Hospital Medicine
A Resource Guide on
Commonly Encountered Inpatient Topics
for Primary Care and Subspecialist Faculty

Core Educator Faculty

Department of Medicine
Inpatient Clinical Staffing Resource for COVID-19
March 2020
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For optimal use this document should be downloaded and cannot be used directly from an attachment in an email client

Note: This resource was collectively developed by the Massachusetts General Hospital (MGH) Inpatient Core Educator Faculty (CEF) to help Internal Medicine trained attendings who are not Hospital Medicine specialists and will be staffing inpatient services during the COVID-19 pandemic. It is not meant to be an all-encompassing resource. Rather, we have focused on some of the most common inpatient clinical topics and developed a section for each topic that collates existing resources. Each topic has links to relevant chapters of the MGH Housestaff Manual (the Whitebook), relevant MGH noon conference series, and some important literature. We have also included rapid diagnostic schema or facts where relevant. We appreciate any feedback on how this resource may be updated so that it could be most useful to our target audience. Please email amulya.nagarur@mgh.harvard.edu with any questions/suggestions.

-Amulya Nagarur, MD on behalf of the MGH Inpatient CEF (Twitter: @MGHCEF)
Inpatient topic Inpatient heart failure
Collating author Amulya Nagarur, MD

MGH Whitebook (DESKTOP): Inpatient Heart Failure and Advanced Diuresis
MGH Whitebook (MOBILE): Inpatient Heart Failure and Advanced Diuresis

Rapid facts:
EF<40: Heart Failure with Reduced EF (HFrEF)
EF 40-50%: Heart Failure with moderately reduced EF
EF >50%: Heart Failure with Preserved EF (HFpEF)

Triage considerations:

<table>
<thead>
<tr>
<th>Congestion at Rest</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Perfusion at Rest</td>
<td>Warm and Dry</td>
<td>Warm and Wet</td>
</tr>
<tr>
<td>NO</td>
<td>Outpatient mgt</td>
<td>Diuresis ± Vasodilators</td>
</tr>
<tr>
<td>YES</td>
<td>Cold and Dry</td>
<td>Cold and Wet</td>
</tr>
<tr>
<td>Inotropes (ICU)</td>
<td>Tailored Therapy (ICU)</td>
<td></td>
</tr>
</tbody>
</table>

Initial inpatient focus is on decongestion with loop diuretics which have a sigmoidal dose-response curve. Double dose until adequate response achieved:

Slide or podcast presentations:
MGH Noon Conference on Heart Failure by Jennifer Ho
MGH Noon Conference slide deck on Heart Failure with Preserved Ejection Fraction by Nilay Patel (and video)
HFpEF Update with Clyde Yancy on Curbsiders Podcast

Relevant literature: Numerous links in MGH Whitebook and 2017 ACC/AHA/HFSA Focused Update of Guideline for the Management of Heart Failure
Inpatient topic: Chest pain (with a focus on cardiac chest pain and acute coronary syndromes)

Collating author: Amulya Nagarur, MD

MGH Whitebook (DESKTOP): ECG Interpretation, Chest Pain, Acute Coronary Syndrome, MI Complications, Cardiac Anatomy & Catheterization, and Noninvasive Cardiac Testing

MGH Whitebook (MOBILE): ECG Interpretation, Chest Pain, Acute Coronary Syndrome, MI Complications, Cardiac Anatomy & Catheterization, and Noninvasive Cardiac Testing

Rapid schema/facts:

Sickle presentation slides:
- MGH Noon Conference on ECGs Part I by Dave Dudzinski
- MGH Noon Conference on ECGs Part II with Dave Dudzinski
- MGH Noon Conference on Acute Coronary Syndromes by Nilay Patel

Relevant literature: Refer to MGH Whitebook links.
Rapid diagnostic schema: Click here for explanatory video

Slide or podcast presentations:
MGH Noon Conference on Approach to Syncope by Bill Kormos
Curbsiders Podcast: Syncope Deconstructed

Relevant literature: 2017 ACC/AHA/HRS Guideline for the Evaluation and Management of Patients With Syncope
Inpatient topic | Atrial fibrillation
Collating author | Vic Chiappa, MD

MGH Whitebook (DESKTOP): Atrial Fibrillation & Flutter and Narrow & Wide Complex Tachycardia
MGH Whitebook (MOBILE): Atrial Fibrillation & Flutter and Narrow & Wide Complex Tachycardia

Rapid diagnostic schema/facts:

- Major considerations for new-onset Afib (assuming hemodynamic stability and no need for urgent electrical cardioversion):
  - Is there structural heart disease? Recent echocardiogram?
  - What is the trigger?
  - Does patient warrant electrical or chemical cardioversion?
  - For most, rate control for HR <110
  - Anticoagulation in most scenarios with DOAC if CHADS2-VASc score is ≥ 2
  *refer to Whitebook for details

- Treating Afib with rapid ventricular response depends on hemodynamic stability:
  - Unstable: DCCV with 150J
  - Stable: IV/PO nodal agents. If IV, always chase with PO for sustained effect
  - In between (systolic blood pressure ~90): Can attempt nodal agents above or try amiodarone or digoxin

Slide or podcast presentations: MGH Noon Conference on Atrial Fibrillation by Steve Lubitz and Curbsiders Podcast with James Furgerson

Relevant literature: See links in Whitebook for numerous links including anticoagulation risk assessment and choice using Sparctool
**Inpatient topic** | **Venous thromboembolism (VTE)**
---|---
**Collating author** | Jeff Greenwald, MD

