The following text and photos are excerpted from a diary written by Leanne M. Yanni MD about her RMED experience in Saranac Lake, N.Y. Note: to protect privacy some names and identifying details have been changed.

Highlights from

A Week in Family Practice

by RMED student Leanne M. Yanni

Saranac Lake, Adirondack Park

Monday My first priority was to meet "C.N.," a pleasant retiree, about to have his knee replaced. I like to show my face first, without the mask, so patients can recognize me after surgery.

While prepping the patient's leg, "Sharon," the nurse, came over to me with a choice of eyewear, but I politely declined. I wear glasses. Her expression became quite serious and she said, "He's HIV-positive."

I was surprised. There were no identifiable risk factors in his admission history or physical, and no medications to indicate that he was HIV-positive. Apparently, he had donated autologous blood before the surgery.

During the surgery we were all careful to double glove, place sharps down properly and keep our eyes on the scene. In a split second, however, "Dr. Gordon" slipped while shaving the patella and the saw nicked Sharon's glove. She immediately took her gloves off and found a small, open cut that she bled and cleaned with hydrogen peroxide. Within the silent room, I could hear my heart pounding.

It is unlikely she will become infected. First, the patient may not be HIV-positive. Second, the viral load is likely to be low because clinically he does not have AIDS. Third, a tourniquet was applied to the leg and the field was relatively bloodless; the saw had only a few drops of blood on it. Fourth, her cut was superficial.

"H.H." was an 87-year-old female with the "dwindles," as Dr. Woods McCahill would say, who was admitted with pneumonia a month ago. She resisted admission, but her condition warranted it. We would treat her with IV antibiotics and send her home in three or four days. When I asked her if

she wanted resuscitation or mechanical ventilation in case of an emergency, she said, “So, it’s come to that now has it?” She died that night.

A Down Syndrome patient was admitted last night for hypoxia and respiratory distress. “J.D.” is 59 and cannot see or speak. I do not know if he can hear. He responds to touch or movement by moaning and withdrawing. This morning, he was obviously having myoclonic seizures. I started IV Ativan and a loading dose of Dilantin with Dr. Shawn Pertunen’s signature.

I reviewed an abdominal CT scan of a 65-year-old man with subacute onset of left upper quadrant pain with the radiologist. A month ago, he was diagnosed with diverticulitis and placed on antibiotics. The pain subsided for a few weeks, but had kept him from sleeping the last three nights. On admission, he has no laboratory abnormalities and his chest and abdominal films are normal. I came up with an extensive differential diagnosis that I reviewed with Shawn. I suggested a CT scan because of the extensive differential, his history of splenic cysts and the need to rule out an aortic aneurysm. After a surgical consult, we were no closer to a diagnosis and the CT scan was obtained. Splenic hemorrhage! On his way to surgery he said, “This wouldn’t have anything to do with the car accident I was in last month, would it?”

Tuesday

This morning, J.D. was exhibiting decerebrate posturing and his Babinski’s were going up. Apparently the seizures had caused cerebral anoxia. His breathing persisted despite a chest x-ray that revealed rapidly progressive infiltrates. We continued aggressive medical care although I felt it was futile.

My second patient was a 57-year-old illiterate man who presented the previous day with atypical chest pain. He truly is a “train wreck”: coronary artery disease, hypertension, hyperlipidemia, peptic ulcer disease and chronic anxiety. He had five-vessel bypass surgery, has a history of alcoholism and smokes a pack a day. He is also noncompliant. His family bombarded me with questions: “What’s wrong with him? Is it his heart? What are you going to do? Can he eat?” I explained that I would review his chart and discuss it with Dr. Pertunen. Once Shawn arrived, the truth came out. Last weekend, the family experienced some “discord” that involved the police. The heart pain diverted attention away from the discord.

I talked with the pathologist about H.H.’s cardiopulmonary autopsy. He found distinct palpable nodules in the lower lobes filled with a liquid. Areas of the lung parenchyma were necrotized. Two of the sputum cultures were growing acid fast bacilli. He suggested we review the slides on Thursday or Friday.

