

Common Calls 3

Chief Residents
Revised 2009

Housekeeping

- Prescriptions

- Stamps to be in mailboxes at end of day

- All scrips must have the following

- A stamp (not hand-written)

- Needs a license number and name (does not need to be cosigned)

- Narcotic Prescriptions

- Need License number, DEA and name (does not need to be cosigned)

- Dispensing quantities written don't put 1 bottle, 5 days)

Housekeeping

- Death certificate
- Primary care appointment line - **212-600-9914**
 - Schedule f/u with you or your resident
- Specialty clinic appointment line - **212-659-8570**
- Post call text paging
 - can now sign out
 - login mssm switch
 - click on asterisk
 - choose covering housestaff
 - choose time
 - ends a 6:55pm

Procedure Consents

- Always risk of infection
- Always risk of bleeding
- Always think of what you could accidentally poke
-Think anatomy- and tell the patient about it.
- Make sure the pt is competent.
- If patient refuses document it.
- Make sure you document that consent was obtained in your procedure note. Also if a follow up CXR etc. is needed make sure that it's ordered and result are documented.
- Surgeons, Interventionalists get their own consents

Cross Cover

First things first...

- Patient's name, MRN and team
- Recent vitals
- Time course of events
- Give the nurse marching orders, ie new vitals, EKG, oxygen saturation, get ABG supplies etc...
- GO SEE THE PATIENT
- If patient looks sick- call TR or your resident

Common cross-cover calls

- Insomnia
- Replacing lytes
- The family/patient wants to talk to the “doctor”
- Pain
- Restarting diets
- Hyperglycemia
- Hypoglycemia
- Hypertension
- Hypotension
- Patient is refusing meds, imaging, etc.
- **INFORM THE FAMILY/Attending IF THERE IS A MAJOR EVENT**

Reasons you must see the patient!

- Chest pain
- Dyspnea/hypoxia
- uncontrolled bleeding
- uncontrolled vomiting
- severe abdominal pain
- seizures
- mental status change
- severe headache
- falls
- new onset pain
- hypotension
- arrhythmias
- fever + change in vitals or mental status
- Deaths
- The patient wants to sign out AMA
- IF YOU EVER HESITATE AND THINK YOU SHOULD...JUST DO IT!

Cross Cover General Rules

- Give them more of what they are already getting
- Don't start standing meds
- Check on patient later in the night
- Keep complete records and sign out changes in am

Hypokalemia

- K+

- What is your goal – 4.0 in cardiac patients
- 0.1 increase for each 10 meq of IV
- PO is quick but can be difficult to tolerate
- IV is slow and can cause burning with the infusion
- You can give a po/IV combo
- Remember a high K+ is bad too, people with elevated Cr need MUCH LESS to replace.
- Do not replace in Dialysis patients unless someone tells you to!

Hypomagnesemia

- Magnesium

- What is your goal – 2.0 in cardiac patients.
- IV is slow and expensive.
- PO can cause GI intolerance
- If 1.8 give 1g IV over 2 hours or 400 mg po
- If 1.6 give 2g IV or 800 mg po
- If 1.4 give 2 g IV x 2 or 800 mg po and recheck
- Remember OB – it is hard to get toxic on Mg.

Hypoglycemia

- Give glucose
 - D50 or juice
- Ask why?
 - New meds?
 - Too much meds?
 - You can hold next doses or halve them - remember we are all caring for each others patients.
- Remember this is a cause of seizures and codes.

Hyperglycemia

- Establish cause
 - dietary indiscretion
 - med compliance
 - failure to reconcile OP medications
 - infection
- <250 less dangerous
- >250 more dangerous (DKA, hypovolemia)
 - Insulin therapy
 - aspart insulin (onset 15min, peak 30-1.5hrs, gone 2hrs)
 - regular insulin (onset 30-60min, peak 2-4 hours, gone 6hrs)
 - lantus insulin (onset 1-2 hours, no peak, lasts 24hrs)
 - Never stack insulin (ie don't use regular insulin)
 - Split long acting/short acting 50/50
 - Consider IVF
 - Recheck FS

Insomnia

- Shut off the lights and turn off the TV
- Ambien 5-10mg po x 1
- Trazodone 50mg
- Avoid benadryl especially in older patients.
- Write only one time doses for your crosscover (ie not standing prn)
- Lower doses in the elderly and liver failure patients!