**MGH Whitebook (DESKTOP):** [VTE Diagnosis](#) and [VTE Management](#)
**MGH Whitebook (MOBILE):** [VTE Diagnosis](#) and [VTE Management](#)

**Rapid schema/facts:**

NEJM 2019: Diagnosis of Pulmonary Embolism with d-Dimer Adjusted to Clinical Probability:

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Blood 2020: Acute Treatment of Venous Thromboembolism:
### Clinical Setting

<table>
<thead>
<tr>
<th>Clinical setting</th>
<th>Patients subgroups</th>
<th>Limitations</th>
<th>Recommended strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal function</td>
<td>Stage II-III KDOQI (GFR 30-59) or IV KDOQI (GFR 29-15) Dialysis</td>
<td>None</td>
<td>DOACs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dose reduction not tested in VTE</td>
<td>DOACs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Avoid DOACs &amp; LMWH</td>
<td>VKAs or halved-dose LMWH</td>
</tr>
<tr>
<td>Elderly</td>
<td>Over 75 years</td>
<td>Very limited data available, comorbidities &amp; concomitant therapies, consider bleeding risk</td>
<td>DOACs, adapt accordingly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consider to avoid thrombolysis</td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>Strong inhibitors/competitors</td>
<td>Potential DOACs overdosing, DOACs underdosing, consider potential interactions, consider to stop ≥1 antplatelet</td>
<td>Consider to avoid DOACs</td>
</tr>
<tr>
<td></td>
<td>Strong inhibitors/competitors</td>
<td></td>
<td>Consider to avoid DOACs</td>
</tr>
<tr>
<td></td>
<td>Moderate inhibitors/inducers</td>
<td></td>
<td>Consider DOACs at standard dose</td>
</tr>
<tr>
<td></td>
<td>Dual antplatelet</td>
<td></td>
<td>Consider DOACs (with ASA)</td>
</tr>
<tr>
<td>Pregnancy &amp; breastfeeding</td>
<td>Pregnancy I trimester</td>
<td>Avoid DOACs &amp; VKAs</td>
<td>LMWH</td>
</tr>
<tr>
<td></td>
<td>Pregnancy II-III trimesters</td>
<td>Avoid DOACs &amp; VKAs</td>
<td>LMWH</td>
</tr>
<tr>
<td></td>
<td>Breast-feeding</td>
<td>Avoid DOACs &amp; VKAs</td>
<td>LMWH</td>
</tr>
<tr>
<td>Cancer</td>
<td>Oral route not feasible</td>
<td>Avoid DOACs &amp; VKAs</td>
<td>LMWH</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal cancer</td>
<td>Avoid DOACs &amp; VKAs</td>
<td>LMWH</td>
</tr>
<tr>
<td></td>
<td>On chemotherapy</td>
<td>Assess for DOACs interactions</td>
<td>Edoxaban/rixaroxaban or LMWH</td>
</tr>
<tr>
<td>Isolated Distal DVT</td>
<td>Asymptomatic DVT</td>
<td>Limited data available, treat as proximal</td>
<td>Consider US surveillance LMWH</td>
</tr>
<tr>
<td></td>
<td>Cancer or previous VTE</td>
<td>Limited data available, treat as proximal</td>
<td>LMWH or VKAs (or DOACs)</td>
</tr>
<tr>
<td></td>
<td>All asymptomatic distal DVT</td>
<td>Limited observational data with DOACs</td>
<td>LMWH or VKAs (or DOACs)</td>
</tr>
<tr>
<td>Isolated Subsegmental PE</td>
<td>Asymptomatic incidental PE</td>
<td>Limited data available, treat as PE</td>
<td>Consider clinical surveillance or DOACs</td>
</tr>
<tr>
<td></td>
<td>Concomitant cancer</td>
<td>Limited data available, treat as PE</td>
<td>Edoxaban/rixaroxaban or LMWH</td>
</tr>
<tr>
<td></td>
<td>Symptomatic PE</td>
<td>Limited data available with DOACs</td>
<td>DOACs</td>
</tr>
<tr>
<td>Vena cava filter</td>
<td>Absolute contraindications for anticoagulant treatment</td>
<td>Limited data available, treat as PE</td>
<td>Start anticoagulant treatment as soon as possible</td>
</tr>
</tbody>
</table>

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**PULMONARY EMBOLISM RESPONSE TEAM ACTIVATION**

**Large Pulmonary Embolus?**

For example:
- PE with abnormal vital signs (tachycardia or hypotension)
- Evidence of right heart strain (echo, EKG or positive biomarkers)
- Central or saddle PE

**CALL x4-PERT (4-7378) TO ACTIVATE THE PULMONARY EMBOLISM RESPONSE TEAM (PERT)**

Please order (unless already done):
- Stat Echocardiogram
- EKG
- CBC, PT/PTT, Creatinine
- Troponin, and NT-proBNP
- Type and Screen

PERT: A Multidisciplinary Team to coordinate and expedite appropriate treatment of Pulmonary Embolus

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**Slide presentation:** MGH Noon Conference on VTE by Hanny Al-Samkari

**Relevant literature:** Diagnosis of Pulmonary Embolism with d-Dimer Adjusted to Clinical Probability
**Inpatient topic:** COPD exacerbation  
**Collating author:** Kristian Olson, MD

**MGH Whitebook (DESKTOP): COPD**  
**MGH Whitebook (MOBILE): COPD**

**Rapid diagnostic schema/facts:**

GOLD ABCD designation for COPD:

![GOLD ABCD designation for COPD](image)

*mMRC (Modified Medical Research Council) & CAT (COPD Assessment Tool) are baseline symptom assessment tools*

COPD exacerbation: Acute worsening of resp symptoms (increased dyspnea, cough, sputum, wheeze) that requires additional therapy. Causes usual infection (70%). Must consider pneumonia, pulmonary embolism, pneumothorax, pulmonary edema.

