

# Binghamton Clerkships Orientation Packet

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## 1. Obstetrics-Gynecology Clerkship

### Structure:

6 weeks

- 1<sup>st</sup> Week      Orientation and classes, a fairly light week.
- Weeks 2-6      Spend time with preceptors in their offices/clinics, usually with 1-2 days in the OR for gynecologic surgery (M-F, typical office hours with occasional classes.)

### Grading:

Topic Report (25%) - 10+ page research paper – You choose the topic.

Preceptor eval/clinical performance (35%)

Shelf Exam (35%)

Class Participation (5%) (attendance at and participation in lectures)

Seminar (Pass/Fail) - 20 minutes – Power-Point presentation. Topics are provided, choose from a list.

### Other Requirement:

You will have a **list of required diagnoses and procedures**, for which you have to have the doctors “sign-off”, indicating that you were able to see patients with the diagnoses or procedures. **DO NOT IGNORE THIS LIST AND DONT PROCRASTINATE.** Start getting signatures early, and if you are not seeing something with your preceptor (ex. Amniocentesis) you should plan to spend time with another doctor. Dr. Kassis can help to arrange time elsewhere to meet your experience requirement.

### Call:

Every 3-4 nights. On weekdays, call starts at 5 pm and ends at 6 am the next morning. On weekends, call is for 24 hours and starts at 7 am. You will be on call in the birthing center at Wilson or Lourdes. You will be based in the hospital your preceptor takes call. Call provides an opportunity for you to participate in deliveries and c-sections. Try to take some call with your preceptor. There are call rooms for sleeping at both Wilson and Lourdes. The nurses will not call you to wake you up if there is a delivery. It is your responsibility to check on the progress of

your patients. However, you should try to get some sleep because you are not off the next day. Try to introduce yourself to the patients early on in labor and ask for permission to be present during the delivery. Labor and Delivery nurses are your primary teachers during call nights. You can learn a lot more if you hang out at their desk and ask questions. Bring review books.

General Info: Unlike the Syracuse campus, you are not expected to write notes on patients in the birthing center and rarely will be expected to write notes in the out-patient setting. Unlike most rotations, there are no long H&P write-ups. You should use your evenings instead to research your Topic paper.

More than any other rotation, you may be frustrated by your lack of involvement. Some patients may be uncomfortable with having you around (especially true for the guys), and many of the preceptors prefer to have you shadow rather than actually see patients on your own. If you have an interest in OB-GYN, talk to Julie Gunster (763-6042) about making sure you are placed with a preceptor who allows for a more hands-on experience. You will be allowed to do more if you are in a clinic rather than a private practice. Some preceptors are much better than others at allowing students to try things on their own.

#### Advice

- For the topic presentation, choose a narrow topic based on a research question – ex. “Does metformin during pregnancy help to prevent the complications of maternal diabetes?” Try to pick something a little controversial to research. Start looking for journal articles early using your LEAP account. Also, contact the librarians at Upstate. They are extremely helpful, and may even be able to provide you with a list of references.
- Do not spend too much time on the Power-point presentation (it is pass/fail).
- Don't put off getting signatures for the required diagnoses/procedures
- Make friends with the nurses in L&D, they can teach you a lot.
- Get some sleep during call.

#### Recommended book:

Case Files Obstetrics and Gynecology, Blueprints

## **2. Ambulatory Surgery Clerkship (ENT/ Ophthalmology)**

### **Ophthalmology**

Structure:

1 week based in out-patient setting with a single preceptor. No weekend responsibilities or call. May spend one to two half-days observing surgery.

Grading:

1 credit total

Final exam (not a shelf exam), 4 page paper, conference attendance, and evaluations from your preceptors at the office visits.

Paper: Choose two case illustrations from the book provided. Answer the questions for each case, and then give a 1-2 page general discussion on the diagnosis and treatment. Include 4-5 references (ex. Textbooks, up to date).

Call: None

Books Used:

You will be provided with a small book on Ophthalmology cases, which will be returned at the end of the week. Notes from lectures should be adequate to study for the final exam.

### **ENT Clerkship**

Structure:

1 week based in out-patient setting with a single preceptor. No weekend responsibilities or call. May spend one to two half-days observing surgery.

Grading:

Total -1 credit

Final exam (not a shelf exam), conference attendance, and evaluations from your preceptors.

Books Used:

You will be provided with a small book on ENT, which will be returned at the end of the week. You should read the book 1-2 times in preparation for the exam. However, there may still be questions on the exam that are not from the book. If you want to do exceptionally well, you may study from another review book, but even then don't get frustrated if you don't know it all.

Note:

ENT/ Ophthalmology are done over a two week period and the test are administered at the end of the two weeks. You should spend more time studying for ENT than ophthalmology, as the ophthalmology portion is generally viewed as easier.

### 3. Family Medicine

#### Books Used :

##### Recommended Text:

- *Essentials of Family Medicine, 4<sup>th</sup> Ed.* By Dr. Sloane. Exam is based on the required chapters from the book. Some of the chapters are online on E-Reserve (<http://www.upstate.edu/library/intra/reserves/fmc/> - note: these may be from old edition). Textbook also available in library.
- Supplemental Texts (can use Blueprints, Appleton & Lange) for general information but exam is from Sloane (selected chapters from Sloane that are noted in syllabus).

Pocket Contents: stethoscope, penlight, reflex hammer, general pocket references (maxwells, tarascon pharmacopia, sanford antimicrobial guide), PDA

What to expect: This clerkship is a bit different than all others, as it is concurrent during the entire year. It is an entirely outpatient rotation, with time being spent in a family doctors office. A half day (Tuesday-Wednesday PM) is spent per week in the office (students with more distant locations—some up to 45 minutes from Binghamton---can go every other week for a full day instead). Because it is with one preceptor for the entire year, it allows for more of continuity of care and mentorship relationship. There is no call. Approximately every other month, a lecture afternoon replaces time in the office. These are usually given by Dr Ryan, the course coordinator, and can be less than interesting. A key part of the class that is pushed heavily by Dr Ryan is participation in an interactive website (nicenet). It allows for the posting of documents and comments on others write-ups. He also uses this to communicate with the class.

Grading: Dr Ryan has a complex means of adding up points that determine the final grade.

There are many, many things included in this, and it difficult to keep up with his evaluating analyses. The tests come very much from his lectures so do your best to pay attention.

\*Note: for those doing RMED, the first 3 credits of the family practice clerkship are done in Binghamton. The last 2 credits are included in the RMED activity

#### Sample Write up:

New patient, seen alone.

S: Pt is a 51 year old woman complaining of a three day history of cold symptoms. Sx began with a sore throat 3 days ago. 2 days ago she felt run down and slept all day. Yesterday she began to develop chest pain that radiated to her back, especially when she coughed. She localized the pain to the superior sternal region. Her cough is non-productive but she has not coughed much because she does not like to cough. She also has decreased appetite and congestion. Her husband has identical symptoms. She has not had relief from taking Alka-seltzer. She has no smoke exposure

O:

Vitals: T 97.6 BP 132/88 HR 80 R 16

Ears: TMs clear bilaterally without erythema

Throat: slight erythema bilaterally in oropharynx

Nose: no discharge; significant congestion

Neck: supple; no lymphadenopathy

Lungs: CTAB; no use of accessory muscles; no wheezing, rales, rhonchi

Heart: S1S2, RRR

A: Viral bronchiolitis

P: OTC Robitussin for cough

OTC Sudafed for congestion  
OTC Tylenol for pain  
Call if symptoms do not improve after 5 days.

## 4. Pediatrics

### Books Used :

- Various supplemental texts: Kaplan, Blueprints, etc. The Harriet Lane handbook is a very good pediatric resource.

