

MISSOURI HOSPITALIST

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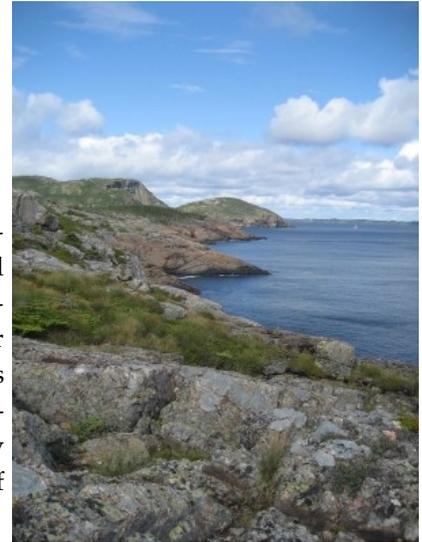
Consultations & Hospitalists

Robert Folzenlogen MD

As we all know, providing and receiving consultations are vital to our Hospitalist duties. National surveys of hospitalists have shown that the performance of inpatient consultations is among their most common responsibilities. In this role, it is important that our service be timely, helpful, directed at the specific area(s) of concern and clearly documented. Of course, we expect the same level of quality from those whom we consult.

Those of us in academic centers have the added responsibility of teaching residents how to provide a thorough yet concise consultation, communicate effectively with the primary physician and provide documentation that supports an appropriate billing level. At MU, we achieve this by presenting an annual didactic conference on the basics of consultation, by maintaining an online resource of consultation-related articles and PowerPoints and by reinforcing these issues during the resident's consult block. We have also established a "Consult Conference," at which the consult residents present topics pertinent to consult medicine or relate interesting and educational consultation cases. It is certainly imperative that all residents develop an appreciation for both the art and the logistics of medical consultation.

Above and beyond the consults themselves, there are systemic issues that may impair effective consultation. These problems are generally interdisciplinary, involving a lack of communication between or differing expectations among the various departments. Perhaps less common in the private sector, such factors are magnified by the buffering effects of fellows and residents in academic centers. Subjects of concern include responsiveness to consultation requests, the quality and specificity of recommendations, the communication of these recommendations via written records and direct contacts, the consulting service's preference regarding orders by the consultant, the willingness of consultants to provide continued follow up and the responsiveness of the primary service to the consultant's recommendations. In order to clarify these issues and to improve communication between Departments, we have established a "Consult Group" at MU, including members of the various inpatient services. Meetings are held every few months to air concerns and develop solutions. (continued)



Finally, the Internal Medicine Hospitalists at the University of Missouri feel that feedback is an important means of improving service. Beginning this fall, we will provide semiannual evaluations of consultation services by the subspecialty Divisions of Internal Medicine and by the other Departments at MU. The evaluation parameters will include timeliness of service, quality of consultations, documentation, communication and consistency of follow up recommendations. Responsible for the largest segment of inpatients at MU, we feel an obligation to provide this input and welcome similar evaluations from the other services. Our goal, after all, is to continually improve the quality of patient care at the University of Missouri.

We are interested to learn about similar programs at other institutions across the State. Your comments and ideas are welcome and, if desired, will be published in the next issue of Missouri Hospitalist.

HOSPITALIST CONFERENCE AT ACP MEETING

A Hospitalist Conference and Luncheon will be held at the annual Missouri ACP Meeting, at Tan-Tar-A Resort, Lake of the Ozarks, in September. Scheduled to begin at 12:15 on Saturday, September 26, the theme of the Conference is Hospital Acquired Infections. The speakers and their topics will be:

John Crass MD, Washington University, [Clostridium difficile](#)

Kyle Moylan MD, University of Missouri, Columbia, [Catheter-related UTIs](#)

William Salzer MD, University of Missouri, Columbia, [Central Line Infections](#)

Your attendance and participation is encouraged. The entire 2009 meeting will provide approximately 22 hours of CME credit. Registration is available online:

<http://www.acponline.org/meetings/chapter/mo-2009.pdf>



CASE OF THE MONTH

DILIP BEARELLY MD

An 86 year old AA woman was referred to University Hospital from the dialysis center where she had complained of worsening dyspnea over the past 2 weeks. She denied cough, fever, chills or rigors. Per her dialysis notes, bi-basilar crackles had been noted in recent weeks and an effort to increase dialysis volume was made; however, this led to episodes of hypotension (confirmed by dialysis records). At the time of admission, the patient also complained of bilateral chest pain which was constantly present but increased with deep inspiration. She also reported intermittent swelling of the right arm and right face over the past 8 weeks which became worse after lying down.

Her PMH was remarkable for adult polycystic kidney disease, aortic stenosis and CKD V requiring dialysis. Two prior admissions for symptoms similar to this presentation led to diagnoses of volume overload and secondary pleural effusion due to insufficient dialysis. She was also admitted 10 months ago for pneumonia and sepsis. Past surgical history was limited to placement of an A-V fistula, six months ago. She denied anorexia or weight loss. Family history was remarkable for a brother with polycystic kidney disease.

