentist:  Ophtho:  Podiatry:

O
Tm  HR  RR  BP  PO2

GEN: alert, NAD
HEENT: no JVD, PERRLA, EOMI, tympanic membranes visualized, moist mucous membranes, good dentition
CV: RRR, no m/r/g, no carotid bruits
RESP: CTAB, no wheezing/rhonchi/crackles
ABD: soft, NT/ND, + BS, no palpable masses, no organomegaly, no abdominal bruits
UE: WWP, palpable radial pulse, good capillary refill, m. strength 5/5
LE: WWP, m. strength 5/5, 2+ DTRs, sensation intact

*atrophic skin changes (thickened nail, hair loss), cyanosis, edema, varicosities, tissue loss, ulcerations

Labs:

HgbA1c:
Lipid panel:

A/P
Rotating at the RAHC in the RGV?

Of course, everything that you’ve learned the past 2 years and in your previous rotations will help you with rotating at the RAHC. Although the RAHC is still a campus of UTHSCSA, there are some key differences. Below are a couple of ideas to keep in mind for each rotation:

**Medicine:**
- Rotate with a residency, but there are not any notes to write. Presentations are your chance to show what you know.
- Morning report is your time to shine with the residency director. He will ask the med students questions and take time to teach you. Pay attention during these rounds. “Vitals are always vital”

**Surgery:**
- Unless you rotate with Dr. Hilmy and sometimes with Dr. Lopez, it is you and the attending. You have to ask questions and ask to be taught. The attendings are fantastic teachers but will let you rotate without pimping or learning if you don’t get engaged.
- If you work hard, you will have plenty of opportunity to 1st-assist and have hands on experiences.
- Get to know the ancillary staff, pull your gloves and gown, and eventually they’ll have it ready for you. They are also excellent teachers.

**ObGyn:**
- No night call
- Deliveries and opportunities to 1st assist if you ask and work hard

**Peds:**
- Inpatient is with a Family Medicine Resident. This is an opportunity to manage several patients. There are primarily 2 attendings that are excellent with teaching students and giving students responsibilities.
- You can write notes and orders. Take advantage of an opportunity to act like a sub-I

**Rules at the RAHC:**
- It’s you and the attending. The role you play as a student is less defined than at an academic center. More often than not, if you ask to do something, you will have the opportunity to do it. You have to take ownership of your education.
- Housing: Really, really, don’t have pets.
- If you rotate on Peds or Family, take advantage of the CSL opportunity. Email Angie Bocanegra, Salina Coleman, or Dr. Valdez.
- Be prepared to drive to different cities. (and to beach for some fun)
HAVE FUN
&
GOOD LUCK!!

Feel free to e-mail us with questions 😊

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