Weekly Calendar

10/31: Noon report: Halloween Party!
11/1: Noon report: Wards Orientation
11/3: AHD: Shock and Sepsis; Senior Prep: Defense of the Measures
11/4: Noon report: Orange team (MSB 5051)

Long Block 11 is ready to roll.

Anonymous Feedback

Our website has a section for anonymous feedback. Think of this like an electronic suggestion box that you can use at any time. The message will be sent directly to Dr. Warm, and is completely anonymous. If you have constructive feedback that you would like to share, please use this tool. The link is: http://www.med.uc.edu/intmed/residency/internal-medicine/residency-feedback
VA UPDATES

The VA is hiring 2 hospitalists for next year! Any interested R3s should contact Thomas for more information. The Veterans are a great population to care for!

Clinic Corner

Welcome to Long Block, LB11! You’ve been looking forward to it for a while, and now it’s finally here! Welcome to being PCPs! Luckily you are walking in to a great multidisciplinary team that is poised to help you provide the highest quality medical care to your patients.

This is a huge transition for you, and so you will have a much needed orientation on 10/31 and 11/1. See you in MSB 2001 on Monday at 8am. Check your email for the details!

Time for a deep clean for the resident lounge and work room! Please remove your personal items and garbage so that the EVS team can spruce the place up!

Night float will need to work in the other location so that our rooms can be effectively cleaned. Clear out of the work room (7214) on the night of October 28th (TONIGHT) and stay out of the lounge (7300) on the night of Saturday, October 29th (TOMORROW). Thanks!

Hey IM residents,
The Pediatrics residents at Children’s challenge you to a friendly game of flag football!

When: Saturday, November 5 at noon
Where: Football field at Madisonville Recreation Center (5312 Stewart Avenue)
Why: Because it’s football season, and we could all use a bit of fresh air with our co-residents.
Hope to see you there!
Thanks,
Pediatrics Residency Council

7NW Interdisciplinary Improvement Team Huddle

Come be part of improving patient care through interdisciplinary teamwork!

EVERY Tuesday at 2pm, Location: UH 7104 (NRR)
Noon Report Round-up!

This week Yellow team presented an interesting case of diarrhea and colitis as a side effect from a patient’s immune checkpoint inhibitor chemotherapy. Let’s talk about it!

Simply, PD1 receptor is an inhibitory molecule that inhibits apoptosis of tumor cells, promotes T cell exhaustion, and decreases autoimmunity. Turning this off with PD-1 inhibitors allows T cells to kill tumor cells again.

<table>
<thead>
<tr>
<th>Side effect</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
<th>Grade 5</th>
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<tbody>
<tr>
<td>Diarrhea</td>
<td>Increase of less than four stools per day</td>
<td>Increase of 4-6 stools per day</td>
<td>Increase of seven or more stools per day, incontinence, hospitalization indicated, limiting self-care activities of daily living</td>
<td>Life threatening consequences, urgent intervention needed</td>
<td>Death</td>
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Treatment options for checkpoint inhibitor-related colitis depends on the severity of symptoms. For mild disease (grade 1) patients can be managed symptomatically. Can consider budesonide. For more severe disease, grades 3 and 4, treatment with the immune checkpoint inhibitor should be permanently discontinued and high doses of corticosteroids should be given. If patients don’t improve on steroids after 3 days, typical recommendation is to give infliximab, and in refractory cases, can consider mycophenolate.

The case presented by Yellow team was a patient on nivolumab for ocular melanoma that was metastatic to the liver. The patient presented for another reason, but mentioned diarrhea. Other autoimmune mediated side effects can be pneumonitis, rash, hepatotoxities, as well as hypophysitis and other endocrinopathies including adrenal insufficiency and autoimmune thyroid disease.

All Hallow’s Eve Noon Report Party!

We will forgo the typical noon report on Monday at UH and have a Halloween party!