**Slide presentation:** [MGH Noon Conference on COPD by Sydney Montesi August 2019](#)

**Relevant literature:**  
Effect of high flow oxygen on mortality in chronic obstructive pulmonary disease patients in prehospital setting, Oral or IV prednisolone in the treatment of COPD exacerbations, Different durations of corticosteroid therapy for exacerbations of chronic obstructive pulmonary disease, Non-invasive positive pressure ventilation for treatment of respiratory failure due to exacerbations of chronic obstructive pulmonary disease, GOLD Report 2020 (Chapter 5), and Susceptibility to exacerbation in chronic obstructive pulmonary disease
Inpatient topic | Pneumonia
---|---
Collating author | Farrin A. Manian, MD MPH

**MGH Whitebook (DESKTOP):** Community Acquired pneumonia, HAP/VAP & Aspiration, Multidrug Resistant Organisms and MGH Antibiogram

**MGH Whitebook (MOBILE):** Community Acquired pneumonia, HAP/VAP & Aspiration, Multidrug Resistant Organisms and MGH Antibiogram

Updates not yet included in MGH Whitebook: [2019 IDSA/ATS CAP guidelines](#)

**Rapid facts based on new guidelines:**

Identify patients at risk of MRSA or *P. aeruginosa* as cause of CAP when any of the following risk factors is present:

- MRSA or *P. aeruginosa* cultured from the respiratory tract within the prior year
- Hospitalization and parenteral antibiotic exposure in the last 90 days (either in or out of the hospital). HCAP is no longer an entity.

**Inpatient workup:**

- Order sputum and blood cultures in patients with severe CAP OR when empirically treated for MRSA or *P. aeruginosa*
- Order rapid influenza molecular assay (PCR) in preference to antigen test when influenza viruses are circulating in the community
- Don’t routinely order urine antigens for pneumococcal or Legionella antigens, except in severe CAP or in the presence of suggestive epidemiological factors
- Don’t routinely order serum procalcitonin to determine need for initial antibacterial therapy
- Note: Above recommendations focus on adults who are *not* immunocompromised or did *not* have recent travel

**Treatment**

1. Select empiric antibiotics based on severity of CAP and risk factors for MRSA and *P. aeruginosa* listed above
2. Treat CAP patients who test positive for influenza with standard CAP antibiotics PLUS oseltamivir irrespective of the duration of symptoms
3. No need for routine anaerobic coverage in aspiration pneumonia unless empyema, lung abscess or large volume aspiration plus poor dentition (latter not in ATS guidelines but reasonable)
4. See tables below for outpatient and inpatient empiric treatment of CAP

**Empiric Treatment of CAP in outpatients** (adapted from 2019 ATS/IDSA CAP Guidelines)

<table>
<thead>
<tr>
<th>Patient factor</th>
<th>Standard Regimen</th>
<th>Comment</th>
</tr>
</thead>
</table>
| No comorbidities or risk factors for MRSA or *P. aeruginosa* (see above) | Amoxicillin 1 g 3x/d or Doxycycline 100 mg 2x/d | Comorbidities include chronic heart, lung, liver or renal disease, DM, alcoholism, malignancy or asplenia
Note: macrolide is now recommended only if local pneumococcal resistance is <25% |
| With comorbidities | Combination therapy with:
Amoxicillin/clavulanate (500 mg/125 mg 3x/d, 875 mg/125 mg 2x/d) or cefpodoxime (200 mg 2x/d), or cefuroxime (500 mg 2x/d) plus
Azithromycin (500 mg on 1st day then 250 mg daily), or doxycycline (100 mg 2x/d) OR
Monotherapy with levofloxacin (750 mg daily) | Comorbidities include chronic heart, lung, liver or renal disease, DM, alcoholism, malignancy or asplenia |
### Empiric Treatment of CAP in inpatients (adapted from 2019 ATS/IDSA CAP Guidelines)

<table>
<thead>
<tr>
<th>Severity</th>
<th>Standard Regimen</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-severe</td>
<td>Ampicillin/sulbactam (1.5 - 3 g every 6 h), or ceftriaxone 1-2 g daily plus</td>
<td>MRSA or P. aeruginosa risk factors: Prior identification of MRSA or P. aeruginosa in the respiratory tract within the prior year OR hospitalization and parenteral antibiotic exposure in the last 90 days in or out of the hospital.</td>
</tr>
<tr>
<td></td>
<td>Azithromycin 500 mg daily</td>
<td>Duration of treatment 7 days when MRSA or P. aeruginosa suspected or proven.</td>
</tr>
<tr>
<td></td>
<td>Extended coverage when MRSA suspected: Vancomycin (15 mg/kg every 12 h, adjust per levels) or linezolid (600 mg every 12 h)</td>
<td>In the absence of prior respiratory isolation of MRSA or P. aeruginosa, extended coverage may be held for respective pathogens pending results of diagnostic tests (eg, blood, sputum, PCR for MRSA)</td>
</tr>
<tr>
<td></td>
<td>Extended coverage when P. aeruginosa suspected: Cefepime 2 g every 8 h, or piperacillin-tazo (4.5 g q every 6 h) or meropenem (1 g every 8 h) or aztreonam (severe penicillin allergy, 2g every 8h)</td>
<td>Duration of CAP due to suspected or proven MRSA or P. aeruginosa should be 7 days.</td>
</tr>
<tr>
<td>Severe (defined by 1 major criterion or ≥ 3 minor criteria)</td>
<td>Ampicillin/sulbactam 1.5 - 3 g every 6 h, or ceftriaxone 1-2 g daily plus Azithromycin 500 mg daily OR Ampicillin/sulbactam 1.5 - 3 g every 6 h, or ceftriaxone 1-2 g daily plus Levofloxacin 750 mg daily</td>
<td>MRSA or P. aeruginosa risk factors: Prior identification of MRSA or P. aeruginosa in the respiratory tract within the prior year OR hospitalization and parenteral antibiotic exposure in the last 90 days in or out of the hospital.</td>
</tr>
<tr>
<td>Major criteria</td>
<td></td>
<td>Duration of CAP due to suspected or proven MRSA or P. aeruginosa should be 7 days.</td>
</tr>
<tr>
<td>• Septic shock with need for vasopressors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Respiratory failure requiring mechanical ventilation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• RR≥30/min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PaO₂/FiO₂ ≤250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Multilobar infiltrates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Confusion/disorientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Uremia (blood urea nitrogen ≥20 mg/dl)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Leukopenia due to infection (WBC &lt;4,000/ul)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Thrombocytopenia (platelets &lt;100,000/ul)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hypothermia (core temp &lt;36° C, 96.8° F)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hypotension requiring aggressive fluid resuscitation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Clinical pearls:**