Pocket Contents: stethoscope, penlight, reflex hammer, general pocket references (maxwells, tarascon pharmacopia, sanford antimicrobial guide), PDA

What to expect: This clerkship is split into a 3 week inpatient service and a 3 week outpatient experience with a pediatrician. It is possible to arrange which comes first by speaking with Julie Gunster, but there is no clear advantage to either. Each day, regardless of which service you are on begins with rounds at 8:00. They are generally led by Dr. Scagnelli, who is a very good teacher and very interactive. At times, the pediatric census could be quite small (1 or 2), but it may swell to 6 or 7. Students doing inpatient should see their patients and, if possible, write notes before rounds. Dr. Scagnelli will have the students present the patients and will pimp on what is going on with the patients, so be sure to know your patients well. Those doing inpatient will also do at least a week of rounds in the NICU. This consists of filling out a form summarizing vitals on your 1-2 patients before rounds, usually at 10 AM. This tends to be mere book-keeping, but it does present exposure to the NICU. Be aware that the NICU nurses are very attentive to washing thoroughly before examining the babies and about wrapping them up correctly. Those people doing outpatient must still go to AM report, but they tend to be more spectators. Outpatient hours are generally a normal 8-5 workday, but some of the pediatricians work weird hours. Call is generally done while on the inpatient service and is approximately q4. Lectures are interspersed throughout the clerkship, but the lecture schedule can get unpredictable at times. There will also be occasional half-days with pediatric specialists in the area (ex. Peds GI, peds endocrinology).

Grading: A combination of attending and intern evaluations and the shelf exam.

### Sample write up:

Admission Date 10/29/05

CC: This is the second hospitalization for this 2-year-old Caucasian male who was diagnosed in the ER previously in the day with croup.

Informant: The patient's mother provided the information and appeared reliable.

HPI: The patient was previously in good health until developing fussiness, red cheeks, and a fever of ~100F two days prior to admission. The patient was well enough to go to day care on that day. These symptoms were unchanged until 8PM on the evening prior to admission when he rapidly developed hoarseness, stridor, sore throat, cough, diarrhea, and decreased appetite. The mother recorded a temperature of 103F, which she treated with Tylenol suppositories. The patient went to bed the night prior to admission, but awoke around 1AM on the day of admission with heavy wheezing and a dry cough. He also displayed a brief period of shaking of his arms, but did not lose consciousness or become incoherent. The patient presented to the emergency room, was diagnosed with croup, and given Prednisone to relieve his symptoms. Chest x-rays on first admission showed the classic "steeple sign" of croup. He improved and left the ED. The patient slept 5-7 AM on the day of admission but again awoke with wheezing and cough and a fever as high as 105.8 rectally. The mother called the PCP who advised them to return to the hospital after hearing the patient over the phone. On his second visit to the ED, the patient was

admitted for treatment and monitoring of croup. There he was treated with nebulized Albuterol. Upon admission to the Peds floor, he was given Decadron 8mg IM.

The patient has a negative history of similar symptoms. The patient has been attending day care 5 days a week. There are no known sick contacts in the house. There are three dogs in the house, but he has never shown any allergy to them. He had his last meal at lunchtime one day prior to admission, but has continued to drink fluids through his illness. His last bowel movement of diarrhea was in the morning of admission.

**PMH:**

**Birth:** The patient was a 36-week vaginal delivery at Lourdes hospital following a prenatal course marked by premature contractions and dilation at 2 months. The neonatal course included meconium aspiration during labor, which required the patient to stay for the three days in the hospital. The patient did not suffer any sequelae from the aspiration.

**Neonatal / Infancy:** The patient had one previous admission to Wilson approximately six months ago for overnight treatment of hand, foot, mouth disease, from which he recovered well.

**Acute illnesses:** The patient's mother reports that he had several bouts of otitis media and sinusitis when he was a newborn. Since then, she feels that he has been very healthy and rarely gets sick.

**Operations/Accidents:** The patient does not have any history of trauma.

**Developmental:** The patient's developmental history was uneventful. He began walking around 8 months and talking around 10 months. His vocabulary and speech patterns were very good for a two year-old, and he was able to speak in full, understandable sentences. Otherwise, his behavior was appropriate for his age.

**Immunizations:** The patient's immunization record was up to date according to the practice, but his mother was not able to provide documentation of this. His last vaccination was around 6/05

**Allergies:** The patient has no known drug or food allergies.

**Medications prior to sickness:** None

**Nutrition:** The patient's mother reports that he generally eats well, but can be picky with what he eats at times. He will not eat meals if he does not like them, and she will not force him to do so. At times, he therefore eats only a meal or two a week. She says his favorite foods are chicken, French fries, cereal, and pb+j. She also says that he does get an adequate amount of fruits and vegetables. He has no restrictions on his diet, and he drinks city water.

**Child/Parent Interactions:** The patient bonded well with his mother and turned to her for support when he was examined or had blood work. At other times, he was in her arms, and she treated him in an appropriate manner.

**Family History:**

The family history is positive for paternal asthma and maternal recurrent bronchitis. There is no other family history of respiratory disease. There is an extensive family history of cancer, coronary artery disease, and DM in second-degree relatives.

Social history: Pt lives in a nearby Binghamton home with his mother, maternal grandmother, and maternal great-aunt. He has no siblings. The patient has lived in this home his whole life, and he has his own room. The family seemed very supportive, and all three above members visited the patient. All members of his house smoke, but his mother denies that he gets any second-hand smoke. Three dogs are in the house as mentioned in HPI. The family does not receive social assistance.

Pt has been in daycare for 9 hours a day, 5 days a week since age 3 months. He has been in the same program continuously, loves going, and gets along well with other children.

The patient's mother is a single-mom who works as a C.N.A. in a local retirement home. She is in good health. She enjoys caring for him after her workday.

The patient's mother would not provide any information on his father except that he is "not in the picture" and that he is in good health. The chart noted that paternal visits must be supervised. While the grandmother and great-aunt live with the patient, they do not seem to play a major role in caring for him.

#### Review of Systems:

HEENT: Rhinorrhea for approximately one week.

Skin shows approximately a dozen 1-2mm pimples in the peri-anal region of each buttock for less than one week.

All other ROS are negative except as mentioned above in HPI.

#### Physical Exam:

Vitals: T 103.2 (on 2<sup>nd</sup> presentation) oral P: 99 R 30 BP 89/39 Wt 29# O2sat: 94% in room air

General: Pt was sleeping in his mother's arms, but awoke for exam; mildly lethargic; not anxious; no signs of dehydration or difficulty breathing

Skin: ~ 12 Small pimples bilaterally on buttocks

Eyes: PERRL, EOMIs, no discharge or redness.

ENT: lips not cracked; mucous membranes moist; normal tonsils without exudate; TM visible bilaterally; pharynx is not erythematous and without exudates; nares patent with no erythema, discharge, or polyps.

Neck: supple; trachea mid-line; mild left pre-auricular lymphadenopathy

Respiratory: stridor and wheezing in anterior and posterior bilaterally over all lobes; fair air exchange bilaterally; no prolongation of expiration; no use of accessory muscles.

CV: RRR; S1 and S2 heard with no extra sounds.

Abdominal: Abdomen soft, nontender, nondistended; bowel sounds present; no organomegaly on palpation.

Lymphatic: pre-auricular lymphadenopathy as mentioned in ENT section.

Extremities: good muscle tone and pulses bilaterally; no edema or acrocyanosis;

Neuro: alert and oriented x3; no focal neurological deficits; cranial nerves 2-12 intact

#### Labs in ER:

No lab work was ordered in the ED.

Chest x ray was negative except for clear "steple sign" of trachea.

Assessment: The patient is a previous healthy 2 year-old male with croup and a two-day history of fever, diarrhea, wheezing, dry cough, hoarseness, and decreased appetite.

Problems: Croup

Plan: The patient was given nebulized Albuterol in the ED. The patient is to be admitted to pediatric floor.

- Administer Decadron 8mg IM x1
- Order Racemic Epi 0.5 neb q3 prn
- Order Tylenol 200 mg PO q4 prn fever >101 or pain
- Full diet as tolerated
- Out of bed privileges
- No blood work required
- Patient's symptoms and fever to be monitored
- Plan to discharge tomorrow AM if well.

