INBOUND

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From the editors:

Welcome to the second issue of Inbound Magazine! We hope you enjoyed the inaugural issue, and have received great feedback from many of you.

We also have good news to report. We are in the process of expanding the publication to include NMC San Diego Emergency Medicine, with Hermann Gonzalez (Chief Resident) and our own Gerald Platt taking on the role of West Coast Editors. Pending approval, we expect to see their contributions beginning with issue three.

In this issue, our feature article explores an issue that almost everyone is familiar with, but that we rarely talk about: VIP Syndrome. We've all experienced it. Unfortunately, it happens all too frequently where a person of a certain stature or with "connections" actually receives substandard care because of the undue attention on them. From the medical treatment aspect, there is little we should do differently for these patients. From the patient care and interpersonal standpoint, we just need to be aware of the favoritism or biases we may have, and take steps to avoid showing that favoritism, and most importantly providing the patient with the privacy and relative anonymity they deserve.

For you history buffs, the cover photograph should be recognizable as the Flying Ambulance invented by Baron Larrey, the Surgeon-in-Chief of Napolean's armies. His revolutionary method of rapid patient transport and treatment served as the foundation for modern operational military medicine.

We hope you enjoy this issue! Remember, this publication is about us, for us, and is only possible with your help. Please give us your feedback, and most importantly, your stories.

– *Todd and Dave*

INBOUND is a quarterly publication to improve patient care in Navy Emergency Medicine. Stories occurred in both Navy and civilian emergency departments worldwide. For more information, or for submissions, please contact the editors at todd.parker@med.navy.mil.

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Have an interesting story, anecdote, medical humor, or cover photo? Email to todd.parker@med.navy.mil

THE VIP SYNDROME:

SOMETIMES IT IS WHO YOU KNOW

LCDR Todd A. Parker, M.D.

The junior resident picks up the chart from the rack. The triage sheet states that the patient is a 52-year old male with 12 hours of abdominal pain and intermittent vomiting. He is in town for a conference, and did not feel well enough to go to his meetings today so came to the Emergency Department, as he doesn't have a local physician.

After seeing the patient and ordering some labs, she presents her findings to the attending physician: a 52-year old male with vague abdominal pain, a tender but non-focal abdominal exam , no fever, normal urine, a normal acute abdominal series, and a normal white blood cell count. The attending physician hears the presentation, briefly sees the patient and agrees with the resident's assessment: abdominal pain, likely gastroenteritis, which can likely be safely managed at home symptomatically with thorough precautions to return to the emergency department for any worsening or signs of appendicitis. Then he notices something at the bottom of the chart: the patient is a Marine Corps Lieutenant General. Count 'em, three stars. Realizing the ramifications of making the wrong diagnosis, he begins to second guess his decision. Even though he still doesn't think that it is appendicitis, he orders a CT scan, in which the appendix is not visualized. Still second guessing his initial impression, he requests a surgery consult. He advises the surgery resident of the patient's rank, and the surgery resident states that he is going to call his chief resident.

Within minutes, the surgery chief is in the patient's room to examine him, and the surgery attending, who was immediately called by the chief resident, arrives minutes later. They examine the General, and advise him that they cannot be certain that it is not appendicitis, and that they'd like to admit him overnight to observe him. The General, already growing impatient from what is now almost six hours in the Emergency Department, is clearly annoyed that he may spend the night in the hospital and still not have a definite diagnosis. He demands that if there is a chance that it is appendicitis, they just take him to the operating room and "get it over with". The surgery attending reluctantly agrees, and takes the general to the operating room, where a normal appendix is removed. The general is discharged the next day, but unfortunately 5 days later develops a wound infection requiring readmission and 3 days of IV antibiotics.

Another case: the wife of a physician colleague comes into the ED with several days of worsening pelvic pain. She has also had some midcycle bleeding the last 2 weeks, and the pain has progressed to a chronic ache. She denies any sexual activity in the last several months since her husband is deployed. She minimizes her symptoms to the Emergency Department attending, and suggests that perhaps it's just her hormones. The ER attending is also reluctant to do a pelvic on the patient, since he occasionally socializes with her and her husband. They mutually agree to try a course of estrogen, and if she doesn't improve she will follow up with her Gynecologist.