On exam, the patient was afebrile. Vitals: BP 106/75, P 84, O2 sat 92% on RA. Diminished breath sounds were noted on the right side. Cardiac exam revealed a systolic ejection murmur; JVD was noted. Abdominal exam was unremarkable. Edema of the right arm and right face were noted and there was an A-V fistula in her right arm; 2+ edema was also found in her lower extremities.

Admission labs revealed WBC 7.6, normal differential, Hgb 8.2, normal LFTs, serum albumin 3.6 and a serum creatinine of 5.1. Admission CXR revealed a large right pleural effusion and a minimal effusion on the left side. Old records (3 months ago) showed that moderate bilateral pleural effusions were present at that time; these records also contained an echocardiogram which demonstrated aortic stenosis and an ejection fraction of 45%.

On admission, our differential diagnosis included subclavian stenosis, Pancoast tumor (or other malignancy), subclavian venous thrombosis, congestive heart failure, constrictive pericarditis, pulmonary embolism and uremic pleuropericarditis. A repeat echocardiogram was unchanged and revealed class 1 diastolic dysfunction. In light of her recurrent pleural effusions, a diagnostic and therapeutic thoracentesis was performed (2L) which was transudative by Light's criteria; her symptoms improved significantly after the procedure. A RUE ultrasound was negative for thrombosis. Due to her ESRD, a chest CT and CT venogram were performed at the same time; no mass was found but the venogram revealed near total occlusion of the right subclavian vein. A percutaneous angioplasty was recommended but the patient refused; after experiencing recurrent symptoms one week later, she agreed to the angioplasty and, following this, her episodic hypotension, pleural effusions and edema resolved.

Final diagnosis: subclavian vein stenosis, presumably secondary to a subclavian line placed during her admission for pneumonia and sepsis (10 months ago).

Discussion: The five most common causes for pleural effusion are CHF, hypoalbuminemia, pulmonary embolism, infection and malignancy. While this woman had classic symptoms, subclavian vein thrombosis or stenosis should be considered in all cases of recurrent pleural effusion. Subclavian vein thrombosis complicates up to 5% of subclavian catheter placements and this condition may have contributed to both her dialysis hypotension and her relatively new onset of diastolic dysfunction; the latter may also be secondary to dialysis related pulmonary hypertension.

FROM THE JOURNALS**Carla Dyer MD**

The following articles should be of interest to Hospitalists:

Perioperative Medicine Update

Jaffer et al. review preoperative beta-blocker use, risk of bleeding with perioperative bridging of anticoagulation and reducing the risk of postoperative respiratory failure, among other issues.

Jaffir, Amir et al., *Perioperative Medicine Update*, Journal of General Internal Medicine, 2009; 24(7): 863-871

Patient Safety Issue

Tija, Jennifer et al., *Medication Discrepancies upon Hospital to Skilled Nursing Facility Transitions*, Journal of General Internal Medicine, 2009; 24(5): 630-635

**ID CORNER****William Salzer MD**Updated IV Catheter Infection Guidelines

The IDSA has updated their practice guidelines for IV catheter infections:

Mermal, LA et al., *Clinical practice guidelines for the diagnosis and management of intravenous catheter-related infection: 2009 update by the Infectious Disease Society of America*. Clin Infect Dis 2009; 49:1-45

<http://www.journals.uchicago.edu/doi/pdf/10.1086/599376>

**MISSOURI
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MISSOURI HOSPITALIST CALENDAR

19th Annual Conference, Caring for the Elderly, Missouri Association of Long-Term Care Physicians, August 21-22, Holiday Inn Select Executive Center, Columbia; call 573-882-0366 or visit the CME website at www.som.missouri.edu/CME;

LOCAL

Missouri ACP Meeting, September 24-27, Tan-Tar-A Resort, Lake of the Ozarks; Hospitalist Conference Luncheon on Saturday, September 26, 12:15 pm; topic: Hospital Acquired Infections; see article on page 2 of this newsletter. **LOCAL**

Hypertension & the Cardiometabolic Syndrome, October 15, 2009, Hampton Inn & Suites, Columbia, MO, University of Missouri Department of Medicine, call 573-882-0366 or visit www.som.missouri.edu/CME; **LOCAL**

CHEST 2009, October 31-November 5, San Diego; information and registration online at www.chestnet.org

The Academic Hospitalist Academy: Essential Skills for Education, Scholarship and Professional Success, Society of GIM, November 8-11, Atlanta, Peachtree Conference Center; for more info, contact Amy Woodward, woodwarda@sgim.org

Please direct all comments, ideas and newsletter contributions to the Editor:

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Please forward this newsletter to Hospitalists that you might know!