Discussion: The differential diagnosis of croup includes various infections and anatomic anomalies that may affect the respiratory tract. The presence of fever, a barking cough, the x-rays, and the history and physical are used to distinguish croup from acute epiglottitis, spasmodic croup, bacterial tracheitis, anatomic defects, upper airway injury, or foreign body obstruction. Epiglottitis, which is decreasing in incidence because of the HiB vaccine, has the high fever and stridor of croup, but does not have the barking cough. It also induces more anxiety and more rapid symptoms than croup. Spasmodic croup has symptoms very similar to croup, but does not have the associated fever. It tends to recur for several nights. Bacterial tracheitis has very prominent sounds associated with lower airway disease and likely produces purulent secretions from the trachea. Anatomic defects may produce the stridor and cough of croup, but tend to have a very prolonged course. Defects usually lack an associated fever. Airway injury is usually obvious with a history of smoke inhalation or ingestion. Foreign body obstruction is marked by a sudden onset of hypoxia and cough in a previously healthy child. (Info from UptoDate "Clinical Evaluation of croup" updated September, 2005.)

## 5. Neurology/Neurosurgery

**Structure** – 4 weeks, usually spent primarily in neurosurgery with 3 days of outpatient neurology. Neurosurgery experience is divided between didactics (one student presents a case *with images* each morning, lecture given by one neurosurgeon each day), the OR (Dr. Bajwa’s secretary keeps the schedule; be sure to read up on cases you will be observing!), and clinic.

**Grading** – Instructor evaluation based on performance in clinic and the OR and at group discussions. 4 write-ups.

**Call** – Variable. Most often one student is on home call each night and is expected to call in all other students if s/he is called in for an emergency. Usually students are only called in to the hospital 1-2 times per rotation.

### Typical Day –

- Pre-round on patients you have chosen; write notes (optional; may reflect favorably on student).
- 7:45 AM: responsible student should arrive at office early, obtain list of all neurosurgery patients, photocopy & distribute to other students. *Dr. Bajwa expects all students to have most recent list of neurosurgery patients every day!*
- 8:00 AM: Case discussion & lecture
- 9:00 AM: students disperse to OR, clinic, or neurologist’s offices

### NEUROSURGERY HISTORY AND PHYSICAL EXAM

**Patient:**

**Date of Admission:** 3/27/05

**Source of Information:** Patient and husband

**Patient Interaction:** I met this patient s/p ventriculostomy and coiling.

**Attending:** Dr. Meirelles

**Age: DOB:**

**Reliability:** Good

**CC:** Patient presented with the chief complaints of the “worst headache of her life,” lethargy, nausea, vomiting and photosensitivity for several hours duration.

**HPI:** Ms. Moore is a 37 year old, right-handed woman with no significant past medical history. She presented to Chenango Memorial Hospital around noontime the day of admission complaining of the “worst headache of her life.” Apparently she went tanning the day of admission and was lying supine with no complaints when “all of a sudden” the next second got a very severe headache, “the worst headache of her life,” which she attributed to a migraine. The pain was very severe (10/10) and generalized. She walked home 2 blocks, all the while grabbing her head, thinking it would relieve the pain. When she arrived home she immediately laid down on the floor. She doesn’t recall anything past this point, and the rest of the history is per her husband. She starting vomiting and complaining of photosensitivity, so her husband turned out the lights and put a wet towel on her head. Over the next 4 hours, she would vomit every 45 minutes and would fall in and out of sleep. Her husband did not think to seek immediate medical attention because she kept saying she thought this was a migraine and if she only could fall asleep she would probably feel better. She denies any falls or trauma to the head. She denies any headaches in the day’s prior.

According to the physician following her at Chenango Memorial, was alert and followed commands, moving all 4 extremities. A CT scan was performed and revealed the presence of a subarachnoid hemorrhage. The patient was sedated for an unknown reason, and was intubated for transport to Wilson Hospital. During transport, she woke up from sedation and was agitated and confused, at which time additional sedation was given.

Dr. Meirelles was called upon her arrival to Wilson Hospital

**Past Medical History:**

1. Menstrual migraines in her 20s. She has not had a migraine since giving birth to her son 14 years ago.
2. Cervical cancer – 2003 – treated at Hamilton
3. Right knee surgery – unknown dates

**Medications:**

1. Depo-Provera shots – 150 mg IM q 3 months

**Allergies:**

1. Penicillin gives hives
2. ASA – unknown rxn
3. Latex – throat swells
4. Iodine – throat swells
5. Shell fish – throat swells

**Social History:**

Patient lives at home with her husband and her 14-year-old son.  
She smokes 1 pack of cigarettes per day since she was in her 20s  
She does not drink alcohol or use any recreational drugs

**ROS:**

General: Denies any changes in weight over the past 6 months. Denies night sweats, fever chills.

Skin: Denies any lesions or rashes

Head: See HPI

Eyes: Complains of photophobia, denies blurry vision, diplopia.

Ears: Denies difficulty hearing, denies ear pain, tinnitus

Nose: Denies difficulty with smell, epistaxis, congestion, sneezing

Throat/Mouth: Denies cough, hoarseness, sore throat

Endocrine: Denies diabetes, cold or heat intolerance

Respiratory: Denies SOB, asthma, wheezing, coughing, hemoptysis

Cardiac: Denies chest pain, palpitations, murmurs

Lymph nodes: Denies enlarged nodes, tenderness

GI: Denies constipation, diarrhea, dysphagia, jaundice, blood in stool

GU: Denies dysuria, urgency, frequency, hematuria, nocturia, polyuria, stones

Neurologic: See HPI, denies weakness, parasthesia, difficulty with balance, seizures,, difficulties with speech

Musculoskeletal: Denies arthralgia, myalgia

**Physical Exam**

*Note: Did not perform exam at this point. Exam is per hospital report on admission (Please see below for my physical exam s/p coiling procedure)*

Vitals: HR 82, BP 91/54, RR: 18, T: 99.2, O2 sat: 100%

HEENT: Head is normocephalic and has no signs of trauma. There were no raccoon or battle signs.

Cardio: Regular rate and rhythm, no murmurs, rubs, gallops, S1 S2 audible.

Lungs: Clear to auscultation bilaterally

Abdomen: No lesions, nondistended, bowel sounds audible in all 4 quadrants, soft, nontender, no masses, hepatosplenomegaly, guarding, rebound.

Neurologic: The patient was partially sedated upon arrival to Wilson. Pupils were equal, round and reactive to light. Corneal reflexes present in both eyes. Gag reflex present. The patient was able to move all 4 extremities spontaneously and attempted to grab the endotracheal tube.

Labs:

WBC: 13.6, Hb: 13.1, Hct: 38.0, Platelets: 220

Na: 140, K: 3.8, Cl: 105, HCO3: 21, Glu: 98, BUN: 7, Creat: 0.7, Ca: 8.6,

Alk Phos: 71, AST: 22, ALT: 30, INR: 0.9, PTT: 25.8

Imaging:

CT head revealed the presence of subarachnoid blood in the basal cisterns. There was a small amount in the 4<sup>th</sup> ventricle. Early hydrocephalus was also noted in the lateral ventricles.

CT angio revealed the presence of an anterior communicating artery aneurysm, measuring 6mm.

**Assessment:**

This is a 37-year-old woman who presents with the worst headache of her life. Imaging revealed the presence of a subarachnoid hemorrhage, with early hydrocephalus, as well as a 6mm anterior communicating aneurysm. Neurologically it is difficult to assess her status, however her brainstem reflexes are intact and she can move all 4 extremities.

**Plan:**

1. Admit patient to the ICU on ventilator
2. IV hydration - NS with 20 KCl at 75cc/hr
3. Blood pressure is currently controlled – Nipride drip will be given if BP >120/80
4. Seizure prophylaxis – Dilantin 100 mg IV q 8 hours
5. Vasospasm prophylaxis -- Nimodipine 60 mg po/q 4 hour
6. Early hydrocephalus – a ventriculostomy will be inserted for drainage of CSF
7. 6mm anterior communicating artery aneurysm – coiling procedure

**Date:** 3/28/06

**Procedure:** Insertion of ventriculostomy and intracranial pressure monitor

**Date:** 3/30/06

**Procedure:** Endovascular brain aneurysm embolization

1. Approximately 6 X 5mm right anterior communicating artery complex aneurysm which projects anteriorly-superiorly and towards the left
2. Brain aneurysm endovascular embolization with approximately 85% obliteration of the aneurysm lumen
3. Minimal filling defects/thrombus demonstrated in the proximal right A2 segment with delayed flow within the right distal anterior cerebral circulation. However, there was good collateral flow via the right middle cerebral artery to right anterior cerebral artery circulation identified.

