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SCHEDULE-

DAILY
1. Rounds depend on the senior and on how many patients are on the list. With BP my rounds would start anywhere from 5:45 to 7:00 am. Pretty basic stuff on rounds, only they prefer the R2 ENT resident to write notes on certain patients; so don't get offended if they take the chart away and give it to the R2.

2. After rounds I'd usually park in the resident's room and put in all the orders and then sneak into the OR until I started getting paged for consults.

3. The day gets passed in a haze of consults/ chores/ OR time.

3.5 you will be called uPon to Assess patients In dr. kellmaN's clinic for h&p's on preop patients. this takes about 15 min max. (my opinion of this part of the day is in capital letters in the first sentence of this entry.)

4. Around 3.00 pm they'll fax the OR list for the next day from the OR to the clinic. Take this and enter the Pre Op patients into the database for the list so that they appear as PREOP. Enter all the information including 'Procedure Performed' as the surgery they'll have tomorrow. For scut write POC and the time of their surgery.

5. Try and update the list as you get consults because it sucks to be doing it at 5.50 when everyone wants to leave.

WEEKLY

1. Grand Rounds- are Wednesdays from 7.00 am to like 10.00 am. They usually have an R3 or R4 presenting and then they have a massive pimp session (don't worry they never ask you anything). Then they go over to the ROC to have teaching conference / M&M which is much more casual.

2. Call: you NEVER have call. You have to come in on Sunday and round with the chief. Otherwise you have the whole weekend off.

3. Clinic Schedule: Clinic is good because they'll let you do scopes and small procedures like abscesses and small lesions. Clinic is Every Hour of Every Day. I'm not joking. You can always be put to good use in the clinic.

CONSULTS

General:

1. I'd usually go to the ED, pick up a billing card and put a sticker on it. Then I'd flip to the nurse's intake page in the ED chart and write the vitals under the sticker on the card. then look at labs and imaging first and write them on the card. Then see the patient and take a history and write the pertinents on the card. The Card is what I'd dictate my notes from. Otherwise, if the pt was getting admitted I'd take a Progress Note and start writing all this crap on it so that I could just stick it in the chart with a plan once I knew what the plan was.

2. Run up to the OR and review the consult with the chief: he'll give you the beginnings of the plan and you execute.

3. Sometimes decisions will be deferred until someone comes out of the OR to review the case.

Specific consults: NPLs, Lacerations, Trach, and Fractures will be addressed later. Or just do "Find on Page" from the "Edit" menu and you can get there.

History: Good H&P as you can certainly do better than I. Focus on the following ENT elements: (pharynx is where the GI tract and Resp tract meet so both)

Airway:
Dyspnea, Snoring, apnea, stridor, stertor, coughing, throat clearing

Nose
nasal drip, nasal discharge, anosmia, hx of trauma, snoring, bleeding

GI Function
dysphagia, odynophagia, choking, gagging

Voice
Pitch, duration of note, aphonic gaps, whispering,
quality: breathy, raspy/gravely, deep, broken

Record the exposures clearly. They're big on occupational exposures and the usual social exposures.

PMHx, SxHx, Meds, Allergies, Fam Hx as in any other consult.

SPECIFIC CONSULTS:

1. Tracheostomy consults. Typically from MICU or Neuro ICU because the Trauma surgeons do the trachs in SICU. Here's the deal.

The indication for tracheostomy is respiratory failure or ventilatory failure or airway protection failure in its myriad forms. In ENT they're very specific about what needs to happen before they even SEE the patient:

1. Pt has been intubated 14 days or more.
2. Pt has failed weaning attempts or extubation attempts at LEAST twice.
3. Pt's Family has been made aware of the possibility of a Tracheostomy by the PRIMARY team.

Once all of these criteria are met then you go see the patient. Here's a format that a chief told me was good:

History: 2 sentences about what brought the pt to the hospital. The rest should document their attempts at weaning or extubation, the crappy ABGs they've had etc. (i.e. focus on hospital course with respect to vent needs)

Vitals:

Vent Settings: Document PIP (high is indication for trach)
Document PEEP
Document Rate, FiO2, Tidal Vol, & Mode.

if you feel comfortable then you can do a Spontaneous Breathing Trial while you're seeing the patient:

-Record the pt's vent settings
-Switch the vent to SPONT
-Watch for a minute or two minutes to see how Tidal Volume drops, Rate goes up, PIP goes up etc.. all the signs of ventilatory failure.
-Then record the new numbers and switch the pt back to the prior mode
-The PIP, PEEP, Tv and RATE on SPONT are more supporting or detracting data for the need for the trach.