She takes the estrogen, the bleeding resolves, and the pain seems to improve but never really goes away. She continues to minimize, until two months later when the pain is getting worse again and she finally goes to her OB/Gyn, where the diagnosis of invasive cervical cancer is ultimately made.

What do these cases have in common? Both patients were "VIPs"…and both received suboptimal care. VIP syndrome was first identified in 1964 in an article by Dr. Weintraub, and has been identified in many articles since then

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(1). The difficulties in caring for these types of patients are very real. As stated by the Israeli doctors who cared for Israeli Prime Minister Ariel Sharon after a devastating intracranial hemorrhage:

"*The VIP syndrome is characterized either by decisions to minimize the number of diagnostic and therapeutic procedures or, alternately, to work-up every minor abnormality to appear very thorough. Another aspect of this syndrome is fragmented care, i.e., care by multiple specialists each focusing only on their area of expertise."(2)*

Many hospitals maintain lists of VIP's. The Dallas News reported in 2007 that the state-sponsored, taxpayer funded UT-Southwestern keeps a VIP-list, and if anyone on this list comes to the hospital for any reason, they get a special parking spot, escorts to wherever they need to go, and special physician's meet them in the emergency room to coordinate their admission (3,5).

Navy Medicine, while not maintaining VIP lists or providing the amenities above, can still provide preferential treatment. Most caregivers are acutely aware when a Flag Officer is being treated in the hospital. While there are no policies directing different care, it is inevitable that these individuals may receive more attention then the average sailor or dependent. These patients often have additional, unnecessary testing done, or alternatively may have essential elements of the workup omitted to avoid embarrassment or make the patient uncomfortable.

The reality, however, is that these patients are rarely uncomfortable when receiving standard care. Despite their stature, they are human beings and are subject to the same fears, hopes, and most importantly biology as the rest of us. What most really want is appropriate care, not special treatment.

As Dr. Block states in his article in Chest, "It is necessary for the attending physician to take command and lay down the law. The VIP rarely objects to the attending physician's taking command of the medical care. It is the followers of the VIP - the hospital administrators, the important family and friends, and the curious onlookers - who are made uncomfortable. The best decisions in reversing the ravages of the VIP syndrome are to take measures to ensure the privacy of the VIP, to place limits on the visitors, and to explain that the care will be identical to that given to all other patients with the same condition. There is nothing biologically different about a pope or a president, and there is no need to alter one's thinking in caring for them."(6)

"VIP Syndrome is characterized either by decisions to minimize the number of diagnostic and therapeutic procedures, or to work-up every minor abnormality"

(1) Weintraub, W. The VIP Syndrome: A Clinical Study in Hospital psychiatry. J Nerv Ment Dis. 1964:138

(2) Weiss YG, Mor-Yosef S; Caring for a major government official: Challenges and Lessons Learned. Crit Care Med. July 2007:35(7)

(3) The Dallas News, Nov 9, 2007.

(4) Smith MS, Shesser RF; The Emergency Care of the VIP Patient. N Engl J Med, Nov 1988: 319 (21).

(5) Wachter R; Dennis Quaid's Kids – are VIP's Safer? The Health Care Blog, Nov 26, 2007.

(6) Block AJ; Beware of the VIP Syndrome. Chest, 1993:104.

VIP Syndrome:
It happened to me (And I don't think anyone is important!)

Robin Marshall, M.D.

VIP Syndrome Definition: Anyone whose presence in the healthcare setting, by virtue of fame, position, or claim on the public interest, may substantially disrupt the normal course of patient care."

-JA Block, Beware of the VIP Syndrome, Chest, Oct 1993: 104(4);989

Jackie Gleason died of cancer in 1987. Because of his fame his physicians routinely deferred rectal exams as part of his physical precluding early detection and treatment of his rectal tumor.

Despite pervasive reports of alien abduction, Elvis Presley died in 1977 at age 42 of a poly-substance overdose. Subsequent investigation of the circumstances led to charges against his personal physician for having prescribed 5300 doses of stimulants and depressants in the 7 months preceding his death… the justification "the king gets what he wants".

Eva Peron, first lady of Argentina took ill in 1950 with anemia and abdominal pain. Because of her position a complete physical exam was never performed. She was ultimately taken to the operating room for suspected appendicitis where disseminated cervical cancer was discovered. "Evita" received a secret hysterectomy and radiation treatments but ultimately died in 1952 never knowing her diagnosis.