I saw a woman with atrial fibrillation that led to a discussion about its etiology. Dr. Chris Hyson and I discussed the findings of a literature search I did on Klinefelter’s Syndrome and thrombophlebitis. One of Chris’ patients has a known XXY genotype and infertility. He was on testosterone shots a few years ago that did not lead to conception. He was admitted a month ago with his second DVT. I found an association between Klinefelter’s Syndrome and hypercoagulability. This certainly provides enough evidence for life-long anti-coagulation.

Wednesday J.D. is no longer posturing. His lungs have cleared significantly. Maybe the combination of diuretics, steroids and a change in antibiotics eased his respiratory distress. He may be able to go home in a few days.

The "train wreck" was in good spirits, ready to go home. His barium swallow showed thickened gastric folds, typical of severe gastritis and not surprising given his history of alcoholism. Mental health suggested family therapy. I arranged for medical follow-up, wrote prescriptions, dictated his discharge summary, and sent him on his way.

Dr. Handler, a hospital internist who dabbles in rheumatology, was interested in H.H.'s autopsy findings. When I mentioned lung nodules, he described two patients with rheumatoid arthritis and lung disease. His recommendation had been to start H.H. on anti-tuberculosis medication despite two negative PPDs, three negative sputum samples and negative bronchial washings for AFB. Because of her rapidly deteriorating state, we held off on the medications.

In Lake Placid today I saw the obstetric patient I have been seeing for seven months. She is 39 weeks, 2 days. She delivered her last child two weeks early so I've been on my toes all week waiting for the phone to ring. Today, her fundal height was 40cm, the head down, and the fetal heart rate strong at 140. She was 1 cm dilated and almost completely effaced. I suspect tonight!

After lunch I did a general exam, pap and pelvic on a 41-year-old woman. I discussed three issues with her: osteoporosis, breast cancer and heart disease prevention. We spent the rest of the time talking about her teaching job and teenage son. I love these visits!

Thursday J.D. was doing fairly well this morning. Apparently, he opened his eyes yesterday. I am encouraged.

On Thursdays I see patients in the OB/Gyn office with Dr. Denise Ferrando. Today, I saw a 43-year-old female, very anxious, who had a D&C "five or six" years ago after some abnormal uterine bleeding. Her doctor at the time recommended a hysterectomy because her uterine lining was "kind of thick." She made an appointment for the surgery, but canceled. She was too scared and never followed up. Today, she was scheduled for an endometrial biopsy. After the interview, her chart arrived. Her D&C was done 10 years ago. The biopsy report revealed endometrial hyperplasia with atypical endometrial cells. Some dysplastic nuclei were present. How could this have been ignored for 10 years?

Friday The Annual Winter Weekend of the New York State Academy of Family Physicians is being held in Lake Placid.

I went to lectures this morning on "Sorting Out the Facts on Good Nutrition," "Alternatives to Smoking," "BPH and Prostate Cancer" and "Seasonal Infections." The case of an elderly woman with tuberculosis was discussed in "Seasonal Infections." The speaker described the differential diagnosis for patients with bilateral pneumonia as well as with cavitary pneumonia. After reviewing H.H.'s case I kept saying, "I should have thought of that."

I learned about metatarsalgia and March fractures after seeing a woman with toe pain. Later, I looked at a possible cholesteatoma. Dr. McCahill makes sure I see every rash he sees. I have seen chicken pox, viral exanthems, drug reactions, dishydrotic eczema, atopic dermatitis and erythema nodosum.

Saturday & Sunday I attended the conference again on Saturday and Sunday mornings. "Congestive Heart Failure" was one of the sessions. I am always amazed at how clinical and academic work coincide.

TB was another recurring theme. Although H.H.'s initial sputum samples were negative for acid fast bacilli, the cultures from all three samples grew acid fast bacilli, determined to be Mycobacterium TB by DNA studies. As Harrison's states, TB is a wasting disease. H.H. fit that description. Now, it seems obvious. Although we had no evidence of TB before her death, I should have thought harder about her case. She might have improved with treatment.

Three closing notes: One, C.N.'s second test for HIV antibodies was negative. Two, the man with the left upper quadrant pain whose CT scan showed a possible splenic hemorrhage actually has a splenic lymphoma. Three, the pregnant patient I was following had her baby three days after her due date – a 7 lb 5 oz boy. It was a perfect birth.

Leanne M. Yanni MD '98 is now practicing Internal Medicine at Medical College of Virginia.