4. Intraarterial spasmolysis and thrombolytic therapy was performed which demonstrated slight interval improvement in amount of intraluminal thrombus burden and better antegrade flow about the right anterior cerebral artery.

**Hospital Day #14** (This was my encounter with the patient)

**Subjective:**

Patient is comfortable, has no complaints, no pain. Is looking forward to going home.

**Objective:**

*Vitals:* BP: 116/70, Pulse: 72, Temp: 98.6, RR: 18, O2 sat: 100%

*Cardio:* Regular rate and rhythm, no murmurs, rubs, gallops, S1 S2 audible.

*Lungs:* Clear to auscultation bilaterally

*Abdomen:* No lesions, nondistended, bowel sounds audible in all 4 quadrants, soft, nontender, no masses, hepatosplenomegaly, guarding, rebound.

*Neurologic exam:*

Mental Status: Awake, alert, and oriented to person, place and time; appropriate mood and affect; speech fluent and comprehensible; judgment intact; insight intact.

CN II-XII intact on specific examination:

CN I: not tested.

CN II: Visual fields intact bilaterally in all four quadrants. Funduscopic examination shows no retinal hemorrhages or exudates, and unremarkable macula, no papilledema

CN III, IV, and VI: pupils equal, round, and reactive to light and accommodation (PERLLA), extra-ocular motion intact (EOMI).

CN V: sensation intact to light touch and symmetrical V1-V3 branches bilaterally. Temporalis and masseter strength full and symmetrical.

CN VII: all facial movements full and symmetrical.

CN VIII: hearing intact and symmetrical to light whisper. No nystagmus appreciated.

CN IX, X: symmetrical palatal lift, intact gag, coordinated swallow of water with no gagging or coughing.

CN XI: trapezius and sternocleidomastoid (SCM) symmetrical bulk, tone, movement, and 5/5 strength bilaterally.

CN XII: tongue midline without fasciculations, movement symmetrical.

Muscle bulk and tone normal. Strength 5/5 all major muscle groups UE & LE bilaterally.

Reflexes 2/4 and symmetrical at biceps, brachioradialis, triceps, patellar & Achilles;

Plantar response downgoing.

Sensation intact to pinprick and proprioception UE and LE bilaterally; Romberg negative.

Finger-to-Nose (F-N) and Heel-to-Shin (H-S) appropriate; Gait stable and unremarkable.

**Assessment:**

This is a 37-year-old woman who presented with the worst headache of her life. Imaging revealed the presence of a subarachnoid hemorrhage, with early hydrocephalus, as well as a 6mm anterior communicating aneurysm. She is now s/p ventriculostomy and endovascular coiling embolization with 85% obliteration of the anterior communicating artery aneurysm. Now with no focal deficits.

**Discussion:**

Subarachnoid hemorrhage (SAH) implies the presence of blood within the subarachnoid space from some pathologic process. Primary SAH most commonly results from rupture of a saccular aneurysm, however it may also result from rupture of AVM, mycotic aneurysmal rupture, angioma, neoplasm, cortical thrombosis. Environmental factors associated with acquired vessel wall defects include age, hypertension, smoking, and atherosclerosis. In this patient's case, history was positive for a smoking 1ppd for approximately 15 years.

Clinically, the patient experiences sudden onset of a severe headache, nausea and/or vomiting, symptoms of meningeal irritation (eg, neck stiffness, low back pain, bilateral leg pain), photophobia and visual changes, and about 50% of patients have a loss of consciousness.

Physical examination findings may be normal, or the clinician may find global or focal neurologic abnormalities, seizures, syndromes of cranial nerve compression, motor deficits from middle cerebral artery aneurysms in 15% of patients, ophthalmologic signs such as retinal hemorrhage or papilledema.

The initial study of choice is an urgent CT scan without contrast. Sensitivity decreases with time from onset and with older resolution scanners. CT scan is 90% sensitive within the first 24 hours, 80% sensitive at 3 days, and 50% sensitive at 1 week. Cerebral angiography is performed once the SAH diagnosis is made to assess the vascular anatomy or reveal any other aneurysms. Lumbar puncture (LP) is indicated if the patient has possible SAH and negative CT scan findings.

The Hunt & Hess Grading scale for aneurysmal SAH serves as a means of risk stratification based on the initial physical exam.

- Grade I - Mild headache with or without meningeal irritation
- Grade II - Severe headache and a nonfocal examination, with or without mydriasis
- Grade III - Mild alteration in neurologic examination, including mental status
- Grade IV - Obviously depressed level of consciousness or focal deficit
- Grade V - Patient either posturing or comatose

Patients with grade I or grade II have a relatively good prognosis, grade III has an intermediate prognosis, and grades IV and V have a poor prognosis. As such emergency care (ABCs) is more extensive in patients with a grade IV, or V SAH, requiring sedation with intubation for example.

Sedation may be necessary in a patient with a lower grade to avoid any increase in ICP due to excessive agitation from pain and discomfort. However, it is recommended to sedate cautiously to avoid masking the neurologic examination, which may jeopardize the reliability of the findings. In this case, Chenango Memorial sedated the patient, who was probably a grade III, presumably on the basis of agitation, however it is possible that this patient may not have needed intubation otherwise. This significantly interfered with the physician's ability to evaluate her grade accurately, and therefore she appeared to have a worse grade than she probably had.

Complications include:

- Hydrocephalus may develop within the first 24 hours because of obstruction of CSF outflow in the ventricular system by clotted blood

- Rebleeding occurs in 20% of patients in the first 2 weeks, peak incidence occurs the day after SAH
- Vasospasm from arterial smooth muscle contraction - symptoms include a decrease in level of consciousness, hemiparesis, or both
- Neurologic deficits from cerebral ischemia (peak at days 4-12)
- Hypothalamic dysfunction causes excessive sympathetic stimulation, which may lead to myocardial ischemia or labile detrimental BP.
- Hyponatremia may result from SIADH and cerebral salt wasting.
- Aspiration pneumonia and other complications of critical care may occur.

In this patient's case, she did show signs of early hydrocephalus, and so the decision was made to place a ventriculostomy. She did not show any other signs of the above complications.

### ***To Coil or to Clip?***

According to a 2005 Cochrane database system review, "for patients in good clinical condition with ruptured aneurysms of either the anterior or posterior circulation there is firm evidence that, if the aneurysm is considered suitable for both surgical clipping and endovascular treatment, coiling is associated with a better outcome."

"For patients in poor clinical grades, there is no reliable randomized evidence comparing the risks and benefits of coiling versus clipping. Because coiling is less invasive than surgery, also in patients with poor clinical condition, coiling seems the preferred option. A disadvantage of coiling is that aneurysms are more often incompletely treated (90% to 100% obliteration) and carry a risk for reopening. The long-term follow-up (>1 year after SAH) of coiled patients, with regard to renewed filling of the aneurysm, is an unknown but important issue that needs further study."

### **References:**

Antoine, Amin K, *Subarachnoid Hemorrhage*, eMedicine: April 4, 2005

Rowland, Lewis P. *Merritt's Neurology 11th Edition*. Lippincott Williams and Wilkins 2005. pp 330-337.

Schaaf, Ivan der, et. al., *Endovascular coiling versus neurosurgical clipping for patients with aneurysmal subarachnoid haemorrhage*. Cochrane Database Syst Rev. 2005 Oct 19;(4):CD003085

## 6. Psychiatry

### **Structure –**

6 weeks, all spent on the inpatient psychiatry service at Binghamton General Hospital, with the exception of two half-days spent at a Childrens' Home. Students are assigned to a preceptor, and clerkship experience is quite diverse depending on the preceptor's clinical practice and responsibilities that he assigns to the student.

### **Grading –**

Preceptor evaluations at mid-term (for your benefit) and at clerkship end (for grade).

Shelf Exam.

2 full write-ups to be handed in to course director.

OSCE.

### **Call –**

Approximately Q3. Two students take call at a time and divide admissions between them. Students are supposed to assess all patients admitted before 11 PM. Call is essentially unsupervised, with no attending or resident interaction during call time. Students present patients whom they interviewed while on call at morning rounds the next day and are expected to have 1-2 assessments per night on call. Many students leave before 11 PM if they have secured 1-2 assessments, although this is not officially sanctioned by the course director.