Hypertension

- How high? Are they symptomatic?
- Acute or chronic? Are they in pain?
- What are they on - may give stat dose of that if vitals will tolerate - i.e. BB or ace
- If no change hydralazine 10-20mg iv or 25mg po.
- Is there a change in mental status.
 - Stroke? Hypertensive urgency/emergency? Then call the TR
- If you doubt the reading recheck yourself and after meds.
 - 15-20 minutes for IV
 - 1.5-2 hours for po
- Chronic? Go slow

Nausea and Vomiting

Identify underlying cause, when possible DDx:

- MEDICATIONS (morphine, codeine, aminophylline, chemo, digoxin, antiarrhythmics, nicotine, bromocriptine)
- INFECTIOUS (gastroenteritis, PNA)
- GUT (alcoholic gastritis, obstruction, PUD, gastroparesis, hepatobiliary, pancreatic, carcinoma, pylonephritis)
- CNS (increased intracranial pressure, migraine, seizure disorders, anxiety/fear, bulimia/anorexia, severe pain, labyrinthine disorders)
- OTHER (AMI, metabolic, pregnancy, radiation sickness)
- Withdrawal (opiates)

Treatment

- mild: PO, severe: IV
- Try reglan, compazine, zofran
- IVF (NS or plasmalyte)

Diarrhea

Acute diarrhea usually self-limiting

- **DDx: infectious, ischemic, fecal impaction with overflow Incont, Laxatives, abx, antacids with magnesium**
- **Labs: CBC, lytes, Stool: culture and sensitivity(only 1st 3 days of hospitalization), O&Px3 , C.diff**
- **Films - KUB looking for dilated colon**
- **Consider: IVF**
- **Correct electrolytes**
- **If c-diff with dilated colon - treat as surgical emergency**
- **Tx: r/o infectious then give**
 - **Loperamide 4mg initially then 2mg PO with each loose BM – after studies negative, max is 16g per day**
 - **Bismuth subsalicylate (Pepto-Bismol) 30cc PO q6hr**
 - **Kaopectate 30 cc prn can be given prior to c. diff results**

Constipation

If no nausea/vomiting, abdominal pain, or fecal impaction

- **Stool Softeners (detergents)**
 - sodium docusate (colace) 100 mg PO bid - does not work well
- **Stimulants**
 - senna 1-2 tabs prn, bisacodyl (dulcolax) 10-15 mg PO qd - these should not be chronic meds
- **Osmotics**
 - lactulose/sorbitol 30cc PO q4-6 hr until BM - best for ESLD
 - polyethylene glycol (miralax/glycolax) 17gm in 8oz water -best evidence of efficacy, causes GI discomfort
- **Enemas**
 - tap water, soap suds, lactulose
 - AVOID FLEET ENEMAS
- **Prokinetic agents**
 - Metoclopramide (Reglan)

Alcohol Withdrawal

1. Tremulous State

- 12-24 hrs after reduction alcohol, 24-36 hrs pronounced
- tremors, mild agitation, insomnia, tachycardia

2. Hallucinosi

- develop w/i 12-24 hrs of abstinence
- usually auditory can be visual, tactile, olfactory
- no clouding of sensorium
- VS usually normal

3. Withdrawal Seizures

- 6-48 hrs after cessation of drinking, peak 13-24 hrs
- generalized convulsions with loss of consciousness
- Diazepam 2.5 mg/min IV until controlled
- check lytes