My patient was a young healthy male who was a restrained driver in a very low mechanism motor vehicle collision. He was ambulatory at the scene and initially pain free but began to experience muscular back tightness after the arrival of EMS. At the EMT's urging the patient was placed on a long board and transported to the Emergency Department for evaluation. In the ED the patient was found to be clinically clear of spinal fracture but with mild lumbar paraspinal muscular stiffness and soreness. The patient was placed on analgesics, given precautions, light duty, and walked out of the emergency department when his friend arrived to collect him. A perfectly mundane encounter that plays out countless times a day in ED's across the globe. What makes this patient extraordinary and what this patient shared with the examples cited earlier was VIP status.

"Knowing is half the battle"
-GI Joe circa 1980's

Unbeknownst to me my patient was a member of an elite special forces unit. Instead of returning home, my patient was transported directly to the radiology department where the physician in charge of the special forces unit had remotely arranged for a complete series of spinal X-Rays. As a member of a special forces (SF) unit the patient had a penchant for jumping out of perfectly serviceable aircraft. Needless to say, his lumbar vertebrae had chronic compressions and degenerative changes but no acute findings. The physician in charge of the SF unit then arranged an emergent Lumbosacral CT scan by phone which again demonstrated chronic changes. As a "precautionary" measure a lumbar brace was ordered by phone and molded the very same day. It was not until a follow-up visit and physical exam with the orthopedics department several days later that the patient was allowed to remove his brace and return to full duty.

We would all like to pretend that we treat

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("Cognitive Errors" Continued from page 6)

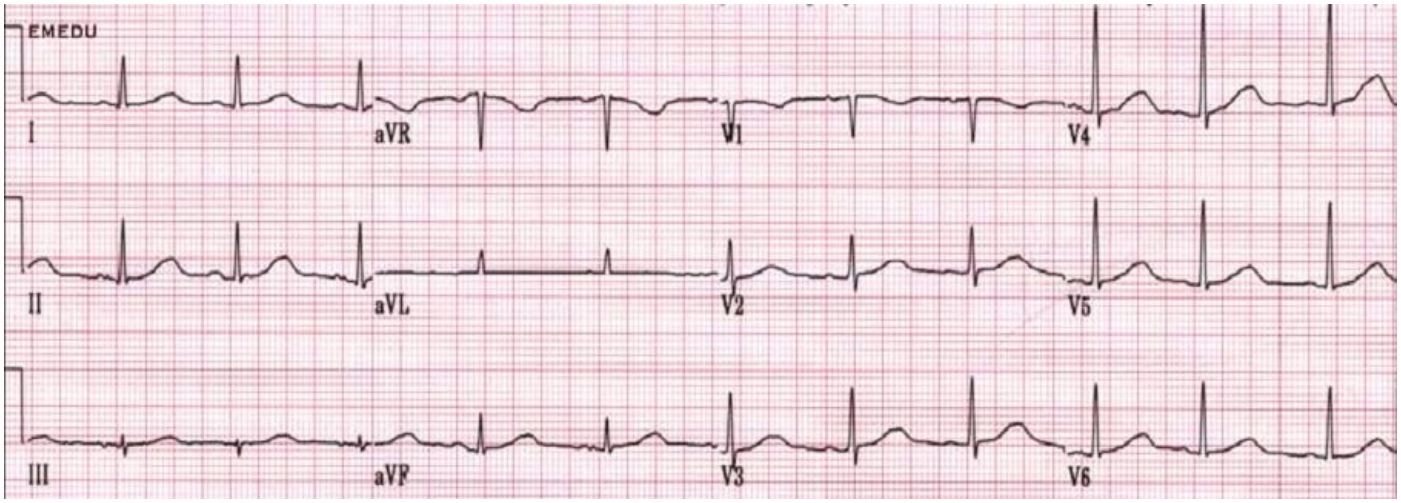
every patient we encounter with the same diligence. Young physicians are trained to treat the elderly as if they were one's mother or father. While the sentiment is genuine the truth is that a family member would probably receive substandard and potentially injurious care by virtue of their place in our hearts. There is good evidence that indicates we are at our worst when we are trying to do our best to go above and beyond. Most VIPs if given the choice would prefer the anonymity of being just a patient at a time of vulnerability such as illness or injury; many are even aware that their status can result in a lower standard of care.