### **Typical Day –**

Follow-up on patients – The student independently interviews/examines patients that she admitted during previous nights on call as well as any patients assigned by her preceptor. She writes notes in the chart for these patients. There is no follow-up on a student's staying abreast with patients seen at admission, and most follow these patients only every 2-3 days.

ECT – Prior to morning rounds there are often patients scheduled for electroconvulsive shock therapy. Students are encouraged to participate (completely optional) and are often given the opportunity to insert IVs, etc.

Morning rounds (1 hour) – Students who had call on the previous night each present 1-2 cases using the H&P format for write-ups. Course director leads a lively discussion of each case in which all students are expected to participate.

Time with preceptor (1 hour) – Time is variously spent depending on the assigned preceptor.

Lecture (1 hour) – Formal didactics. Topics are scheduled beforehand and students are “expected” to read assigned materials.

Group interview (1 hour) – Lecturer from formal didactic proctors a patient interview. Students are responsible to identify patients with pathology appropriate to the day's lecture topic and obtain consent from that patient beforehand to be interviewed in front of the group of students. One student will then interview the patient while the other students look on. After the patient is dismissed, the lecturer and student will discuss the interview.

Afternoons – Various divided between further lecture, free time to be used in completing assessments of assigned patients, completing assigned write-ups, etc. Some preceptors may invite students to their outpatient clinics.

### **Full Psychiatric Write-up:**

**Date:** 3/7/07

**Unit Location:** M5

**Patient Name:**      **Age:**      **DOB:**

**Sex:** M

**Residence:** Lives at Renaissance Plaza

**Race:** Caucasian

**Marital Status:** Single

**Education Level:** High School Diploma

**Occupation(s):** Unemployed, collects social security

**Sources of information:** Patient

**Details of Admission:** The patient is a 53-year-old, single, unemployed, Caucasian, male domicile with multiple psychiatric admissions, this one for swallowing objects.

**Justification of Hospitalization:** Swallowing objects, increasing auditory hallucinations and delusions.

**CC:** "I am hearing voices."

**HPI:** The patient was admitted to M5 after initially being brought in to the CPEP Unit on a 9.41 by the Binghamton Police Department. The patient was staying at the Renaissance Plaza when he started eating things, possibly rocks according to reports. He managed to grab some of the rocks from a vase at the Renaissance Plaza and he started eating them. The patient also stated that college students were coming into his room at night. He was getting bitten by them and he was felt threatened that they would chop off his toes. He said that his guardian angels were telling him to be on guard and defend himself from the college students with a fork and also with tweezers. In addition, he believes he is a CIA agent, working on drug busts. He also hears voices, sometimes the voices have been telling him to hurt himself, but he is not willing to follow those commands.

The patient was speaking to a third person while he was at Renaissance Plaza and also while he was in the ER, so he was responding to internal voices. The patient has a previous history of having been eating and swallowing foreign bodies. On his last admission in May 2006, he reportedly swallowed foreign objects because, "things and elements build up power." In addition, he was hearing voices at that time. At the time the patient was questioned about the reasons why he was eating the rocks from a vase, to which he responded "Well doc, you know what I am doing, why I am doing this. So, if you don't know, I don't know what to say. I want to go."

**Past Psychiatric History:**

This is a patient with a long history of schizophrenia with multiple admissions for swallowing objects, and altered mental status secondary to psychogenic polydipsia.

The patient's psychiatric history is significant for multiple psychiatric hospitalizations at least over 100 times (according to the patient).

His last admission to Binghamton General Hospital was in May 2006, when he spent at least two weeks. Prior to that, he had had several admissions to BGH.

In the past, he had been admitted to hospitals in Milwaukee and Colorado, and the Hutchinson Psychiatric Center in Trenton, New Jersey.

He claims that he attempted to commit suicide on a few occasions: He reports having jumped off a bridge in the past, and then on another occasion he jumped of a three-story building and ended up major injuries.

**Substance Use History:**

Alcohol use: Denies current or past alcohol use.

Smoking: Smokes 1 PPD, for over 40 years

Drugs: The patient states that he has been using marijuana for several years, his estimated consumption is about 2-3 times a week.

**Past Medical History:**

1. History of swallowing objects
2. Psychogenic Polydipsia
3. Scabies, started treatment with permethrin prior to admission
4. Hypertension
5. GERD
6. BPH

**Family Psychiatric History:**

The patient denies any psychiatric history in the family. Patient states that his family members are all successful people, with jobs and families.

**Family Medical History:**

Unable to obtain

**Allergies: NKDA****Current Medication:**

1. Lamictal 50 mg p.o. t.i.d
2. Abilify 30 mg p.o. q.h.s
3. Prolixin 10 mg p.o. qid
4. Geodon 80 mg p.o. b.i.d
5. Prolixin decanoate 50 mg IM q.2 weeks

6. Artane 5 mg p.o. t.i.d
7. Cymbalta 60 mg p.o. q daily
8. Ibuprofen 400 mg p.o. t.i.d. p.r.n
9. Avapro 150 mg p.o. daily
10. Benadryl 50 mg p.o. t.i.d
11. Prilosec 20 mg p.o. q h.s
12. Ferrous sulfate 325 mg p.o. b.i.d

**Past Legal History:** Patient denies any legal history.

**Developmental and Social History:**

The patient was born in Cortland, NY and was raised in Colorado. He was raised by both parents. He reports that his father died back in 1968. He has 3 siblings, 1 brother and 2 sister, both of whom he says are successful people with jobs and families. They all live in the area, but he does not maintain any contact with them for some unspecified reason. In addition, he has a history of aggression toward his cousin for an unknown reason.

He reports being a high school graduate, never having to repeat any grades. He worked several different jobs immediately after high school. In addition he took a few graduate level classes after high school but never finished the coursework.

When asked about his childhood he laughed and replied, "I really don't want to talk about that."

He does not have a support system as his father passed away, and he is not in touch with any of his remaining family. He has lived in Renaissance Plaza for at least three years.

**Review Of Systems:**

Constitutional: Denies fatigue, weight loss, fever, night sweats, malaise, arthritis, trouble sleeping.

HEENT: Denies visual problems, blurry vision, red eyes. Denies hearing problem, ringing in the ears, discharge. Denies nasal allergies, nose bleeds. Denies swollen glands, thyroid problems. Denies swallowing difficulty, frequent sore throats, speech problems

Cadiovascular: Denies chest pain, murmur, palpitations, angina, mitral valve prolapse, valve problems.

Respiratory: Denies asthma, shortness of breath, cough, history of TB

GI: Denies colitis, ulcer, gastritis, barrett's esophagus, polyps, constipation, diarrhea, vomiting, anorexia, bulimia

GU: Denies urinary problems, dysuria, frequency, burning, kidney stones

Neuro: Denies seizures, headaches, convulsions, fainting, ADD, stroke.

Hematologic: Denies easy bruising, spontaneous bleeding, blood clots, or lymphadenopathy

Endocrine: no cold or heat intolerance, no polydipsia, polyuria or polyphagia, no changes in skin or hair quality

Skin: no lesions/rashes.

Musculoskeletal: Denies myalgias or other arthralgias

Psychologic: See HPI and MSE

**Physical Exam:**

Vitals: Ht: 6' 0", Wt: 195 lbs TPR: 98.2 BP: 150/95

General: Well-nourished adult Caucasian male, disheveled, dressed in sweatpants and sweatshirt, in no acute distress, makes appropriate eye contact infrequently, communication is interrupted by thought blocking.

HEENT: PERRLA, EOMI; no ptosis or exophthalmos; sclera white, conjunctiva pink; no sinus tenderness on palpation; TMs clear and non-bulging, oro- and naso-pharynx pink and moist without exudate; no palpable cervical or submandibular lymphadenopathy; trachea midline; neck supple with no palpable goiter or thyroid nodules.

Cardiac: RRR; S1 and S2 heard; PMI palpable at 5th intercostal space along mid-clavicular liner; no murmurs, rubs, clicks, gallops or carotid bruits; no visible JVD.

