Course Director:

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Curriculum

1. The purpose of this rotation is to develop your overall skills as a consultant and prepare you for areas that typically are assessed as part of board certification. A secondary objective is to reduce variability in the consult experience that occurs depending upon the hospital census and clinical preceptor availability. We have developed a formal set of learning activities on this website to assist you in meeting these goals.

2. This website (http://lss.at.ufl.edu) contains the curriculum for the rotation. Residents log-in using their Gatorlink ID and password. The website also contains reference materials that you can access even after you complete the consult rotation.

3. You should complete 3 website Modules by the end of the rotation: “General Consultation,” “Preoperative Evaluation,” and “Consultation Problems.” Each module contains one or more PowerPoint lecture presentations. “General Consultation” and “Preoperative Evaluation” also contain quizzes based upon MKSAP materials.

Expectations:

1. You should have a password for all ShandsUF computer systems including “NetAccess,” “Citrix,” and “Stentor.” You must have a Gatorlink userID and password to access the consult syllabus. Please make sure these are active before you start the rotation. If you are a medical student, please see the Student Affairs office for assistance.

2. You should be at work by 8AM; new consults are seen Monday-Friday by housestaff beginning at 0800. Please telephone your preceptor when you arrive so that he/she can confirm any new consults or urgent follow-ups.

3. Consult Clinic is held Tuesday and Friday mornings at the Shands Medical Plaza (3rd floor) beginning at 0830. Please check NetAccess for the clinic schedule or telephone the clinic one-day ahead at 265-0139 to determine the specific clinic schedule.

4. New consults should be dictated. Progress notes should be written in SOAP format. Telephone the requesting service and write your own orders in any urgent/emergent situation. Do not write orders for antibiotics, blood, pain medications, or diet without first discussing these with the requesting service. In the surgical IMC/ICU’s you should discuss any recommendations with Critical Care Medicine (CCM).
a. Immediately after you see a new consult, write a brief, timed note in the chart stating, “Patient seen and examined, full consult to follow.”

b. If it is important to change therapy or obtain new diagnostic tests, please do not wait until rounds to discuss your preliminary recommendations – page your preceptor as soon as possible to discuss the case.

New inpatient consults should be DICTATED STAT using the following format:

- Job Type is #7.
- Dictate “STAT”(#6)
- State the requesting attending physician (full name) and their department
- State the reason for the consultation – (e.g., “management of hypertension”, “preoperative assessment secondary to history of chest pain, COPD”) 
- Include a comprehensive review of systems
- End with an impression that discusses your differential diagnosis followed by a concise numbered list of recommendations.
- Include instructions to send a copy to the requesting attending physician
- (See example of inpatient consult dictation at the end of this handout)

New outpatient consults should also be dictated STAT using Job Type #67.

5. Please have your notes written before we round.

6. You are excused from your consult duties to attend your regularly scheduled continuity clinic. On those days faculty preceptors will staff any new afternoon consults. You are not expected to return to make rounds after your clinic.

7. At night, the resident AOD may be paged for consultation requests. However, nighttime consultation should be performed only in urgent cases (e.g., a patient in the emergency department requiring urgent preoperative assessment before surgery; a patient on a non-monitored unit with severe hyperglycemia or tachycardia). The AOD is to contact the daytime consult attending to staff these cases. These cases are to be entered in the online consult portal for hand-off (Consult attendings are to keep their pagers on at all times while on the consult service).

8. Hand-offs are critical to the quality and continuity of our consultation services. High quality sign-out is needed daily to ensure physicians have the latest information regarding our current consult census. Sign-out occurs online using the IM Consultation Portal. Housestaff and faculty access the IM Consult Service Portal through the Department of Medicine home page located at http://www.medicine.ufl.edu/ (see directions on the following page).
Directions to access Consult Service portal follows:

1. Click on “New Medicine Intranet” located on the left hand side of the page.

2. Log in using your Department of Medicine email account and your Department of Medicine password. Username would be in the format of john.smith@medicine.ufl.edu

3. Choose “Internal Medicine” under the Division column.
4. Choose “Internal Medicine Consultation Service” under the Categories.