- New CAP diagnostic guidelines from Pearls4Peers
- New 2019 CAP treatment guidelines from Pearls4Peers
- 2016 HAP guidelines form Pearls4Peers
- When to switch to po antibiotics in CAP from Pearls4Peers

**Relevant literature:** [2019 IDSA/ATS CAP guidelines](#) and [Management of adults with hospital-acquired and ventilator-associated pneumonia: 2016 clinical practice guidelines by the IDSA and ATS](#)
Rapid facts:

- The majority of cases of cellulitis are nonculturable and therefore the causative bacteria are unknown.
- The diagnosis of cellulitis is based primarily on history and physical examination.
- Treatment of uncomplicated cellulitis should be directed against Streptococcus and methicillin-sensitive S. aureus.
- Failure to improve with appropriate first-line antibiotics should prompt consideration for resistant organisms, secondary conditions that mimic cellulitis, or underlying complicating conditions such as immunosuppression, chronic liver disease, or chronic kidney disease.
- Refer to whitebook for cellulitis mimics (or pseudocellulitis).
- “Bilateral cellulitis” should prompt an alternative diagnosis.
- **ALT-70 score**: Developed to assist with evaluation of lower extremity redness, which may be inappropriately diagnosed as cellulitis (versus mimickers, or “pseudocellulitis”). Most patients with cellulitis have acute onset, unilateral involvement (usually one leg), and are sick with an elevated white blood cell count, tachycardia, and/or a fever. Validated in a small cohort of 67 patients.

Slide presentation: [MGH Noon Conference on Cellulitis and the Other Red Leg by Daniela Kroshinsky](#)

Relevant literature:

- [JAMA: Cellulitis: A Review](#)
- Refer to [ALT-70 score](#) link for linked original literature as well as validation
Inpatient topic | Decompensated cirrhosis  
Collating author | Daniel Restrepo, MD

MGH Whitebook (DESKTOP): Alcohol Related Liver Disease, End-Stage Liver Disease and Hepatorenal Syndrome  
MGH Whitebook (MOBILE): Alcohol Related Liver Disease, End-Stage Liver Disease and Hepatorenal Syndrome

Rapid diagnostic schema/facts:

Precipitants

<table>
<thead>
<tr>
<th>HE</th>
<th>Ascites/Edema</th>
<th>HRS</th>
<th>GI Bleed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed lactulose</td>
<td>Missed diuretics</td>
<td>SBP/Infection</td>
<td>SBP</td>
</tr>
<tr>
<td>GIB</td>
<td>Sodium intake</td>
<td>Large Volume Paracentesis</td>
<td>HCC</td>
</tr>
<tr>
<td>SBP/infection</td>
<td>GI/B</td>
<td>GI/B</td>
<td>PVT</td>
</tr>
<tr>
<td>HypoK</td>
<td>SBP</td>
<td>IV diuretics</td>
<td>PVT</td>
</tr>
<tr>
<td>Opioids/BZDs</td>
<td>HCC</td>
<td>Alcoholic Hepatitis</td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td>PVT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PVT</td>
<td>TIPS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Slide presentation: Common Complications of Cirrhosis - Part 1 by Michael Thiim (audio) and Common Complications of Cirrhosis - Part 2 by Michael Thiim (audio) and Hepatorenal Syndrome: An Update on AKI in Cirrhosis by Andrew Allegretti (audio)

Relevant literature: Treatment of Patients with Cirrhosis
Inpatient topic | Gastrointestinal bleeding
---|---
Collating author | Amulya Nagarur, MD

MGH Whitebook (DESKTOP): Upper GI Bleeding, Lower GI Bleeding, GERD and Peptic Ulcer Disease
MGH Whitebook (MOBILE): Upper GI Bleeding, Lower GI Bleeding, GERD and Peptic Ulcer Disease

Rapid schema and facts:

Triage considerations:

### MGH GI Taskforce Protocol for Acute Upper GI Bleed Management
- **Criteria:** BP < 90 and HR > 100 x 2 30min apart; Hct < 20 regardless of vital signs, and evidence of active significant bleed in 12hrs; requirement of >2L IV/2L IVF or 2U pRBCs to prevent instability/keep Hct > 25; ATLS hemorrhagic shock class III; clinical judgment
- **Consults:** page/call GI fellow; call Medical Sr for MICU bed; consult Trauma team and/or Interventional Radiology when needed
- **Resuscitation:** crystalloid IV/IVF via 2L IV; pRBC to keep Hb > 7 or higher if co-morbidities; correct coagulopathy rapidly to therapeutic goal; IV PPI (+ octreotide if suspected portal HTN)
- **Urgent EGD in the ICU:** performed within hr after effective resuscitation and securing safe airway; If no ICU bed, should be performed in ED (sedation and intubation if needed); IV erythromycin (250mg) is recommended 30 mins prior to EGD