Respiratory: equal bilateral respiratory expansion; no use of accessory muscles, CTAB, no wheezes/rhonchi/rales

Abdominal: ND/NT; normoactive bowel sounds heard in all 4Q; no audible rushes or high pitched bowel sounds noticed; no guarding or rebound tenderness; no ascites; no hepatosplenomegally on percussion; no costovertebral angle tenderness on percussion; no palpable AAA

Neurological: patient is right handed; alert and oriented to person, place, and time; CN's II-XII grossly intact; no visible muscle wasting, fasciculation, or myoclonus in upper or lower extremities; 5+ strength bilaterally; upper and lower extremity tone normal; pinprick, vibratory and light touch sensation in upper extremities and lower extremities intact; deep tendon reflexes 2+ bilaterally; cerebellar and coordination intact as assessed by finger-to-nose, romberg, rapid alternating movements, and heel-to-shin testing; gait and heel/toe walking normal

Extremities: upper and lower extremities warm to touch and normal color; 2+ radial and pedal pulses; no pedal edema bilaterally; no cyanosis or clubbing

Skin: without lesions, rashes or scaling.

**Admission Labs:** WBC 8.6, Hgb 14.5, Hct 40.2, Plt 408, Na 130 (L), K 4.9, Cl 97 (L), HCO<sub>3</sub> 28, BUN 26 (H), Cr 1.8 (H), Glc 92, Ca 9.4, Alb 3.8, alk phos 126 (H), AST 18, ALT 34, Total bili 0.5, Urine tox screen negative, TSH 1.16

**A. Psychiatric Problems**

1. Schizophrenia
2. Recent episodes of swallowing objects
3. Psychogenic Polydipsia

**B. Medical Problems**

1. Hypertension

2. Gastroesophageal reflux disease
3. Benign prostatic hypertrophy

### **C. Family Problems**

1. Unknown

**D. Social-Interpersonal Problems:** He does not keep in touch with his family.

### **E. Occupational Problems**

1. Unemployed

### **F. Educational Problems**

1. Has high school diploma, says to have taken a few classes after high school but did not pursue higher education.

### **G. Economic Problems**

1. Unemployed, collecting social security.

### **H. Ethnic Problems**-none

### **Psychodynamic Formulation:**

This patient's disease and symptoms are probably a result of spontaneous occurrence, as he has no family history of psychiatric illness, and all family members are successful people.

In addition, he was a well-functioning individual before his illness began, having finished high school, and attempting to take college-level courses, which he could not finish as a result of his illness.

### **Mental Status Exam:**

*Appearance*- The patient was dressed sweat pants and sweatshirt, appeared disheveled, had fair hygiene, poor grooming. Drinking a cup of coffee. The patient is responding to internal stimuli, talking to himself occasionally. The patient is not willing to cooperate much with this interview. He seems angry.

*Behavior* - The patient was slumped over with the hood of his sweatshirt on his head. He had slow movements, looked down at the floor often, had good eye contact when he looked up.

*Speech:* Patient had normal rate, rhythm and tone of speech.

*Thought:* Thought rate was slowed, taking several seconds to answer my questions, sometimes answering it appropriately, sometimes having to be reminded of my question (thought blocking), and sometimes answering it with an unrelated answer (loose associations). In addition, sometimes he has circumferential answers to questions.

*Language:* His native language in English and he is fluent in English.

*Depression*- 1/9 criteria met (depressed mood). Denies wakefulness from sleep, diminished interest, guilt, change in energy, change in concentration, change in appetite, psychomotor retardation or agitation, or recurrent thoughts of death/suicidal and homicidal ideations.

*Mania/Hypomania* – negative; no period of days to weeks when pt. felt unusually hyper, high, euphoric, or irritable; answered all mania questions as negative

### **Psychosis -**

Ideas of reference: not currently, in the past, or during admission

Ideas of influence: not currently, in the past, or during admission

Delusions of persecution: He believes college students were coming into his room at night. He was getting bitten by them and he was felt threatened that they would chop off his toes.

Delusions of grandeur: Believes he is as CIA agent, working on drug busts, etc.

Delusions of thought broadcasting/insertion/withdrawal: not currently, in the past, or during admission

Somatic delusions: not currently, in past, or during admission

Hallucinations: Hears voices coming from outside his head, who he refers to as his guardian angels. Says they say vulgar, sexual things to him, they also tell him to be on guard from people who may harm him. In addition, he sometimes he hears voices outside his head telling him to hurt himself, but he is not willing to follow those commands.

Illusions: not currently, in past, or during admission

*Judgment*: Judgment of everyday life situations was fair to poor.

*Orientation*: Patient was alert and oriented to person, place, time, and situation.

*Memory*: Immediate recall was good, delayed recall - patient correctly identified 1/3 objects after 3 minutes; recent and remote memory intact.

*Affect*: Flat with no lability.

*Cognition*: Cognition was poor, as he gave concrete interpretations of 6/6 proverbs. Patient identified similarities in 4 of 4 paired object sets.

*Insight/Motivation*: Insight was fair regarding current symptoms and circumstances. He knows that he has a mental illness and that no one else hears the voices he hears, but he still believes the voices are real and that he is a CIA agent.

### **Admitting Diagnosis:**

**Axis I:** Clinical Disorders / Clinical Attention needed:

#### DDx:

1. Schizophrenia
2. PICA
3. Schizoaffective Disorder
4. Bipolar Disorder

## 5. Major Depressive Disorder

### Primary Dx:

1. Schizophrenia – ruled in because he has several characteristic symptoms, including delusions of persecution, auditory hallucinations, disorganized speech, and flattening of affect (Criteria A of Schizophrenia). He also satisfies criteria B of schizophrenia (social/occupational dysfunction) as he could not maintain employment, and is not in touch with his family members. This has been going on for several years (Criteria C of schizophrenia), and these symptoms could not be explained by any other axis I disorder or general medical illness (Criteria D and E).
2. Pica – ruled in because he has persistent eating of nonnutritive substances for at least several months (meets Criteria A of Pica), and this eating behavior is not a culturally sanctioned practice (Criteria C of Pica), and it is severe enough to warrant independent clinical attention (Criteria D of Pica).

### DDx considered and reasoning behind r/o:

1. Schizoaffective Disorder: r/o because he only satisfies 1/9 criteria for depressive episode (and therefore does not satisfy criteria A of Schizoaffective disorder).
2. Bipolar Disorder: r/o because of lack of a manic or hypomanic episode (does not meet Criteria A of Bipolar disorder).
3. Major Depressive Disorder: r/o because he only satisfies 1/9 criteria for depressive episode (and therefore does not satisfy criteria A of MDD). In addition his symptoms satisfy criteria for Schizophrenia (does not meet criteria for criteria B of MDD)

**Axis II:** None identified

### **Axis III:** General Medical Conditions:

1. Recurrent episodes of swallowing objects
2. Psychogenic Polydipsia
3. Chronic scabies, under treatment at the present time.
4. Hypertension
5. Gastroesophageal reflux disease
6. Benign prostatic hypertrophy

**Axis IV:** Psychosocial and Environmental Problems: Limited primary support system in the area, chronic mental illness, unemployment

**Axis V:** Global Assessment of Functioning: 25 severe

### **Admitting Treatment Plan:**

Admit to M5 and provide safe environment  
Group and individual psycho therapy  
Regular diet

1. Admit the patient to Psychiatry, Memorial 5, on a 9.39 legal status.
2. Regular diet
3. Increase Prolixin decanoate from 50 mg to 6.25 mg IM q.2 weeks

4. Benadryl is going to be discontinued after the scabies is properly treated.
5. Otherwise continue current medications
6. Dermatology consultation requested to evaluate the patient for chronic scabies.
7. Individual and group psychotherapy
8. The patient was encouraged to be compliant with medications.

## 7. Medicine

Typical Day – Inpatient at Wilson (Guthrie is similar but varies depending on your service (GI, Heme-Onc, Infectious Disease, Renal/Pulmonary):

Prerounds: come in around 6:30, before the sign-out (see below) and obtain the vitals, labs for your specific patients and if you have time, go in and check on each patient...ask them how their night was, do a quick physical exam, ask the nurses if anything happened overnight.

Sign out (7am): Night float resident fills in the teams about overnight admissions, problems, etc. Take on new patients if assigned.

After sign-out: continue to see your patients, prepare for morning rounds.

Morning Rounds: with your interns, residents and attending, walk from patient to patient, discuss the patient's status, treatment plan, etc.