DON'T do this if you haven't done SICU with Lopez and been shown how to do this without killing the patient.

On Exam: Head: Document trauma

Nose: is there an ET Tube? Is there an NGT. Is there alar necrosis

Mouth: ET Tube size in cm, depth in cm, which commissure it's in. Comment on whether there's an airleak when the cuff is down. Comment whether the cuff is inflated or deflated. teeth, toungue, trauma, palate. Try and estimate the Mallampati.

Neck: Length of neck. Comment if short and fat. Thyromental distance. Comment whether Thyroid & Cricoid cartilages are palpable or not. Comment whether normal laryngeal crepitus is present.

Resp: comment on lungsounds. that's pretty much it.

Labs: ABGs are relevant. Recent Coags are relevant. CBC for recent infection. BMP for renal clearance of anaesthesia.

Imaging: no real need to get any.

Assessment: say whether or not you'll do it

Plan: schedule for tracheostomy to discuss with team.

Consent: The benefits of Trach (for patients): Ease of weaning- liken breathing through ETT as breathing through a straw, it can get tiring. So a trach is a shorter straw. Temporary- it usually comes out in 6-10 weeks. No further need for sedation- this is a big one. No pressure on Larynx.

The risks of Tracheostomy: Infection, Bleeding (mention big vessels in neck), Injury to anatomy: vagus nerve, esophagus, larynx, thyroid. And as always... anaesthesia.

SCOPE CONSULTS:

Dysphagia, hoarseness, stridor, pharyngeal trauma all indications for the Flexible scope.

1. Get the OR scope from the back hallway.
2. Stamp or sticker a card and stick it in the box with the scope. (for when you give the scope back to the OR and they have something to bill from.
3. Go down to the clinic and grab the video machine from the storage room.
4. Get Ron to show you how to hook the two things up
5. Go to town.

Here's what you comment on in Naso Pharyngo Laryngoscopy. I'd just report on whether you visualize the structures, and whether they were normal or bleeding or edematous etc:

Nasopharynx- mention the mucosa, any trauma, masses, mucus, exudate

Adenoids
Posterior Pharynx- same items as nasopharynx
Base of Tongue
Valleculae
Epiglottis
Aryepiglottic folds
Arytenoid
Pyriform
Posterior Cricoid
False Vocal Cords
True Vocal Cords- abduction/adduction. Mention paralysis
With the cords in view have the patient say "EEEEE" and "MEMEMEMEE"

LACERATION CONSULTS
Carry some Lido in your pocket.
See the patient. Assess whether you can do it alone or not.
Hose it down with some saline.
Numb it up with the lido in your pocket
Then take the hx, vitals, and a picture with your camera phone up to the OR to show your chief and ask if you can just do it with the NP or alone.

FACIAL FRACTURE CONSULTS
These are usually 'Radiological Consults' in the sense that ED or Trauma notice the thing on a CT scan and then call you. But you should still see it as if you were evaluating it clinically. Remember the only Urgent OR for these is when there is ExtraOcular Muscle Entrapment. Even Mobile Midface fractures are left until the patient is otherwise stable. Here's what you do:

Orbital Fractures
Hx
Mechanism of injury
Visual Changes
    visual acuity loss
    diplopia
    extraocular movement restriction
Facial Numbness
Vagal Symptoms (oculocardiac reflex)
Other injuries

Ph Ex

Inspection
Face: Symmetry
    Proptosis
    Enophthalmos
    Ocular dystopia

Intercanthal distance
Ptosis
Globe: Extrusion
Tear shaped pupil
hyphema
Chemosis

Palpation: Zygomatic Arches, Malar Eminences, Orbital Rims, Frontal bones

Nerve Testing: Visual Acuity, EOMS, Facial Sensation, Facial Motion

Structures
Supraorbital Nerve
Globe
Extraocular Muscles
Facial Nerves

For the rest of the face: Wiggle the Nose bridge. Grab the upper incisors with one hand and the forehead with the other and wiggle the midface. Comment on stability, crepitus, mobility etc.