### Etiologies of Upper GIB (Di Gastroenterology 2018; 63:1286)
- Ulcers (~50%): PUD, H. pylori, NSAID, ZE, ETOH
- Varices (~5%): EVB (esophageal) > gastric
- Esophagitis or Gastritis (~30%): GERD, pill, ASA, NSAIDs, clopidogrel, ETOH, infectious
- Vascular lesions (~5-10%): Dieulafoy's, AVM, GAVE, OR/HHT, XRT, aortoenteric fistulae
- Traumatic (~5%): Mallory-Weiss, foreign body, Boerhaave's
- Neoplastic (~5%): primary > metastatic
- Post-procedural (varies): polypectomy, sphincterotomy

### Etiologies of Lower GIB/Hematochezia
- Diverticulosis (30-65%)
- Ischemic colitis (5-20%)
- Hemorrhoids (5-20%)
- Brisqu GIB (~13%)
- Colorectal polyps or neoplasms (2-15%)
- Angioectasias (5-10%)
- Post-polypectomy (2-7%)
- IBD (3-5%)
- Infectious colitis (2-5%)
- Stercoral ulceration, colorectal varices, radiation proctopathy, NSAID induced colopathy, Dieulafoy's lesion (0-5%)

Slide presentation: MGH Noon Conference on GI Bleeding with Nneka Ufere

Relevant literature: Refer to MGH Whitebook link for original literature including NEJM 2016: Clinical Practice: Upper Gastrointestinal Bleeding Due to a Peptic Ulcer and NEJM 2017: Acute Lower Gastrointestinal Bleeding
Inpatient topic | Acute kidney injury (AKI)
--- | ---
Collating authors | Amulya Nagarur, MD and Andrew Fenves, MD

**MGH Whitebook (DESKTOP):** [Acute Kidney Injury](#) and [Glomerular Disease](#) and Renal Replacement Therapy

**MGH Whitebook (MOBILE):** [Acute Kidney Injury](#) and [Glomerular Disease](#) and Renal Replacement Therapy

**Rapid diagnostic schema/facts:** Adapted from MGH Whitebook and [Clinical Problem Solvers intrarenal AKI diagnostic schema (with accompanying video)](#)

### Slide presentations:
- [MGH Noon Conference on Acute Kidney Injury by Andrew Lundquist](#)

### Relevant literature:
- Numerous links in MGH Whitebook and [JHM 2015: Before you call renal: AKI for the hospitalist](#) and [JHM 2016: Things we do for no reason: Urinary fractional excretion indices in the evaluation of acute kidney injury](#)
Inpatient topic | Hyponatremia
Collating author | Cindy Cooper, MD

MGH Whitebook (DESKTOP): Hyponatremia
MGH Whitebook (MOBILE): Hyponatremia

Rapid diagnostic schema/facts: Accompanying video here

- Treat acutely symptomatic patients 100cc bolus of 3% saline, aiming to increase SNa by 2-3mEq/L
- Involve renal consult team for severe hypoosmolar hyponatremia SNa <120
- Aim to increase SNa no more than 8 mEq/L/day; no more than 4-6 mEq/L/day if high risk for Osmotic Demyelination Syndrome (ODS)
- Patients at highest risk for ODS include:
  - Serum sodium <105 mmol/L
  - Hypokalemia
  - Alcoholism
  - Malnutrition
  - Advanced liver disease

Slide presentation: MGH Noon Conference on Hyponatremia by Andrew Lundquist

Relevant literature: JASN 2017 Diagnosis and Treatment of Hyponatremia and CJASN 2018 Risk Factors for Osmotic Demyelination Syndrome
Inpatient topic | Urinary tract infection  
Collating author | Steven Knuesel, MD  

**MGH Whitebook (DESKTOP):**  
Urinary Tract Infection and Multidrug Resistant Organisms and MGH Antibiogram  

**MGH Whitebook (MOBILE):**  
Urinary Tract Infection and Multidrug Resistant Organisms and MGH Antibiogram  

**Rapid facts:**  
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**Our approach to categorizing UTI in adults and adolescents**  

| Acute simple cystitis* | Acute UTI that is presumed to be confined to the bladder  
| There are no signs or symptoms that suggest an upper tract or systemic infection (refer to below)  
| Acute complicated UTI | Acute UTI accompanied by signs or symptoms that suggest extension of infection beyond the bladder:  
| Fever (>99.5°F/37.5°C)*  
| Chills, rigors, significant fatigue or malaise beyond baseline, or other features of systemic illness  
| Flank pain  
| Costovertebral angle tenderness  
| Pelvic or perineal pain in men  

| Special populations with unique management considerations | Pregnant women  
| Renal transplant recipients  