Morning Teaching Rounds: All of the teams assemble with several attendings and one patient is presented, the group participates in making differentials, thinking about treatment plans, etc.

Notes: you are responsible for writing a detailed SOAP note on each of your assigned patients-see sample SOAP note.

Follow-up: this includes checking on labs that were not back in the morning, checking the results of diagnostic tests such as ultrasounds/CT/MRI, completing discharge paperwork, and making sure you are aware of any problems your patient's may have had during the day.

Admissions: go down with your residents and help them admit patients by obtaining H&P's and helping them with admission orders.

Afternoon Rounds: Once or twice a week there is a second set of rounds "teaching rounds" in which attendings go around and show you interesting physical exam findings, or they teach you some basic core medical knowledge in sit down type of setting, or they may have you present an interesting patient.

### Books Used:

Text book: Cecil's Essentials of Medicine (GREAT text for reading up on your patients)

Review books: Kaplan, First Aid,

Question Books - Kaplan Q-Book, Appelton & Lange, Pre-test, BRS

Pocket Contents: Stethoscope, penlight, reflex hammer, maxwells, pharmacopoeia, sanford antimicrobial guide.

## Medicine M3 Progress Note

**S:** Patient still complaining of intermittent abdominal pain and LE pain b/l. Rates the pain as 7/10. Denies any chest pain (CP), shortness of breath (SOB), or cough. Denies nausea/vomiting, diarrhea or constipation. Denies fevers, chills or night sweats. No complaints of headache or dizziness. Patient is sleeping well and taking good po. Has not gotten out of bed.

**O:** Tm 37.7, BP 130/80, P 65, RR 20, O2 sat 96% on 2L  
In/Out: 1200/800 plus 2 bowel movements (BMs) in 24 hrs, Urine output: 156cc in last shift.

**General:** Patient lying comfortably in bed, awake, alert, and oriented to person, place, time (AAA x 3). Appears to be in no acute distress (NAD)

**HEENT:** Pupils equal, round, reactive to light and accommodation (PERRLA), Extraocular muscles intact (EOMi). Mucus membranes moist (MMM), no exudates or erythema noted. No cervical or supraclavicular lymphadenopathy (LAD). No carotid bruits or JVD.

**CV:** Regular rate and rhythm (RRR); S1 and S2 heard, No rubs or gallops.

**Pu1m:** Decreased breath sounds in base bilaterally (b/l). Exp wheezes in apices b/l. L>R. No rhonchi or crackles (r/c). No use of accessory muscles.

**Abd:** Soft, nontender (NT), nondistended (ND), positive bowel sounds in 4 quadrants (+ BS x 4), no rebound or guarding.

**Ext:** No clubbing, cyanosis, edema (c/c/e). 2+ dorsalis pedis (DP) pulses b/l. Warm, well perfused.

**Neuro:** No focal motor or sensory deficits noted.

Labs: 

140	100	10	}
2.1	25	1	
			130

9.0	2	180
		36

**A/P:** Patient is a 54 y/o black male with a h/o of sickle cell disease, COPD and DM Type II presenting to the ER with increasing SOB and admitted for COPD exacerbation. Hospital day #3 (HD# 3)

1. COPD - Patient continues to have exp wheezes and decrease breath sounds – Continue with solumedrol 20 mg N q 12 hrs, and will consider prednisone taper in 1-2 days if patient's condition is improving. Continue with nebulizer treatment prn for SOB.
2. Hypokalemia: Replace KCL 20 mEq x 2 today only and recheck BMP in a.m
3. Diabetes: Continue regular insulin sliding scale, continue on 1800 cal ADA diet.
4. Abdominal pain – Possibly secondary (?/2°) to SC crisis (?/2° hypoxia). Will continue with protonix 40 mg qd. Guiac stools x 3. Zofran 4 mg po for n/v. Will call GI for consult.
5. Lower extremity pain - Possibly secondary (?/2°) to SC crisis (?/2° hypoxia). Will start morphine drip for pain control. Will get lower extremity doppler to rule out (r/o) DVT.

## 8. Surgery

### Typical Day - Binghamton

You are assigned one preceptor to work with. There are no residents.

Lecture at 7am. After that, your schedule is your preceptor's schedule. If he has surgery, you scrub in, if he has clinic, you observe him there. Visit patients and write notes per his instructions.

### Typical Day - Guthrie

Surgery at Guthrie is divided into three separate services:

- Trauma/Breast
- Vascular
- General

During your 6 weeks you will spend 2 weeks on each service. This offers you the opportunity to see the full spectrum of surgery as opposed to Binghamton or Syracuse where your experience will depend heavily on which preceptor/team you are assigned too.

The days typically started at 6 am with rounding for about an hour (students carry 1-3 pts), followed by a lecture from 7 to 8. Most days are spent in the OR, with about 2 or 3 half days a week being spent in clinic.

There is a resident's conference every day at noon with lunch provided.

Student involvement in the OR is somewhat varied, but generally pretty good, a lot of suturing/closing, but also a lot of retraction.

The environment is generally very friendly without too much "malignancy". You'll generally be back to the "motel" (they provide you with housing) between 5 and 7 just about every night. As you get more comfortable there, you get better at finding time to yourself to study during the days.

If you are a Binghamton student interested in a surgical field I would recommend that you do your rotation at Guthrie as it gives you an opportunity to see what the residency/training is like at a somewhat more academic institution.

#### Books Used:

Surgery Recall – EXCELLENT for the wards and OR. Most pimping questions you will get come directly out of this book. Review it before going in on a case.

Review Books - Kaplan Surgery (very good), BRS Surgery / Lawrence's Essentials of General Surgery (very long but very detailed)

Question Books - Kaplan Q-Book, Appelton & Lange Surgery, Pre-test, BRS

#### Pocket Contents:

SURGERY RECALL (carry it!), Pharmocopeia, Maxwell, pens, stethoscope, pen light, exam gloves

### Surgery MS3 Progress Note POD#1

- S:** Patient without complaints. No problems overnight. Minimal pain over incisional area. +flatus, no bowel movements. Tolerating clears. Has been out of bed and ambulating.
- O:** T: 37.5-->37.0 BP: 120/72 P: 74 RR: 20 O2: 98% on room air (RA).  
In/Out: 1200/800 in 24h. Urine output: 400cc in last shift.  
ALL DRAIN OUTPUTS: eg. JP, NG, Hemovac, Pleurovac, etc.  
**General:** Patient awake, alert, oriented, in no acute distress (NAD)  
**HEENT:** Extraocular muscles intact (EOMi), Pupils equal, round, reactive to light and accommodation (PERLLA), neck supple  
**CV:** Regular rate and rhythm (RRR), no murmurs, rubs or gallops (no m/r/g)  
**Lungs:** Clear to auscultation bilaterally (CTAB)  
**Abd:** Soft, non-tender (NT), non-distended (ND), Positive bowel sounds in 4 quadrants (+BS x 4), no guarding, rebound.  
**Incision:** Clean/dry/intact  
**Ext:** Warm, well perfused. No clubbing, cyanosis, edema (no c/c/e). Dorsalis Pedis (DP) and Anterior tibeal (AT) pulses 2+ bilaterally

Labs: 

140	100	8
4	24	0.8

9.0	13	200
	40	

**A/P:** Pt is a 54 y/o female s/p lap chole post-op day #1 (POD#1)

1. Pt. stable and afebrile
2. Will advance diet as tolerated (ADAT)
3. D/C foley
4. Encourage out of bed (OOB) and ambulation
5. Encourage pulmonary toilet (inspirex)
6. Pain well controlled – continue 1-2 tabs percocet q6h prn
7. Will discuss d/c planning with attending.

### Surgery H&P

(One full H&P is to be written every week of the elective, handed in to Dr. Bogdesarian)

#### Date of elective surgery 9-6-05

This patient was introduced to me in the OR, on the day of the Endovascular AAA. On POD#1 I interviewed her and I will write the H&P as if she presented in the clinic for an evaluation and then write a post-op surgical note.

**CC:** 83-year-old female presents to the clinic for an evaluation of her abdominal aortic aneurysm.

**HPI:** Patient is an 83-year-old woman who has had an aneurysm, identified 4 years ago by her primary care physician after he administered radiological imaging for her lower back pain. Dr. Anderson has been following the aneurysm's growth twice a year by ultrasound over the years and the patient's most recent imaging studies reveals that it has grown to 5.3 cm. She does not have any abdominal pain, nor is she conscious of an abdominal mass. She is anxious about the presence of the aneurysm and would like to fix it surgically.