I recently had the opportunity to care for a very high ranking military officer in our department's urgent care. He had managed to escape notice thanks to a civilian triage nurse who did not recognize his rank code on his paperwork. He was cordial, pleasant, and more than a little relieved that he had been able to get care "without a fuss". He shared that he had put off coming in for fear of being recognized and that he was weary of his usual primary care provider's habit of referring him to specialists for what ultimately turned out to be mundane. By way of confession: I can take no credit for his ordinary care. I did not register his rank until I was giving him his discharge instructions. To this day I find myself second guessing my diagnosis and plan.

Medicine is an inherently subjective enterprise. Awareness of our biases and the way we react to our patients is our only hope of defense against subjecting our patients to iatrogensis. We need to know who our VIPs are. They are our friends, our family, our colleagues, our superiors. They are the celebrities, the famous, the infamous, the unusually attractive. They are anyone that makes us react and deviate from what we know to be sound common practice. They are a permanent fixture in our landscape.

Old Sawbones says... "When some high-falootin' bigwig comes to my ED, I tell 'em I refuse to give inferior medical care to my seniors or friends. Usually shuts 'em right up. Plus, it gives me the chance to explain why the rectal is necessary and the MRI ain't. Also, those fancy pants tend to be impressed with big words...so use em!"

VISUAL STIM



A 19-year old female has a witnessed syncopal event after being startled at a "haunted house". On arrival, the above ECG is noted.

What is the diagnosis? See page 9 for answer

How (not) To Make A Good First Impression!

I was rotating at an outside Emergency Department, and was excited because the volume and acuity of patients at this ED was among the highest of residency. Sure enough, one of my first patients came in hypotensive, febrile, and appearing septic. The early goal-directed therapy algorithm was fresh in my mind, so I signed up for this patient ready to have him square-dancing back at his assisted living facility that very night. I began resuscitating this patient with IV fluid boluses and early antibiotics through a small peripheral IV. While some community EMDs often forego central lines and CVP monitoring if you have good peripheral IVs, this patient clearly needed a central line and better access.

The attending gave me the go ahead to put in the central line, and I discussed this with the patient and his spouse who agreed to the procedure. I looked for the ultrasound, intending to do an ultrasound-guided internal jugular line. I was directed to the VW Bug-sized machine in the corner, and quickly realized that US guided central lines were still a foreign concept here. I proceeded to set up for a left subclavian line, which is the landmark-method I am most comfortable with. He asked if I was comfortable with the line, then stepped out.

Like most of my procedures, I have a ritual, whether it be a mnemonic or some other system. to ensure I do things the same every time. I had my equipment set up exactly the way I always do, and just as I was starting the attending walked back in the room. He began "assisting" with the procedure, picking up an item, handing it to me, then taking it away as soon as I had was finished with it. He was clearly pushing me to put the line in as fast as possible, and was casually discussing his take on Early Goal Directed in a busy community ED. As soon as he took an item away, he threw it in either the sharps container or the trash. We slid the triple lumen catheter into the vein, and I checked for flush and return on the three lines. Two seemed to work just fine, but the brown line flushed but was very difficult to get blood return in.

I had flushed the lines before starting the procedure and was surprised there was a malfunction with the line. Regardless, we knew we were in the vein, and that we had access, so he wasn't too worried about it. I was preparing to suture the line in place, and then it occurred to me that I didn't remember removing the guide-wire from the brown line. He had been pushing me to move so fast that I truly couldn't recall, so I looked at my "used" items to verify the guide-wire was there. Unfortunately he had already thrown all the used items away. I asked him if he recalled throwing away the wire, and he said he was pretty sure he did, so I sutured the line in place but told the nurses to hold off doing anything with it.

It only took a few minutes to get the post-procedure x-ray, which confirmed my worst fear…there was the guide-wire, with much of it inside the central line. We briefly considered pulling back on the line to see if we could expose and grasp the wire. Pursuing the better part of valor, we swallowed our pride and called vascular surgery. They looked at the x-ray, and told us that they had a tool to pluck the wire out under fluoroscopy. We went in and told the patient and his spouse what had happened, and what we needed to do. They fortunately were very nice and understanding and agreed to let vascular save the day.