Work-appropriate costumes encouraged!
A 62 year old woman with past medical history of hypertension, hyperlipidemia, coronary artery disease and previous coronary artery bypass grafting, is being evaluated in the hospital. She complains of 2 weeks of worsening chest pain and dyspnea. Her medications are aspirin, atorvastatin, metoprolol, and furosemide. On exam, her temperature is 98.8°F, blood pressure is 114/72 mm Hg, pulse rate is 89 bpm, respiratory rate is 16/min and she is saturating 94% on room air. She has JVD. Heart sounds are regular rate, with a 3/6 late-peaking systolic murmur best heard at the heart base, as well as a 1/6 diastolic murmur. Echo shows a calcified and bicuspid aortic valve with severe high gradient aortic stenosis and moderate aortic regurgitation. Which of the following is the more appropriate treatment for this patient?

A. Surgical aortic valve repair  
B. Surgical aortic valve replacement  
C. Transcatheter aortic valve replacement  
D. Balloon aortic valvuloplasty

A. The correct answer is B, surgical aortic valve replacement. This patient has severe aortic stenosis that is symptomatic, and therefore had indication for valve replacement. According to the 2014 AHA/ACC guidelines, surgical aortic valve replacement is recommended for patients with an indication (severe AS with symptoms by history of or exercise testing, asymptomatic patients with severe AS and LVEF <50, and patients with severe AS undergoing other cardiac surgery) who are low or intermediate surgical risk. This patient has no history of CKD, IDDM, CVA, and is revascularized, so she is presumed intermediate surgical risk per RCRI criteria. TAVR, or transcatheter aortic valve replacement, is recommended for patients with AS who have an indication for AVR (see above), and who have a prohibitive surgical risk and a predicted post-TAVR survival of >12 months, and is a reasonable alternative for surgery in patients with AS with an indication for AVR but are high surgical risk. Recent data suggests that intermediate risk patients may be considered for TAVR over SAVR but AHA/ACC guidelines would not support TAVR for this patient., also TAVR is not approved for patients with concomitant valve disease (like aortic regurgitation) and a bicuspid valve. Repair is typically restricted to only aortic regurgitation. Balloon valvuloplasty is contraindicated in significant aortic regurgitation.
**Weekend to-do!**


**Saturday:** The Malice Ball: Over-the-Rhine Masquerade, 8:30 p.m.-1 a.m., Christian Moerlein Brewery, 1621 Moore St., Over-the-Rhine. Brewery transformed into mysterious spooky hall. DJ, dancing and spooky photo booth. $30, $25 advance; includes free parking shuttle. bit.ly/2doQR16.


**Sunday:** Tillie’s Chili Cook-off for CAIN, 6-8 p.m., Tillie’s Lounge, 4042 Hamilton Ave., Northside. Tillie’s Lounge kicks off month-long canned food drive with chili cook-off. Bring spiciest, tangy-est, most savory or otherwise impressive pot of chili. $10 to enter, $10 to taste. Free admission.

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⭐⭐⭐⭐⭐⭐⭐⭐⭐⭐ First correct answer wins a $5 Starbucks gift card!

What is this? What procedure results in these specimens? What disease does this treat?

**TRIVIA**

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Congrats to Elyse Harris (again!) for diagnosing emphysematous cholecystitis and recommending immediate antibiotics and surgical consultation!

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**SHOUT OUTS!!!**

- To Eric Cohen, “for a multitude of reasons: 1) working late daily, on the sickest renal census I’ve seen, to ensure solid patient care, 2) handling access issues (on renal!) during the day, 3) and giving great sign-out to NMT, particularly on ill patients.” Thank you Eric for your excellent care of patients!

- To Javy Baez “for being an incredible and thorough senior” and for making his intern feel supported while teaching constantly. She said, “He does a wonderful job with patients and I feel like our patients receive high quality medical care when he is involved. I can’t say enough how fantastic he is and how grateful I am.” Lovely words from an intern to a fantastic senior (and future chief!)

- To everyone who came to the Finding Meaning in Medicine meeting this week!

- To Bo Franklin, for pinch hitting senior noon report last week and doing noon report this week! You ‘da real MVP!

- To our great “Difficult Patient” participants at AHD: Ashley Cattran, Matt Cortese, Matt Doers, Reza Ghoorkhanian, Natalie Hood, Jeff Miller, Gene Novikov, Akshita Sharma, and David Young. You all did a great job!

- To Rita Schlanger, for being “my rock” as AOD, from a thankful intern.

- To Andrea Portocarrero for staying behind in clinic to see a patient for another resident who was having a crazy clinic. We appreciate your team work!