**PMH:**

1. Abdominal aneurysm – dx 4 years ago, followed by Dr. Anderson 2x/yr
2. Arthritis in right knee and back - dx by primary care doctor 6 months ago
3. Cervical cancer – at age 36, required TAHBSO, disease-free ever since
4. Osteoporosis – ob-gyn dx by bone density scan 5 years ago
5. Carcinoma of the vocal cord – 20 years ago, required 38 radiation treatments, has been disease-free.
6. Hypothyroidism – dx 5 years ago
7. Hypertension – dx 15 years ago, well controlled with meds
8. Glaucoma OU – dx 15 years ago. Lost vision in right eye from progressive glaucoma. Left eye IOP and vision is well controlled with drops, goes to ophthalmologist regularly for check-ups.
9. Cataracts OU – 20 years ago she had intraocular lenses placed in both eyes.

**Meds:**

1. Celebrex – 200mg p.o qdaily
2. Bisoprolol/ HCTZ - 2.5/6.26mg PO qdaily
3. Darvocet N 100mg 1 tab p.o q4h prn (back pain)
4. Pilocarpine - 1 gtts bid (OS)
5. Docusate sodium – 100mg PO qdaily
6. Miralax - 17g p.o qdaily

**Allergies:**

Sulfa - causes hives  
Floracine – causes nausea  
Erythromycin – causes nausea  
Biaxin – causes diarrhea  
Percocet – causes dizziness, nausea and itchiness  
Hydrocodone – causes numbness of hands

**PSH:**

Total abdominal hysterectomy & bilateral salpingo-oophorectomy (TAHBSO) - age 36 for cervical cancer.  
Radiation therapy for vocal cord carcinoma - 20 years ago

Cataracts – 20 years ago  
Breast biopsy – at age 24, benign finding  
Tonsillectomy – at a very young age  
Appendectomy - at age 19

**SH:** Patient is a retired receptionist from Binghamton General Hospital. She quit smoking 22 years ago and has not smoked since. Prior to that she smoked a pack and a half for 43 years. She also drinks 3 glasses of whiskey every night at supper. CAGE negative. In addition, she swims for exercise for 1 hour 3x/week.

**FH:**

Father died of laryngeal carcinoma at age 76  
Mother had breast cancer and died of an MI at age 90.  
Youngest daughter died at age 45 from breast cancer.  
Older daughter is well.

**ROS:**

General: She has no recent change in her weight, fever, chills or sweats or fatigue.  
Skin: Denies any rashes or moles.  
Head: Denies headaches  
Eyes: She has glaucoma but denies any acute visual change. She has diminished vision in the right eye resulting from the glaucoma chronically.  
Ears: Denies hearing loss, tinnitus, vertigo, earache  
Nose: Denies rhinorrhea, stuffiness, sneezing, itching, allergies  
Mouth, throat, neck: Denies bleeding gums, hoarseness, sore throat, swollen neck  
Breasts: Denies skin changes, masses/lumps, pain discharge  
Respiratory: Denies cough, shortness of breath, wheezing, hemoptysis.  
CV: History of hypertension, but well controlled with medications. Denies exertional chest pain, murmurs, angina, palpitations.  
GI: Denies nausea, vomiting, diarrhea, constipation.  
GU: Denies urgency, frequency, hematuria.  
Vascular: Denies leg edema and claudication.  
Musculoskeletal: Complains of chronic back and knee pain.  
Neurologic: Denies loss of sensation/ numbness, weakness, tingling, tremors.  
Psychiatric: Denies stress, depression or anxiety.

**PE:**

**Physical Exam:**

Vitals (taken from preop report): T: 97.1, P: 72, RR: 20, BP: 120/60, O2: 97% on RA  
Height: 5 foot 6, Weight: 150 lbs.  
General Appearance: Well-nourished female; does not appear in any distress.  
Head: symmetric; without deformity, masses, or tenderness  
Eyes: conjunctivae are without erythema or discharge; sclera are white.  
Nose: straight; without deformity; mucosa is pinkish-red and not edematous; nasal airway is patent

Throat: pharynx is pink and moist, without erythema, exudates, or tonsillar enlargement; there are no oral mucosal lesions

Neck: No JVD, no carotid bruit, trachea is midline, no thyromegaly.

Chest: symmetric, without deformity or tenderness; respiratory excursion is equal bilaterally

Lungs: good air movement bilaterally; lungs are clear to auscultation, without crackles or wheezes

CVS: regular rate and rhythm, with normal first and second heart sounds; no murmurs rub, or gallops;

Abdomen: Soft with a large, palpable nontender aneurysm.

Extremities: No cyanosis, clubbing or edema

Vascular: Carotid, radial, femoral, popliteal, DP and AT pulses are palpable, equal bilaterally.

Neurologic: She is without focal deficit.

### **Pre-op labs (8-30-05)**

WBC: 6.4, Hb:14.5, Hct: 42.6, Platelets: 214

Na: 139, K: 4.7, Cl: 99, CO<sub>2</sub>: 26, Glucose 110

BUN: 26, Creat: 1.8,

Abdominal CT (8-5-05): Infrarenal suprailiac aneurysm with maximum diameter of 5.3cm. The abdominal aorta in the infrarenal location measures approximately 2.3cm. The right common iliac artery is calcified and has a maximum diameter of approximately 1.6cm. The left is smaller in size measuring approximately 1.4cm. There is no evidence of active extravasation or aneurysm leak.

Chest x-ray (Aug 17): WNL,

EKG (Aug 17): normal sinus rhythm

**Assessment and Plan:** The patient presents with 5.3 cm abdominal aortic aneurysm.

1. Discuss alternatives for treatment – conservative management, open surgical repair, endovascular repair.
2. She is a candidate for endovascular repair since optimal anatomy includes an infrarenal neck that is at least 15 mm long and less than 26 mm in diameter (hers is 23 mm). In addition, the diameter and length of the iliacs provide adequate attachments for the graft.
3. Discuss risks of endovascular repair which include: 3% mortality risk, the risk of bleeding, infection, distal atheroembolization, renal failure, mesenteric ischemia and the possible need to convert to open surgery to properly complete the operation.
4. The patient understands and wishes to proceed. Surgery is scheduled for 9/6.
5. Since she has some renal insufficiency (high baseline BUN and creat) to prevent renal injury we will take the following measures:
  - o Limit the amount of contrast given perioperatively
  - o Administer mannitol perioperatively (1 dose 1 g/kg IV). Mannitol is thought to provide renal protection by increasing tubular flow by augmenting filtrate volume through its osmotic diuretic effect.
  - o Administer mucomyst (600 mg po bid x2d) post-operatively for radiocontrast-induced nephropathy prophylaxis

## **Surgery Progress note POD # 2**

### Subjective:

Patient resting in bed, minimal pain over incisional area. No problems overnight. +flatus, no BMs. Tolerating solid food. Has been out of bed and ambulating with assistance. Foley was removed yesterday, she voided several times throughout the night.

### Objective:

T: 97.2, BP: 115/60 P: 73 RR: 22 O2: 100% on RA.

I/O: 1200/800 in 24 hours

Urine output: approximately 280 in last shift

HEENT: EOMI, neck supple

CV: RRR no m/r/g

Lungs: CTAB

Abd: Soft, tender around incisional area, non-distended, +BS x4, no guarding, rebound.

Groin Incisions: Clean/dry/intact, some ecchymosis around incisions.

Ext: Warm, well perfused. No clubbing, cyanosis, edema. DP and AT palpable

### Labs:

WBC: 7.3, Hb: 11.0, Hct: 32.3, Platelets: 176

Na: 134, K: 4.4, Cl: 101, CO2: 26, Glucose: 126, BUN: 24 (baseline), Creat: 1.7 (baseline)

Assessment/ Plan: Pt is an 83 y/o female s/p endo AAA POD #1

8. Pt. stable and afebrile
9. Encourage OOB and ambulation
10. Pain well controlled – continue pain management regimen
11. Will discuss d/c planning with attending.

## 9. Geriatrics