Once in this program, a current census will be visible. Your faculty preceptor will supervise updating of this census on a daily basis. Please work with your faculty attending to ensure accuracy and timeliness of this list.
GENERAL INTERNAL MEDICINE CONSULT SERVICE REQUIREMENTS

CONSULT REPORT TEMPLATE

1. There is a direct relationship between the quality of your consult report and the likelihood that the recommendations you make will actually be implemented and appreciated by the requesting physician. The key task for preoperative assessment is to clarify the status of a patient with cardiopulmonary problems or any other significant chronic diseases that are associated with perioperative morbidity. The key task for most other consultation requests is to clarify and answer the specific question(s) posed by the requesting physician.

2. Note that the Requesting Physician and the Reason for the Consultation are explicitly dictated.

3. The Reason for the Consultation is not “preoperative assessment” – it must be a specific sign, symptom, or diagnosis that a general internist would reasonably be expected to evaluate prior to surgery.

4. Note that the report ends with a narrative “Impression” and then a very simple, straightforward list of Recommendations. Note the discussion of the patient’s specific risks for surgery, rather than any mention of “clearing” the patient. We order our own stress tests, labs, consultations rather than just recommending to the surgeon that he/she do so.
EXAMPLE #1: OUTPATIENT CONSULT

01/01/1990

INTERNAL MEDICINE CONSULTATION CLINIC

REQUESTING PHYSICIAN: John Smith, MD, General Surgery

REASON FOR CONSULTATION: Preoperative evaluation of diabetes mellitus, congestive heart failure and COPD before right inguinal hernia repair.

HISTORY OF PRESENT ILLNESS: The patient is a 44-year-old white female with COPD on home O2 at night, diabetes mellitus and congestive heart failure who presents for preoperative evaluation of medical issues before a right inguinal hernia repair currently scheduled for July 21st. The patient was recently discharged in May for resection of necrotic bowel due to an incarcerated hernia; apparently further revision is needed. There is no mention in her discharge summary of any pulmonary or cardiovascular complication during this hospitalization and the patient states that her shortness of breath has remained near her baseline. She denies any increasing shortness of breath or dyspnea on exertion. She has had no episodes of exertional chest pain or resting chest pain. Her functional capacity is good and includes mowing her 1.5 acre lawn before becoming short of breath. Her most recent echocardiogram in 2002 revealed a normal ejection fraction of 55-60%. She does have 3 pillow orthopnea which has been stable. Her diabetes is not yet under good control with blood sugars she reports in the mid 200's-300's; she was recently given a higher dose of Avandia by her primary care physician; she does not follow a diabetic diet. The patient states that her sugars were ranging between 300-370 before her Avandia was increased to 8 mg from 4 mg p.o. daily. She states her sugars now run between 180-220.

Most pertinent history however is that this patient's husband is currently hospitalized and awaiting coronary artery bypass graft surgery scheduled for Monday or Tuesday of next week. The patient states that she will likely postpone her hernia repair.

PAST MEDICAL HISTORY: (1) COPD on home O2 2 liters at night. FEV-1 of 0.87 liters in 2002 (2) Diabetes mellitus type II. (3) Congestive heart failure secondary to non-ischemic cardiomyopathy, likely alcohol-induced with last reported EF of 55-60%. (4) Moderate left renal artery stenosis. (5) Depression. (6) History of Rocky Mountain spotted fever in 1981.

PAST SURGICAL HISTORY: (1) Tonsillectomy at the age of 5. (2) Status post right inguinal hernia repair with small bowel resection 05/05. No history of any anesthesia or bleeding related difficulties.

CURRENT MEDICATIONS: (1) Aspirin 81 mg p.o. daily. (2) BC headache powders one packet p.o. q. a.m. (3) Lasix 40 mg p.o. daily. (4) Zoloft 50 mg p.o. daily. (5) Advair inhalation 250 mcg at one puff b.i.d. (6) Xanax 0.5 mg p.o. q.h.s. p.r.n. (7) Digoxin 0.25 mg p.o. daily. (8) Avandia 8 mg p.o. daily. (9) Glipizide ER 5 mg p.o. daily. (10) Metoprolol 50 mg p.o. b.i.d. (11) Lipitor 10 mg p.o. daily.
ALLERGIES: No known drug allergies.

FAMILY HISTORY: Mother died of lung carcinoma and had hypertension. Father died of leukemia and had hypertension.