The patient was wheeled off to fluoroscopy, returned within 30 minutes, now free of the wire and with all three lumens clear. To be certain, we ordered another chest x-ray which confirmed a central-line, and no other man-made objects, in position in his chest. I instructed the nurses that they could now use the

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line, and went back to debrief with my attending. He told me not to worry about it, "things happen", and just to review my central line procedures. I debated discussing the way in which he participated in the procedure perhaps contributing to the error, but decided I was too new and already had taken a credibility hit, so let it go. Fortunately, the remainder of the month went well and I redeemed myself. Most importantly, the patient did well was back square-dancing at his facility just 8 days later.

I had seen many central line complications discussed over the years, and on events similar to this one I always wondered "How on earth could that have happened?" Now I know. Fortunately, the patient did not suffer any harm, but I now realize how these mistakes can sneak up on you.

I had several important lessons learned from this. First, you must maintain a high level of vigilance no matter what your experience level. My comfort with this procedure probably caused me to let my guard down a little. I got cocky. Second, if you have a set way of doing something, and are comfortable with your routine, do not idly break that routine. Now, anytime I am doing a procedure with a new attending present, I brief them on my procedure and my exact plan. I have them tell me ahead of time how they like to do it, and what role they would like to take. If despite this, they start changing the plan during the procedure I pause and stop what I am doing to take in what they are saying. I am certain that this attending's very active participation in the procedure, while intended to help, threw me out of my routine which contributed to the mistake. Since he was "just helping" and not really supervising, he wasn't paying close attention to the procedure and so also missed the error.

Thirdly, and most importantly, we debated trying to go back in to "adjust the line", mostly for fear of admitting our mistake to the patient. We did the right thing, however, and admitted what had happened. Our honesty was well received by the patient and his spouse, which allowed us to expeditiously resolve the problem and avoided any bad outcome. But regardless, this is not the way you want to start your first shift at a new rotation!

Old Sawbones says... "I know what this feels like! Interruptions or changes in plan have thrown off the most practiced routines. Hence checklists in aviation. You were right in setting up your procedure carefully, but another error-producing situation got you: rank conflict. Many teamwork-training programs teach how to avoid errors when the boss isn't helping as much as they think they are. "

VISUAL STIM **(Continued from page 7)**

Answer: Long QT Syndrome

- Long QT Syndrome is a genetic autosomal dominant disorder and is primarily a disease of the young.
- It usually presents with syncope or sudden death from lethal ventricular dysrhythmias.
- More than 100 mutations have been linked to this disorder, and the common final pathway is a congenital defect in the cardiac sodium ion channel, with altered NA fluxes that prolong the QT interval. These patients have structurally normal hearts, but a genetic Na channel conduction disturbance, which predisposes them to ventricular ftachycardia and ventricular fibrillation, often in response to physical exertion, emotional stress or startle events.
- An abnormal ECG at rest is the key to the diagnosis, as the QTc will be abnormally prolonged. A normal QTC for women is <460 msec, and for men, it is <440 msec.
- Management for LQTS victims with a history of syncope, V-Tach, or an arrest with recovery, is placement of an AICD. Such patients should not participate in organized sports which can lethal trigger ventricular tachydysrhythmias.
- In addition, it is important to screen all next of kin for the disorder once a proband is ID'd.
- It may account for many cases of SIDS

Courtesy of Dr. T. Bottoni, EMEDU, EMedicine, and Up-to-Date.

"Unexplained Tachycardia: Maybe she always runs high?

For good reason we are reluctant to discharge patients with abnormal vital signs without an appropriate explanation. This lesson saved me at the end of a long shift "holding down my side" a few months ago. Patient flow had gone reasonably well that night, the only hiccup being one young woman who had been turned over to me with the words "sudden onset worst headache of my life" written on her chart obligating me to a CT Scan/Lumbar Puncture workup. I was awaiting the report of her head CT before doing the lumbar puncture. With a normal neurological exam and her headache completely resolved with standard migraine therapy, I was less excited about doing the LP on this turnover patient, especially watching her giggling with her friend and furiously texting on her cell phone, but I knew it needed to be done. The CT report came back about 30 minutes before the end of my shift, and I was happy that I could probably get the tap done and still get out reasonably on time.