4. Delirium Tremens

- 28-96 hrs after cessation of drinking
- confusion, tachycardia, dilated pupils, diaphoresis, hallucinations
- 15% mortality if untreated
- Tx: IVF, electrolyte repletion

Alcohol Withdrawal

- Place patient in environment not in danger to self or others, ie sitter or restraints
- **Treatment:** (hold for lethargy, abnormal vitals, abnormal neurological signs)
- Lorazepam (Ativan)
 - 2 mg PO/IV/IM q6-8 hrs
 - scheduled and/or PRN (q2h)
 - (preferred if jaundice or known liver disease)
- Chlordiazepoxide (Librium)
 - 50-100 mg PO qid
 - taper dose over several days
- Thiamine 100 mg PO/IV/IM qd
- Folate 1 mg PO qd
- REMEMBER TO GIVE THIAMINE BEFORE GLUCOSE

Seizures

- Causes: Electrolyte d/o (hypo/hyper Na, hypocalcemia, hypomagnesemia), hypoglycemia, uremia, hypoxia, Etoh/drug withdrawal, Drug Intoxication, CVA, head trauma, Intracranial Bleed
- Evaluation:
- Check FS, electrolytes
- Is patient in status? Ativan 2-4mg IV q min phenytoin IV (watch for hypotension) , fosphenytoin IV
 - Lie patient on their side to help protect airway
 - If prolonged status -> Intubate
 - Call neurology asap
- Consider imaging

Falls

- Vitals/Fingerstick and current status of patient – Chest pain? Hypoxia?
- Brief report of event - event note with rn
- See the patient
 - On the way there look at the signout – look at their meds
 - Eval for injuries and need for head CT, plain films
 - Fall precautions

GI bleeds

- When called:

- 1. VS
- 2. Onset of bleeding, reason for admission
- 3. Upper or Lower
- 4. How much blood lost

- While you are on your way order:

- 2 - 18Ga IVs, CBC, Coags, Type and Cross, orthostatics if possible, fluids running
- Type and cross should be sent first
- Consider FFP if liver disease, DDAVP if Renal Disease

GI bleeds

- Evaluate Patient

- If stable make sure access is adequate and check serial hemoglobins

- If unstable

- Fluids, fluids, fluids

- Transfuse, unit or stepdown

- consider: reversal of coagulation defect with platelets, Vit K, or FFP Upper bleed: consider NG, octreotide (if variceal bleed) Lower bleed: tagged RBC or IR embolization Surgery consult

- Call GI Bleed fellow if indicated - active bleed

Pruritis

DDx:

- Drugs – make sure there is no signs of anaphylaxis, check vitals
- Metabolic/Endocrine
- Heme
- Hepatic Disease
- Malignancy
- Infestations
- Psychogenic State
- OTHER

overnight try:

- Benadryl
 - 25-50 mg PO q6-8 hr PRN
 - 10-50 mg IV/IM q2-3 hr PRN (Max 400mg/d)
- ** LOW DOSES IN ELDERLY PTS
- Hydroxyzine
- Atarax, Vistaril
- 25 mg PO q6-8 hr PRN
- Cortisone Lotion

Rash

r/o anaphylactic reaction

- IF: urticarial rash with SOB, wheezing, laryngeal edema, hypotension
- THEN:
 - large bore IV for IVF
 - epinephrine, 0.5 mg (1:1000) IV or SQ
 - benadryl, 50 mg IV or 50-100 mg IM
 - hydrocortisone, 250 mg IV
 - intubation if needed
 - REMEMBER ABCs
 - Don't forget to document

Rash

Most common cause simple rash in hospitalized patient:

- DRUG REACTION
 - hold suspected medication
 - IF pruritic
 - Benadryl 25-50 mg PO q6-8 hr
 - Atarax 25 mg PO q6-8
 - Allegra 180 mg PO qd
 - Claritin 10 mg PO qd
 - IF severe
 - corticosteroid cream
 - PO steroids
- -Dermatology or Allergy consult in AM