SOCIAL HISTORY: The patient lives in Happysville, Florida, with her husband. She has three children and is a homemaker. She smokes one pack per day and has done so for the last 40 years. She used to drink a 12-pack of beer per day but quit approximately five months ago. She denies any use of illicit drug substance.

REVIEW OF SYSTEMS: The patient is positive for three pillow orthopnea, but describes it more as a cough than shortness of breath. No PND and no palpitations. Has a cough in the a.m. but says this is unchanged over the last months to year. No fevers or chills. No light-headedness or dizziness. No visual changes. No nausea and vomiting. She does state she has had a 20-pound weight loss over the last two to three months and says that she feels she gets full quickly describing early satiety. No diarrhea or constipation. No melena or bright red blood per rectum. No burning on micturition or dysuria. All other review of systems is negative other than that stated in the HPI.

PHYSICAL EXAMINATION: VITAL SIGNS: Blood pressure 153/72 (on recheck 128/70), pulse 80, temperature 98.8 degrees Fahrenheit, and weight 151 pounds.

GENERAL: The patient is a 54-year-old white female who appears much older than stated age and somewhat chronically ill-appearing, but in no apparent acute distress.

HEENT: Normocephalic, atraumatic. Pupils are equal, round and reactive to light. Extraocular movements are intact. Sclerae anicteric. Oral mucosa is moist and without lesions. Poor dental hygiene. NECK: No thyromegaly and no lymphadenopathy. Positive JVD to approximately 8 cm. LUNGS: Clear to auscultation bilaterally. HEART: S1-S2 with a 2/6 systolic ejection murmur heard best in the left lower sternal border. ABDOMEN: Positive bowel sounds in all four quadrants, soft, nontender and nondistended. EXTREMITIES: Trace edema bilaterally. Dorsalis pedis pulses are 2+ bilaterally.

LABORATORY DATA: E.C.G. 1/1990 revealed normal sinus rhythm; Labs on 5/12/05 revealed Creatinine 0.3, glucose 148, potassium 3.1. Hematocrit 37%.

IMPRESSION: The patient is a 44-year-old white female who has poorly controlled diabetes mellitus and a history of non-ischemic cardiomyopathy with very good functional capacity and a history of a normal ejection fraction in 2002. She underwent bowel resection two months ago with no cardiopulmonary complications. She would benefit from better control of her diabetes to help prevent infection and promote good wound healing. She would also benefit from reinitiation of her ACE-inhibitor to assist with blood pressure control and maintenance of needed afterload reduction and remodelling for continued optimal cardiac function. She needs to stop smoking. Her smoking and history of C.O.P.D. place her at increased risk of perioperative pneumonia.

RECOMMENDATIONS: (1) We have instructed the patient to quit smoking. Ideally, the patient should be off of tobacco products for approximately eight weeks preoperatively for maximum benefit. The patient has also been instructed to continue her
COPD regimen which includes Advair and albuterol inhalers as scheduled. (2) Patient should discuss increasing her Glipizide ER to 10 mg p.o. daily with her primary care physician. (3) We recommended strongly that the patient be reinitiated on Lisinopril and instructed her to followup with her primary care physician on this issue. (4) Repeat B.M.P. to check for persistent hypokalemia noted on last lab draw in May.
INTERNAL MEDICINE CONSULTATION SERVICE

REQUESTING PHYSICIAN: Brain Surgeon, III, MD, Neurosurgery.

REASON FOR CONSULTATION: Poorly controlled hypertension.

HISTORY OF PRESENT ILLNESS: Patient is unable to provide a history secondary to aphasia and not following commands. The following has been gathered from medical records. The patient is a 270-year-old Asian female with essential hypertension who had a sudden onset of mental status change, aphasia, and right-sided hemiparesis on 06/30/76 and was taken by EMS to Shands at AGH. She was intubated and placed on propofol and a Nipride infusion for blood pressures greater than 203/133. CT of the head revealed a left thalamic hemorrhagic CVA and interventricular hemorrhage into left lateral ventricle. She was transferred to Shands at UF for further management. She was seen by neurosurgery who placed a ventriculostomy on 06/30. Subsequent CT scans have shown no further bleeding and gradual resolution of edema. She had a percutaneous tracheotomy performed on 07/01 for ventilator dependance and a G-J tube placed on 07/02 to facilitate nutritional input. Per nursing, she has become more alert over the last couple of days, but continues with aphasia and right-sided hemiparesis.