HOARSENESS CONSULTS:
Hoarseness:

Function of Larynx:

1. Voice generation as exhaled air interacts with vocal cords.

2. Airway protection from ingested materials by laryngeal elevation, epiglottic deflection, and false and true cord closure.

3. Cough production by transient glottic closure which allows increased intrathoracic pressure--> rapid glottic opening during cough facilitates upward movement of air and tracheal contents.

Anatomy

hypopharynx
epiglottis--> aryepiglottic folds
thyroid cartilage
cricoid cartilage
pyriform sinuses
false vocal folds
ventricles
true vocal cords

arytenoid
corniculate
thyroarytenoid muscle
cricoarytenoid muscle

Recurrent laryngeal nerve
Superior laryngeal nerve

Phonation: interaction of exhaled air and approximated cord
true vocal cord mucosal wave
pitch -- cord length
loudness-- air pressure
articulation in anterior pharynx tongue teeth and lips.

Clinical History

Duration
Pattern of Onset
Triggers: vocal abuse, urti, allergens, toxins
Other head and neck symptoms:
Resp distress
Stridor
Cough-- full cough hx (pneumonia, gerd, asthma, sinusitis, subglottic stenosis)
Hemoptysis
Ear Pain
Throat Pain
Dysphagia
Odynophagia
Weight loss
Exposure History
Smoking
EtOH
GERD
Vocal use Pattern
Thyroid Sx
Radiation Tx
Base of Skull Sx
Mediastinum Sx

Physical Exam
Voice Quality:
coarse, rough, gravelly, husky---> irregular medial phonatory surface
weak, breathy--> paralysis (persistent glottic gap)
wet, gurgling, full, hotpotato--->peritonsilar abscess with supraglottic salivary pooling
Loss of vocal range with cracking--> muscle tension dysphonia vs strain
Intermittent aphonia, whispering--> psychogenic, spasmodic

Respiratory pattern and comfort

2 weeks of hoarseness: laryngoscopy-- look at
laryngeal surface of epiglottis, pyriform sinus, post cricoid region

Etiologies: Any disruption of the vocal cord surface and motion can cause hoarseness

Acute Laryngitis- Viral URTI- rhinorrhea, cough, sore throat
Vocal Strain- submucosal cord hemorrhage and edema
Self limited
Humidify, hydrate and voice rest
Moraxella Catarrhalis, H. Flu-- but don't treat
Don't use steroids

Chronic Laryngitis: Chronic irritants
GERD
Sinusitis
EtOH
Strain

GERD- hoarseness may be presenting complaint. May not have esophagitis.
Antisecretory therapy: response in 8 weeks
Head of Bed, EtOH, Smoking, Supine position,

Laryngopharyngeal Reflux: treat with PPI

Vocal Hyperfunction/ Muscle tension dysphonia:
strain, excess tension, recruitment of counterproductive mechanisms--> structural lesions like polyps, ulcers and granulomas.

Spasmodic Dysphonia:
focal laryngeal dysphonia.
excess adduction
voiceless gaps in speech (esp in vowels)
Use botox

Poypoid Corditis: Reinke's Edema
Middle Aged
Female
Smokers
bilateral erythema and edema of cords
cords- redundant, floppy and bag like (like a middleaged smoking chick)
Associated with: GERD, EtOH, Hypothyroidism
Therapy and surgery

Polyps
Structural manifestation of chronic cord irritation
Smoking, GERD, Muscle Tension Dysphonia,
submucosal hemorrhage and assoc. edema
Anterior 1/3 of cord
Can ball valve if big enough.

Nodules
vocal cord callus from chronic vocal microtrauma. Occur at point of maxvibration.
Women, children, bartenders, cheerleaders
Correct the strain pattern

Conversion disorders
Paradoxical Vocal Cord Motion-- mistaken for asthma

Paralysis
Unilateral: paramedian cord position. weak breathy voice, rarely airway complaints,
poor cough
aspiration

Etiologies: Base of skull tumor
neck tumor
mediastinum tumor

Trauma
Thoracic aneurysm

Iatrogenic: thyroid sx
Skullbase surgery
Polio, MS, Vasculitis

Bilateral- normal voice, resp distress. Thyroid surgery in PACU