Just then a new patient was brought back by wheelchair that appeared slightly uncomfortable. I considered letting her wait for the oncoming doctor since I still needed to do the LP, but my conscience forced me to do the right thing and go see her.

"Vital signs are vital. Abnormal vital signs are especially vital."

I walked into the room to find a 50ish woman in a wheelchair fully dressed in slacks, a blouse, and a button-up sweater. Her hands and wrists were twisted and deformed from the ravages of long-standing rheumatoid arthritis. She stated that she had been having some upper abdominal pains since the day prior. She was obviously very stoic and despite her demeanor I suspected she was uncomfortable, but nonetheless she did not appear "sick". Her only abnormal vital sign was a pulse in the low 120s. She denied nausea, vomiting, diarrhea, GI bleeds, and alcohol use (giving me that "Of course I don't drink alcohol look!" when I asked) She was using NSAIDs, steroids, and an immune modulator for her RA, but was otherwise healthy.

She was reluctant to get disrobed or into a gurney due to her disability, and stated she was more comfortable in her wheelchair. After taking an appropriate history, I attempted to examine her but an inadequate exam ensued. She had diffuse epigastric tenderness as best I could tell, and her abdomen seemed soft, but really no reasonable comment as to peritoneal signs could be made. She was clear that she did not want any IVs or blood work because she stated that she was a very "hard stick." I told myself that her tachycardia was probably just a result of pain, anxiety, or dehydration. So armed with a new treatment regimen that I had recently learned from one of our experienced physicians, I decided to try and negotiate the care of this patient on her terms. We

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agreed on a plan to include antiemetics, oral fluids, Mylanta, viscous lidocaine, and sulcralfate, with no labs or IVs except a urinalysis, and I prayed that this was indeed just gastritis.

It was turnover time, and I still had that LP to do, which I was now even less excited about. I asked the oncoming resident to keep an eye on her and make sure she improved, and figured I could disposition her after the LP. I then began the two-hour ordeal of attempting to coax CSF from this pain-free, happy young girl who I knew was going to have a negative tap. Two physicians and a mere 3½ -inch spinal needle were proving inadequate for the job, and just when we were about to give up we hit paydirt with a longer needle. Fortunately she kept a good attitude, and her ability to laugh with her friend and continue texting during the procedure helped distract her from considering what kind of barbaric beast was attempting this procedure on her.

During the lumbar puncture, I was able to peripherally keep track of my abdominal pain patient, and it was apparent that my somewhat pathetic attempts to write her off to dyspepsia were coming back to haunt me. I had made no strides in treating her pain, dehydration, or tachycardia. I fleetingly considered sending her home with "more of the same" ("ahh, she's probably always a little tachy!") as well as an H2 Blocker or PPI, but after a discussion we decided to bite the bullet and work her up properly.

After some coaxing, the patient finally agreed to put on a gown and get onto the gurney. Her exam showed worse upper abdominal tenderness to palpation than I had originally appreciated, but fortunately no peritoneal signs. Our differential was appropriately expanded, an IV was placed intravenous fluids were started, and a CBC and complete metabolic panel including LFTs and lipase was ordered.

The rest of the story can probably be guessed. The diagnosis of my patient with "unexplained" tachycardia became more clear when her lipase came back at 1600. Her disposition was completely solidified when a right upper quadrant ultrasound confirmed gallstone pancreatitis. She was admitted to the surgical service and taken to the operating room the next morning. Her tachycardia fortunately helped us increase our clinical suspicion that something was awry, which helped keep me from sending the patient home, therefore allowing me to discuss the patient here rather than in conference as an M&M.

Many lessons were learned and reinforced nonetheless. Vital signs are vital. Abnormal vital signs are especially vital, and need to be explained. If they can't be explained then you probably are missing something. As a certain legendary physician has reinforced, patients should be undressed in a gown on a gurney and we need to make sure this is so. When we don't do this, we are going to miss things. Histories and physical exams need to be thorough and complete for the appropriate presenting complaint. And think worst first. My chance of trying to help this patient on her terms would have done no one any favors in the long run.

Old Sawbones says...

"Close call cowboy! Looks like you fell victim to a variation of VIP syndrome - we call that "customer service syndrome." You get more concerned with making the patient happy than with doing the right thing. The good news is you eventually did the right thing, thanks to your vigilance to those vitals. They call 'em vital for a reason!

