Pancreatitis (Dr. Hudson)

- Definition → acute inflammation of pancreas
- Presents with epigastric/sometimes RUQ pain
- Dx: Two of the following
    - Characteristic abdominal pain
    - Lipase >3x upper normal
    - Characteristic findings on imaging
- Workup: Labs +/- imaging
    - Imaging can evaluate for GB causes OR pseudocysts
- Management
    - Supportive care
    - IVF
    - Diet → NPO if they can't tolerate, progress slowly
- Diagnosis
    - Discharge if no gallbladder disease, tolerating PO, well appearing, pain controlled
    - Admit if otherwise

The Choles (Gallbladder Disease)(Dr. Lyons)

- Symptomatic Cholelithiasis
    - Dull discomfort in RUQ triggered by fatty meals
    - Lasts 30 minutes to 6 hours
    - Caused by contraction of gallbladder against obstruction
    - Workup → CBC, CMP, RUQ ultrasound
    - Management → NSAIDs, opioids
- Acute cholecystitis
    - RUQ pain, murphy's sign, NV
    - Workup → same as above
        - US → pericholecystic fluid, thickened wall (3-3.5 mm), sonographic Murphy sign
    - Management → antibiotics, pain control, surgery consult
- Choledocolithiasis
    - RUQ, Murphy's sign, NV, AND jaundice, scleral icterus
    - Workup → CBC, CMP, lipase, RUQ US
    - US → CBC > 6 mm (+1 mm for every 10 years over 60 years old)
    - Management → pain control, fluids, NPO, surgery consult, IV antibiotics
- Ascending cholangitis
    - RUQ pain, Murphy's sign, NV AND Charcot's Triad (fever, jaundice, RUQ pain)
        - Only 50% of patients
        - Cholelithiasis + fever
    - Management → pain control. Fluids, NPO, antibiotics, ERCP within 24-48 hours

GI Bleeding: R2 Pathway (Dr. Kushner and Dr. Aiello)

- Upper vs lower determined by ligament of Treitz
- Upper GI Bleeds
    - Tend to be sicker
    - Epidemiology → H. pylori, prescriptions
    - DDx: Ulcers, varices, fistulas
    - Management
        - ABCs
        - NPO
        - 2 large bore IVs
        - O2
        - Fluids/blood
        - PPI
        - Octreotide and antibiotics if you suspect varices
- Lower GI bleeds
    - Less sick
    - Different causes
    - Management
        - ABCs
        - Vitals
        - Stool color not reliable for location
        - Abdominal pain may mean perforation
- Labs
    - CBC, CMP, coags
    - EKG/trop for increased risk of MI
    - Repeat HGB
    - BUN:Cr or Urea:Cr of >30:1 or 100:1 suggest UGIB
- FOBT not recommended for GIB, only approved for screening of lower GI malignancy
- Imaging
    - KUB not great unless looking for perf
    - CT angiography very sensitive/specific
        - Can determine site of bleeding, 93% accurate
    - Angiography and scintigraphy also options as inpatient
- Decision making tools
    - Glasgow-Blatchford Bleeding Score (GBS) → probably the best
    - Rockall Score for Upper GI bleeding
    - AIM65 Score
- Considering elective intubation
    - Ongoing hematemesis
    - AMS
    - High aspiration risk
    - Associated with worse clinical outcomes in critically ill patients
- Balloon Tamponade
    - Temporizing for life threatening variceal bleeding until endoscopy
    - Intubate first

- Dispo
    - Active bleeding/instability → ICU
    - Others → floor with tele
    - Outpatient for lowest risk
    - Consults
        - GI, heme, surgery, IR. Depends on the patient.

Room 9 Follow Up (Dr. Ferko)

- Case
    - 18 year old male moped vs auto, helmeted.
    - EMS concern for unstable pelvis
    - HR 160, BP 100/32
    - Xrays with multiple lower extremity fractures, widened mediastinum
    - PE
        - Multiple abrasions, open wounds to fractures
        - No pulse LLE
    - Workup
        - Pan scan with max face
        - BLE CTAs
        - Trauma labs
    - Imaging results
        - Aortic dissection with active extrav
        - Hemothorax, hemomediastinum
        - Hemopericardium
        - Grade 4 R renal laceration, ?L renal laceration
    - Chest tube placed by trauma → 200 cc initial, 500 cc following
    - Lab results
        - K 2.6
        - WBC 47.9
        - ABG → BE -7
    - Vascular surgery consulted, esmolol drip started
- Hospital course
    - Taken that night for TEVAR
    - L femur pin placed the next day, pulseless in extremity
        - CTA BLE repeat shows L peroneal artery occlusion, concern for L popliteal aa occlusion
    - Taken to OR emergently for LLE thrombectomy as well as LLE 4 compartment fasciotomy
    - Heparin gtt started next morning
    - Concern following for decreased mentation, ?seizure
        - CTH shows cerebral edema, possible infarct
        - Neuro consulted, MRI pending. Concern for TBI, DAI.
- Learning Points
    - Aortic dissection
        - Type A vs Type B
        - Risk Assessment
            - Chest pain + back pain + neuro symptoms (may be transient)
            - Risk factors → age, connective tissue disease, HTN, bicuspid valves, long term steroids/immunosuppression
            - ADD-RS
        - Workup

        - CBC, CMP, troponin
        - EKG
        - CTA
            - Can start with CXR, can also get US
                - Loss of aortic knob
        - Can check BP on BUEs
            - Difference of >20 mmHg can indicate
    - Treatment
        - Target vitals → lower BP and heart rate (HR 60, 110 systolic)
        - Meds → esmolol, nitroprusside, nicardipine
        - Surgery → TEVAR
- Compartment Syndrome
    - Plenty of causes
    - Immediate threat → nerve and muscle. Delayed → rhabdo, renal failure
    - 5 P's
        - Pain (especially with passive stretch)(early)
        - Pulselessness (late)
        - Pallor
        - Paralysis (late)
        - Paresthesia (early)
    - Workup
        - CK
        - Compartment pressures (>30 mmHg abnormal)
        - Xrays if indicated
        - Chemistry
    - Treatment
        - Fasciotomy
        - Remove splints or casts
        - Avoid ice

Jeopardy (Dr. Eisenstat and Dr. Stucker)

- Candy and good times.