**Empiric Antibiotics**  

| Complicated UTI (includes Pyelo) | Output: CPO 500mg BID x 5-7d OR LVO 750mg x 5-7d OR TIS DS BID x 7-10d. Can give 1x IV CTX prior to oral b.  
| Inpt: CTX OR CEF, Narrow to oral agent if improving. Add Vanc / Linezolid if c/t GPC infxn (e.g., if GPC on urine G/stain). Duration: 5-14d, depending on clinical course and oral agent chosen (5-7d for FQ; 7-10d for TIS; 10-14d for β-lactam). Alternatives: PI/T (if PsA); CBPN if c/t ESBL on micro  
| CAUTI | (CTX OR FQ) AND VANC (risk of MRSA)  
| Duration: 7d if improving; 10-14d otherwise  
| Alternatives: PI/T OR CEF (if c/t PsA); CBPN if c/t ESBL on micro  
| Funguria | FLUC 200-400mg (pyelo) PO QD 14d OR conventional AmB 0.3-0.6 mg/kg QD x1-7d if c/t FLUC-R  

| Notes | Avoid NFT if CrCl<40 and empiric TIS if resistance is >20% (E. coli 28% at MGH)  
| Avoid NFT and fosfomycin (poor soft tissue penetration from oral administration)  
| Remove (or replace) coated uro devices  
| Low threshold to image to define anatomy  
| Remove catheter ASAP, obtain repeat UA/UCx from new cath PRIOR to abx  
| Common colonizers; ONLY tx if sx or neutropenic, before uro procedure  
| If resistant C. glabrata or krusei; use conventional AmB  

**KEY:** NFT-nitrofurantoin; TIS-TMP/SMX; CTX-ceftriaxone; FQ-fluoroquinolone; P/T-piperacillin/tazobactam; CEF-E-cefepime; CBPN-carbapenem; AMG-aminoglycoside; CPO-ciprofloxacin; LVO-levofoxacin; FLUC-flucnazole; AmB-amphotericin B; R-resistance  

**Relevant literature:**  
See Whitebook for numerous links to primary literature.  
**IDSA 2010 Update on Acute Cystitis and Pyelonephritis in Women**  
**IDSA 2019 Practice Guideline on Asymptomatic Bacteriuria**  
"Urinary Tract Infection" - Requiem for a Heavyweight
Inpatient topic | Altered mental status (with a focus on delirium)
Collating author | Amulya Nagarur, MD

**MGH Whitebook (DESKTOP):** [Altered Mental Status](#) and [Delirium](#)
**MGH Whitebook (MOBILE):** [Altered Mental Status](#) and [Delirium](#)

**Rapid diagnostic schema:** [Accompanying explanatory video here](#)

---

**“MIST positive AMS”**

- **Mnemonic**
  - Apathy
  - Disorientation

- **Metabolic**
  - Electrolytes
  - Organ dysfunctions
  - Others
  - Vitamin, B12, B6

- **Infection**
  - Extra-CNS
  - CNS

- **Structural**
  - Subdural hematoma

- **Toxin**
  - Opioids
  - Benzodiazepines

---

**“MIST Negative AMS”**

- **Dementia**
  - Rapidly progressive
  - Pick's
  - Autoimmune
  - Vascular

- **Psychiatric**
  - Catatonia

- **Strategic Stroke**
  - Brainstem
  - Thalamus
  - Dominant parietal lobe
  - Frontal lobe
  - Superior sagittal sinus

---

**Slide presentation:** MGH Noon Conference on AMS by Eyal Kimchi

**Relevant literature:** [NEJM 2017: Delirium in Hospitalized Older Adults](#) and [Annals 2019: Antipsychotics for Preventing Delirium in Hospitalized Adults: A Systematic Review](#)
Inpatient topic: Alcohol withdrawal
Collating author: Kathleen Finn, MD

MGH Whitebook (DESKTOP): Alcohol withdrawal
MGH Whitebook (MOBILE): Alcohol withdrawal

Rapid diagnostic schema/facts:

![Pathophysiology diagram showing the effects of alcohol withdrawal on GABA and glutamate levels.]

<table>
<thead>
<tr>
<th>CNS Stimulation (GABA)</th>
<th>Adrenergic Hyperactivity (Glutamate, NMDA)</th>
<th>Dopamine Dysregulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uneasiness</td>
<td>Chills</td>
<td>Disorientation</td>
</tr>
<tr>
<td>Mild tremor</td>
<td>Fever</td>
<td>Delirium</td>
</tr>
<tr>
<td>Restlessness</td>
<td>Diaphoresis</td>
<td>Hyperalertness</td>
</tr>
<tr>
<td>Irritability</td>
<td>Moderate tremor</td>
<td>Impaired reasoning</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Nausea and vomiting</td>
<td>Agitation</td>
</tr>
<tr>
<td>Seizure</td>
<td>Palpitations</td>
<td>Hallucinations</td>
</tr>
<tr>
<td></td>
<td>Increased HR, BP, RR</td>
<td></td>
</tr>
</tbody>
</table>

*Abbreviations: BP, blood pressure; HR, heart rate; RR, respiratory rate.*

<table>
<thead>
<tr>
<th>Table 5: DSM IV-TR alcohol withdrawal syndromes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Withdrawal (First 48 hours After Cessation of Drinking)</td>
</tr>
<tr>
<td>Uneasiness</td>
</tr>
<tr>
<td>Tremor</td>
</tr>
<tr>
<td>Restlessness</td>
</tr>
<tr>
<td>Irritability</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Fever</td>
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<td>Nausea and vomiting</td>
</tr>
<tr>
<td>Increased HR, BP, RR</td>
</tr>
<tr>
<td>Alcohol hallucinations</td>
</tr>
<tr>
<td>Seizures</td>
</tr>
</tbody>
</table>

*Abbreviations: BP, blood pressure; HR, heart rate; RR, respiratory rate.*

Slide presentation: MGH Noon Conference on Alcohol Withdrawal by Kathleen Finn and MGH Noon Conference on DTs and Phenobarbital by Kathleen Finn