Regarding her hypertension, her husband reports she continues to have labile readings at home. Her regimen has consisted of a beta-blocker and ace-inhibitor. Her primary care physician is Dr. Internist here in Gainesville. There is no reported history of cardiovascular disease and no prior stroke.

PAST MEDICAL HISTORY: 1) h/o poorly controlled hypertension. 2) h/o TIA in 1772.

PAST SURGICAL HISTORY: 1) Tubal ligation in 1772. 2) D&C in 1772. 3) Uterine polyp removal in 1772. 4) Ventriculostomy placement on 06/30/01. 5) Percutaneous Tracheotony on 07/05/66. 6) G-J tube placement by IR on 07/07/01. 7) Replacement of G-J tube on 07/09/33.

CURRENT MEDICATIONS: (1) Enalapril 5 mg IV q.4. (2) Lopressor 100 mg b.i.d. (3) Labetalol 400 mg b.i.d. (4) Minipress 1 mg q.6. (5) Colace 100 mg b.i.d. (6) Heparin 5000 units subcu b.i.d. (7) Dilantin 150 mg q.12. (8) Protonix 40 mg IV b.i.d. (9) Diflucan 400 mg IV daily. (10) Hydralazine 10 to 20 mg IV q1 p.r.n. (11) Lopressor 10 to 20 mg IV q.1 p.r.n. (12) Labetalol 10 to 20 mg IV q.2 p.r.n. (13) Morphine IV p.r.n.

ALLERGIES: Shellfish and Iodine (?reaction)

FAMILY HISTORY: Father, mother, and sister with hypertension. Father had a CVA and died of MI at 76. Mother had an MI at 72.

SOCIAL HISTORY: She lives here in Gatorville with her husband who is a retired diesel inventor. Her son is a malpractice attorney in Bigcity, California. She used to
work as a diesel mechanic. She does not smoke, occasionally drinks alcohol, and has never use illicit drug substances.

REVIEW OF SYSTEMS: Unable to obtain due to patient's aphasia and somnolence.

PHYSICAL EXAMINATION: Vital signs: Temperature 38.5 degrees Fahrenheit, pulse 102, blood pressure 164/75, O2 saturation 99% on 28% aerosolized trach collar, respirations 24. General: The patient is a 60-year-old Asian female who appears much younger than stated age, lying on a hospital bed asleep, but in no apparent acute distress. HEENT: Normocephalic, atraumatic. There is a right-sided ventriculostomy in place. Site is clean, dry, and intact. Pupils are equal, round, and reactive to light. Extraocular muscles not assessable. Oral mucosa is moist and without lesions. Neck: No lymphadenopathy, no thyromegaly, and no JVD. Lungs: Clear to auscultation bilaterally. Heart: S1 and S2, tachycardic. No murmurs, rubs, or gallops noted. Abdomen: With bowel sounds present. Soft, non tender, nondistended with no organomegaly. G-J tube site is clean, dry, and intact. Extremities: No clubbing, cyanosis, or edema. Neurologic: The patient is arouseable and tries to maintain eye contact. Patient with gross right-sided hemiparalysis. Moves left upper and lower extremity spontaneously. Does not follow commands.

LABORATORY DATA: Sodium 136, potassium 4.5, chloride 112, carbon dioxide 21, BUN 6, creatinine 0.4, glucose 162, calcium 7.9, magnesium 1.9, phosphorus 2.5. WBC 12.7, hemoglobin 9.4, hematocrit 29.3, platelets 597.

STUDIES: EKG reveals a sinus tachycardia with increased voltage approaching left ventricular hypertrophy.

ASSESSMENT: The patient is an amazing Asian female status post left thalamic CVA status post ventriculostomy who requires consolidation of her antihypertensive medications. Blood pressure has been stabilized on intravenous and prn medications but she would benefit from refinement of this regimen.

RECOMMENDATIONS:

(1) We discontinued oral Lopressor, IV hydralazine, and IV Lopressor.

(2) We changed IV Enalapril to oral Enalapril 15 mg per G-tube q.12.

(3) We increased labetalol to 600 mg per G-tube q.12.

(4) Will leave Minipress for now but will discontinue at some point in favor of an alternate drug that is longer acting if needed.

(5) Continue close monitoring of blood pressure and we will titrate oral medications accordingly.