And don't forget, "worst headache of their life" does not obligate you to anything. Just look for the red flags and make sure you document their absence carefully in the chart. "

The Psych Room

When a patient is put into the "psych" room, I'm never excited to go see them. It's one of my idiosyncrasies, but these patients are difficult and rarely interesting, so I have to muster my strength to ask all the pertinent questions. I had an hour left in my shift, and I figured I could disposition this guy before my shift was over.

This patient was there with a complaint of facial swelling after a fall, but was in the psych room because he's a schizophrenic with dementia who lives in an assisted living facility. His daughters were there, and were very concerned about a lack of "assistance" at his facility. Despite being only 54 years old, he was quite weak and required assistance whenever he ambulates. Last night he got out of bed on his own and was found down in the hallway.

Today, when his sisters came to visit, he told them about the fall and complained of right-sided upper back/chest pain. They, however, were concerned that the right side of his face seemed swollen, and they thought he might be having an allergic reaction to a new anti-psychotic he recently started.

When I went to examine him, he was not in a gown but was in his own shirt and a cardigan. I had several other patients to dispo, so I thought, "I don't have time to wait" and examined him without undressing him. His facial swelling was unremarkable and limited to his right eye, and there were no other systemic signs of an allergic reaction or other eye problems. He was tender on the right side of his chest and upper back midway up, and he felt a little "squishy" (he was also quite flabby), but he had equal breath sounds. I did think it sounded a little "scratchy" when auscultating his chest, but since I examined him with his clothes still on, I thought I was just hearing his shirt rubbing on his sweater. His vitals and oxygen sats were also normal.

Because of the swelling, pain, and unwitnessed trauma, I decided to order a head CT and a chest x-ray. His head CT was done first, and interestingly, was normal except for some subcutaneous air around his right eye. He went right to x-ray after the CT was done, so I didn't get to examine him until after he returned. The chest x-ray, however, caused me to go in his room and immediately disrobe him...it showed posterior 5th and 6th rib fractures with diffuse subcutaneous emphysema that tracked up his neck, into his face, and yes, around his eye. Fortunately, there was no pneumothorax.

I ordered pain meds, placed him in a gown, and admitted him to the surgery for pain control and observation. He did well and required no interventions except pain control.

Despite the fact that my mentor and model for how to be an emergency physician (whose name rhymes with "Dr. Seuss") had admonished me on more than one occasion for not disrobing my patients, I didn't make this man get into a gown. I probably would have made the diagnosis within minutes rather than waiting for the xray. I also fell into the common trap of trying to wrap up my shift in a nice little package. Fortunately, the patient did well despite my inadequate exam.

I also was reminded of that despite my visceral reaction to the psych room patients, they are not always presenting with psychiatric complaints, and if I'm not careful, I run the risk of missing serious medical illnesses. While I don't really believe in the phrase, "it's better to be lucky than good," I'm always glad each time it comes true.

Old Sawbones says...

"Good thing Dr. "Seuss" wasn't on this case...he'd have eaten you for lunch! We undress patients for a reason, but fortunately an ancillary study saved you. Just remember, your history and physical should guide your studies...not the other way around!"

Not Another One!

It was my second busy night shift in a row, and we had finally powered through a waiting room full of folks that, for lack a better way to put it, had slightly different definitions of "Emergency" than we did. But we managed to assuage their fears, and the end was in sight.

It was about 0500, and it looked like we might turn over a clean board. Right about then a 30-something young man with another apparent difference of opinion came into the department, seemingly in more agony than his initial appearance would warrant. I was exhausted from working multiple night shifts as well as the volume of patients that we had seen, and at that particular moment I did not have the energy to tackle this patient. So I did what any attending would do—I told the senior resident that was on to go see him. But he wasn't up to it, either, so he did what any senior resident would do—he told the junior resident to go see him….who then told the Intern who, proving that things can only roll so far downhill, went to see the patient.

The patient was presenting with fever, cough, a little post-tussive emesis, and generally the same presentation as half the other patients we had seen that night. The only difference was that he had a really annoying cough, one of those coughs that we could hear throughout the ED. It seemed like anytime no one was in the room, the cough got "worse" which further cemented in my mind that this patient encounter was going to culminate in a request for a work note. I lamented the fact that this patient had a primary care doctor who would be at work in only two hours, and cursed the forces in the universe I had apparently angered to bring us together at this moment. To bring everyone some peace, however, we gave the patient an albuterol nebulizer, and then (a good trick to keep up your sleeve, by the way) nebulized lidocaine - which restored peace to our efforts to clean up the board in preparation for turnover.