Relevant literature: Inpatient Alcohol Withdrawal Review

Useful EPIC Tip: Place Addiction Consult Team (ACT) consult to help with inpatient management and aftercare planning.
### Inpatient topic | Inpatient diabetes management
---|---
Collating author | Margaret Chapman, MD

MHG Whitebook (DESKTOP): Inpatient Management of Diabetes and DKA & HHS
MHG Whitebook (MOBILE): Inpatient Management of Diabetes and DKA & HHS

**Stepwise approach:**

#### Guiding principles
- You can manage almost everything you need to with fingersticks, glargine, and lispro
- Start Low – Go Slow – hypoglycemia is worse than hyperglycemia, short-term
  - Risk factors for hypoglycemia: nausea/vomiting/malaise leading to less PO intake than anticipated, NPO for test or procedure leading to less PO intake than anticipated, they don’t use their home meds as much as prescribed
- Use the Epic order set “Adult Basal/Bolus Insulin”. It contains every order you need for inpatient AND important safety meds. Do NOT order each part separately.

#### Step 1: On Admission
- Obtain medication history
  - What agents?
  - Approximate idea of how well blood sugars are controlled at home (if they check)?
  - For Type 1: do they use a pump? How do they manage sliding scale? Last few days of blood sugars?
- Order an A1c (this will come in handy for discharge below)
- Order QID fingerstick glucoses (before each meal and at bedtime)

#### Step 2: Initial Orders
- Patients who use **ORAL hypoglycemics** (e.g. anything other than insulin)
  - Is this a very straightforward admission where the patient is expected to eat and drink normally, have minimal testing, and discharge within 48 hours? Consider continuing home agents
  - For everyone else:
    - Stop home oral hypoglycemics (and injectables other than insulin)
    - Start a LOW DOSE sliding scale insulin (uses lispro insulin)
    - Order “Carbohydrate Managed” diet
- Patients who use **INSULIN** at home
  - Is this a very straightforward admission where the patient is expected to eat and drink normally, have minimal testing, and discharge within 48 hours AND they can tell you they have good control at home? Consider continuing home agents at home dosing
  - For everyone else:
    - Start their home insulin regimen
    - Consider dose reducing by 25% on day 1 to minimize risk of hypoglycemia
    - Order Sliding Scale insulin
      - LOW dose for anyone using <40 units of insulin TOTAL per day
      - MEDIUM dose for anyone using 40+ units of insulin TOTAL per day
  - For patients using a pre-mix insulin (e.g. 70/30), consult pharmacy or endocrinology
- For **TYPE 1 diabetes**
  - Do NOT hold basal insulin – even if NPO!
  - Restart the patient’s home insulin
  - If they use a pump, contact endo to help get the orders set up. It’s safer to use the patient’s pump than it is to switch their insulin regimen in most cases

#### Step 3: Daily Adjustments
- Review the FASTING blood sugar (aka the “pre-breakfast” blood sugar)
  - <100: reduce basal insulin by 25-50% to avoid hypoglycemia
  - 100-180: no changes needed
  - 180+: change basal insulin
    - Already on glargine? Consider increase of 10-25%
    - Not on glargine? Your patient probably needs scheduled insulin rather than just sliding scale
      - Total daily units of insulin = patient’s body weight * 0.25units/kg/day
- 50% of the total units of insulin will be glargine – schedule this to be given at 2200 (basal is given the night before)
- 50% of the total units will be divided up by 3 and given at each meal
- For example: 80kg person → total units insulin=20 → 10 units glargine at 2200, 3 units lispro with each meal

- Review the MEAL-TIME blood sugars
  - If the patient is already on scheduled meal-time insulin
    - If you have adjusted the basal glargine that day → consider waiting until the next day to adjust prandial (to avoid hypoglycemia)
    - If all three readings are >180, increase prandial dose by 10-25%
  - If the patient isn’t already on scheduled meal-time insulin → go back to scheduling insulin instructions above

### Step 4: Discharge

- Is the A1c 6.5-8.5?: discharge back onto the patient’s home regimen
- Is the A1c <6.5?: dose reduce by 25% to avoid home hypoglycemia AND close follow up with primary care
- Is the A1c>8.5?: consider increased dosing OR close follow up with primary care
- Is the A1c>10?: consider new insulin start

- If a type 1
  - Well controlled – restart home regimen
  - Poorly controlled – talk to PCP, endocrinologist or inpatient Diabetes Management Consult

- New insulin start?
  - Discharge with diabetes supplies: Use Epic Order Set is called “Insulin/Diabetes Supplies Discharge”. It is available in the D/C Order Rec section of the discharge navigator.
    - Include: glucometer, lancets, test strips, alcohol prep pads
  - Discharge with insulin
    - If insulin pens – will need pens and pen needles prescribed
    - If insulin vials – will need vials, syringes, and needles prescribed
  - Ask nurses to do bedside teaching

**Slide presentation:** [MGH Noon Conference on Inpatient Diabetes by Nancy Wei](https://example.com) and [MGH Noon Conference on DKA by Nancy Wei](https://example.com)

**Relevant literature:** [Management of Hyperglycemia in the Inpatient Setting](https://example.com) and [Things We Do For No Reason: Sliding Scale Insulin as Monotherapy for Glycemic Control in Hospitalized Patients](https://example.com)
1) Perioperative cardiac risk gets more attention than other categories of risk, but other complications like postoperative delirium, pneumonia, and renal failure can have serious consequences. Clinical judgement remains paramount in evaluating patients prior to surgery. Think carefully about the whole patient, including chronic medical problems, medications, and current health status. Does the patient seem well enough to withstand the stress of surgery? Are there particular things to look out for in the postoperative period?