Transfusion reactions

- ANY REACTION – temp increase 1 degree, arthralgias, hematuria, rash, anaphylaxis
 - stop transfusion till you evaluate the patient
 - Report to the blood bank
- IF **acute hemolytic** reaction is suspected
 - send blood and patient's blood for cross match, Coombs' test, CBC, DIC panel, total bilirubin, BMP
- IF severe, **nonhemolytic reaction** suspected (anaphylactic, wheezing, SOB, T >104)
 - send blood and patient's blood for crossmatch
 - benadryl 25-50 mg PO/IV
 - hydrocortisone 250 mg IV
 - epinephrine 0.5-1.0 mL (1:1000) IM
 - CXR - R/O TRALI
- If hives without anaphylaxis
 - As above without epi
 - Can continue transfusion if premeds given

Transfusion reactions

- IF volume overload
 - decrease rate of transfusion
 - lasix 20-40 mg IV
 - CXR if desats and/or worsening exam
- IF Temperature <104 F
 - decrease rate of transfusion
 - acetaminophen 650 mg PO
- Note:
 - A fever is NOT a contraindication to transfusion

Headache

- Vitals including O2 sat, severity of HA, has there been a change in consciousness?
- Has the patient had Headaches like this in the past?
- If the HA is acute, severe, or associated with N/V, changes in vision, fever or decreased consciousness you must see the patient immediately.
- Major causes:
 - Tension, vascular, cluster, drugs, temporal arteritis, infectious, trauma, CVA, HTN, mass lesions

Headache

- Things you don't want to miss
 - Meningitis – fever, meningeal signs
 - Subarachnoid hemorrhage – worst HA of their lives
 - Mass lesion associated with herniation – retinal exam, seizure, change in mental status

Altered Mental Status

- Vitals, time course of changes, recent med changes
- Exam – include MMSE
- Ask Nurse/family/signout - is this different from baseline?
- Major causes:
 - Structural – trauma, hydrocephalus, CVA/TIA, dementia, postictal states, tumor
 - Systemic/metabolic – drugs, ETOH, hypoglycemia/DKA, organ failure, HTN, hypotension, infection, endocrine

Altered Mental Status

- Treatment – correct underlying problem
 - If trauma – STAT CT head
 - If infection – IVFs and Abx
 - Glucose/Metabolic
- What you don't want to miss:
- Sepsis, meningitis, ETOH withdrawal, Intracranial mass or increased pressure

Decreased Urine Output

- Definition 100-400 cc/24h, <30cc/hr
- On phone: Vitals
 - If already catheterized, FLUSH foley
 - If not cathed – do a PVR
- If PVR > 200 cc, insert foley or do intermittent cath
- If PVR okay, Fluid challenge, check BCP
 - Check if patient is in renal failure
- Causes:
 - Urinary Retention:
 - ?Sacral n disease, cord compression (suspect if patient has metastatic disease to vertebra)
 - BPH
 - Narcotics sedatives
 - If not retaining urine:
 - Volume depletion
 - Oliguric Renal Failure

Decreased Urine Output

- If patient in ARF, check serum and urine lytes, FENa or FE Urea
 - Through the night
 - If fluid overloaded, hi dose diuretics
 - Make sure K is okay – if + EKG changes – CaGluconate, o/w kayexalate, insulin and D5, bicarb, diuretics, albuterol nebs, dialysis if above doesn't work
- Indications for emergent dialysis:
 - **A**cidosis
 - **E**lectrolytes - K high, unresponsive to tx, EKG changes
 - **I**ntoxication - Lithium, Dilantin
 - **O**verload / not diuresing/ +Hypoxia
 - **U**remia with peicarditis or encephalopathy

Take one for the team

- Do the work
 - Give teams feedback
 - Document
- 

References:

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- Sabatine. *Pocket Medicine – The Massachusetts General Hospital Handbook of Internal Medicine* . 2000.