Despite my certainty that this patient had nothing more than the "crud" that we had seen dozens of the last few nights, I ordered a chest x-ray. He did have a fever and cough, and his pulse oximeter was in the low normal range after all. But one thing that was definitely not normal was his pulse, which was in the 120-130 range. I hadn't worried too much about this due to his fever, but I then realized he was no longer febrile and his pulse had still not budged. I rationalized that he had probably been coughing so much that he had become dehydrated, which I would remedy with a couple liters of IV fluids.

But now I was in trouble…I wasn't fixing the guy, and turnover was rapidly approaching. His chest x-ray was non-specific and had unfortunately not given me the answer I was looking for. I had two competing thoughts stuck in my craw: his pulse was still abnormal, but I really, really, wanted to discharge him. Fortunately, my training kicked in, and I realized that perhaps my emotions were impacting my medical decision making. Would I be in such a rush to discharge this patient if it were the middle of my shift? I knew that answer, so I bit the bullet and turned him over—hoping that the fresh morning crew would understand.

Fortunately, the turnover was made more palatable to everyone when we went back in to introduce the oncoming doctor, and he was now febrile and more importantly hypotensive. We quickly began more aggressive fluid resuscitation, and then appropriately

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worked him up. He responded to the fluid boluses, and his workup revealed that he was septic from influenza. He was admitted to the hospital, did well, and was discharged a few days later. I went home that day and slept much more soundly, knowing that I had done the right thing by asking a colleague for a second opinion when I felt my judgment clouded by emotion.

Two important things came out of this. Turnover is one of the most dangerous and error-prone times in emergency medicine. Also, we learn this lesson time and again: vital signs are vital for a reason. I couldn't explain this patient's tachycardia, and it kept me from making a dangerous mistake.

Old Sawbones says...

"Yikes! Turnover always gets Old Sawbones a little nervous. Not much to add on this one though...you said it all! Just remember, sick patients don't care where you are in your shift. If it's close to turnover, and you're trying to dispo a patient, you should always ask yourself if you are treating the patient the same as you would if it was the start of your shift. If not, think again."

Fast (Laugh) Track

The lighter side of medicine

Best "Chief Complaints"

- 24 year old male: "My Ovaries Hurt"
- "I need checked for syphilis. My girlfriend and roommate both have it."
- "I've got HIV-pylori"
- "I'm unconscious"
- "I have aspiration" (further clarification: "My bottom is sweating excessively!")"
- "My child can't read (9 month old baby)"
- "I need a milligram" (mammogram)
- "I ran out of my peanut butter balls and might fall out" (Phenobarbital)
- "Child drank dog's milk from the dog's nipples"
- "My child needs a circumcision because his tonsils/adenoids are so big"
- "I can't find my baby's birthmark"
- "He has a problem with his manlihood"
- "My baby is afraid of his hands"
- "Need a mental extraction"
- "She has romantic fever"
- "He has cereal palsy"
- "I have swollen asteroids"

Thanks to the internet

- "I got bacterial vaginosis from the internet"
- 28 year old male with several days of heartburn: "I think I have congenital heart disease." Why? "I looked up my symptoms on the internet. I think I need surgery".

Questions Patients Asked

- "Hello, I would like to schedule an emergency"
- "Does your hospital carry breast milk?"
- "May I speak to Dr. Dimetapp?"
- "My baby can't breathe. What time can I bring her in?"

Other Amazing Things Said by Parents

- Doctor: "What kind of convulsions has he had in the past?" Mother: "Oh, he vomits once and then runs around the house chasing the cat".
- Doctor: "Give him 3 baby aspirins every 4 hours for the fever".
  Mother: "I would but my other 2 kids ate the bottle of aspirin at home this afternoon"(!!!)
- Mother of a 12 year old girl with abdominal pain: "I don't think it's the you-know-what. She ain't a virgin yet".

Sources:
1. Nelson, DS. Humor in the Pediatric Emergency Department: a 20-year retrospective. Ped, 1992: 89(6)
2. www.allnurses.com