2) Vascular surgery carries much higher risk than other non-cardiac surgery. Consider Cardiology consultation for patients undergoing vascular surgery.

3) Surgery in patients with cirrhosis is associated with very high morbidity and mortality\(^1,2\). Surgery in patients with MELD scores (type .MELD in Epic note to get MELD score) 15 and above associated with very high mortality and is generally avoided unless the surgery is transplantation.

4) Preoperative albumin is an independent risk factor for postoperative morbidity and mortality. Surgery in patients with low albumin carries high risk\(^3\).

5) Preoperative BNP can be helpful in risk stratifying patients\(^4\).

**Slide presentation:** [MGH Noon Conference on Perioperative Cardiovascular Management by David Dudzinski](https://example.com)

**Relevant literature:** Refer to MGH Whitebook for numerous links as well as [Perioperative Evaluation and Management of Patients with Cirrhosis](https://example.com), [Surgical Risk in Patients with Cirrhosis](https://example.com), [Preoperative Serum Albumin Level as a Predictor of Operative Mortality and Morbidity](https://example.com), [Preoperative N-Terminal Pro-B-Type Natriuretic Peptide and Cardiovascular Events After Noncardiac Surgery](https://example.com).
Inpatient topic | Disposition (with focus on discharge to post-acute care and capacity/legal issues)
--- | ---
Collating author | Amulya Nagarur, MD

**MGH Whitebook (DESKTOP):** [Post-Acute Care](#) and [Discharge Summaries](#) and [Consent, Capacity, and Legal](#)

**MGH Whitebook (MOBILE):** [Post-Acute Care](#) and [Discharge Summaries](#) and [Consent, Capacity, and Legal](#)

**Rapid facts:**

<table>
<thead>
<tr>
<th>Setting (most to least intensive)</th>
<th>Description</th>
<th>Patients / Diagnoses</th>
<th>Avg LOS</th>
<th>MD</th>
<th>Therapy / Ancillary Services</th>
</tr>
</thead>
</table>
| **Long Term Acute Care Hospital (LTAC)** | High intensity hospital-level care | - Tracheostomy  
- Chemotherapy  
≥ 3-day ICU stay required to qualify | 20+ days | Daily MD visits | - RT  
- PT/OT PRN  
- HD |
| **Inpatient Rehabilitation Facility (IRF, ”acute rehab”)** | Intensive therapy for recovery of function | - Post-stroke  
- Spinal cord injury  
- Note: Specific dx codes required to qualify | 7-21 days | 2-4x/week MD visits; PM&R presence | - 3+ hours of therapy/day (pt must be able to participate) |
| **Skilled Nursing Facility (SNF)** | ”Sub-acute” rehabilitation; looks/feels like nursing home; must have 3-night hospital stay to qualify under Medicare | - CHF, PNA, UTI  
- Generally older patients with functional decline / unsafe at home | 3-21 days | ~1x/week MD visits; very limited capacity for management changes | - 1-2 hours of therapy/day (pt must be able to progress) |
| **Home Health** | Home-based services post-hospitalization or via PCP referral | - Wound care  
- IV antibiotics  
- Post-hospital functional decline  
- Home safety eval | N/A | Managed by PCP or prescribing outpatient clinician | - 4-8 PT/OT visits  
- RN visits as needed |

Physical Therapy, Occupational Therapy, Speech and Language Pathology, Nutrition, and Social Work consults available to guide discharge planning

**Slide presentation:** [MGH Noon Conference on Post-Acute Care by Melissa Mattison](#)

**Relevant literature:** [Assessment of Patients’ Competence to Consent to Treatment](#)
Best Practices in Clinical Teaching: Teaching On-Service

Apply Adult Learning Theory —— Ideas for Inspiration

1. Involve Adult Learners
   - Residents create educational agenda & assign topics
   - Learning builds upon prior patient experiences

2. Engage Prior Knowledge
   - Clinical Reasoning
     ➢ Journal Club, E&M
     ➢ Diagnostic Time Outs

3. Immediate Relevance
   - Patient-centered learning with topics inspired by patients on service

4. Problem-Centered
   - Humanism
     ➢ Narrative Medicine
     ➢ Perspective Pieces
     ➢ Sharing Patient Personal Stories

   - Bedside Rounds
     ➢ Physical Exam
     ➢ FOCUS
     ➢ SCCD discussions
     ➢ Group Procedure

   - Team Teaching
     ➢ Chalk Talks with Feedback
     ➢ 1 min Clinical Pearls

Best Practices in Clinical Teaching: Resident Autonomy & Coaching

Strategies

- Empower & Reinforce
  ➢ Set expectation of resident as team leader
  ➢ Redirect questions & presentations to resident (verbally & using gaze)

- Destigmatize Feedback
  ➢ Make the purpose & intentions of feedback transparent
  ➢ Try framing with Deliberate Practice & Growth Mindset

- Silence & Space
  ➢ Let residents speak first to state & justify their plan
  ➢ Give them physical space
  ➢ Allow for stylistic differences

- Make Feedback Collaborative
  ➢ Target feedback towards resident goals
  ➢ Allow resident to self-assess, then develop a plan together

Benefits of Autonomy

- Engages & Motivates
- Improves Confidence
- Solidifies Knowledge w/ Active Learning
- Hones Leadership & Teaching Skills
- Allows Attendings to Assess
- Autonomy is Essential for Coaching

Key Points

Autonomy ≠ Trust

Autonomy is the sense of volition, agency & choice, which all trainees need. Supervision may vary based on competency.

Feedback for All

Reserving feedback only for “struggling learners” stigmatizes feedback and inhibits lifelong learning & growth mindset.