Primary Team

First Reading: Primary Team Patient Narratives

Dr. R. Heya is a 72 yo male internist who presents with diarrhea. 2 months ago he had a open reduction-internal fixation of a right ankle fracture. Shortly afterwards he developed diarrhea, was diagnosed with clostridium difficile colitis, and treated with 14 days of Metronidazole. His diarrhea improved, only to return shortly after stopping his antibiotics. He was treated with another course of metronidazole, with similar results. He presented to the ED today with abdominal distention, nausea, fever, and abdominal pain as well as diarrhea. Abdominal X-ray shows a diffusely edematous colon with thumbprinting. A CT of the abdomen is pending. His exam is positive for diffuse tenderness, hypoactive bowel sounds and rebound tenderness in the RLQ. His past medical history is significant for type 2 diabetes, CKD stage III, blindness from diabetic retinopathy, peripheral neuropathy, a history of a DVT, and several LE fractures. The ER starts him on IV metronidazole, and you add oral Vancomycin because of the severity of his illness.

Mr. Con Fused is a 68 year old man with a history of alpha-1-anti-trypsin deficiency and end-stage liver disease who presents with hepatic encephalopathy. He has been in the hospital for 2 weeks now, and his encephalopathy is now controlled with large amounts of lactulose. As such, he has developed hypovolemia several times as well as a metabolic acidosis. His nutritional status is poor, and was started on TPN. He is in discussion with the liver transplant service about a liver transplant, and his wife is the decision-maker as he is not consistently oriented. Over the last 2 days his creatinine has begun to rise despite TPN and IVF hydration. The renal service suspects hepatorenal syndrome and he will need dialysis for volume overload in the next few days.

Mrs. D. Monas is a 58 year old woman with hypertension and diabetes who presents with a large left lower lobe pneumonia. She has been in the hospital two days, required BiPAP but is now on 4L O2 by nasal cannula. She has developed orthopnea and pulmonary edema after volume resuscitation, and also had acute renal failure likely due to ATN. Her creatinine is recovering, and she was started on scheduled Lasix yesterday to treat her volume status.

Ms. Abby Payne is a 42 year old woman with abdominal pain. 2 weeks ago she had a cholecystectomy for cholelithiasis. She recovered well after surgery when she had sudden onset of RUQ pain and jaundice. Labs showed a conjugated bilirubin of 4,AST and ALT 2 times the upper limit of normal, and a mildly elevated alkaline phosphatase. Ultrasound in the ED showed a common bile duct, and he was admitted to your service. Her past medical history is otherwise unremarkable. She is

scheduled for an ERCP in the morning, as the pancreato-biliary service is unable to see her tonight. Of note, she denies fever or chills.

Priority	Name	Overview	Problems	Medications	To Do
	Dr. R. Heya		DM CAD CKD Stage III HTN	ASA Citalopram Lantus Pantoprazole Metronizadole Simvastatin	
	Conrad Fused		ESLD CKD Stage II Hepatic Encephalopathy Depression	Lactulose Rifaxamin Lasix Spironolactone Citalopram Pantoprazole	
	Sue D. Monas		DM2 HTN CKD Stage II	ASA Hydralazine Imdur Metoprolol Ceftriaxine Azithromycin	
	Abby D Payne		Cholecystectomy 2 weeks ago		

Second Reading

Read the Checklist on the following

page in your packet and be prepared to observe and provide feedback on a hand-off.

Hand-Off Observation Checklist

During the Hand-Off, did you observe the participants perform the following skills:

Yes	No	
☐	☐	Triage & Prioritize -- Detail and history given more on complex patients, less on simple ones
☐	☐	"Tell the Story" -- gives a succinct, relevent presentaition
☐	☐	"Details on Demand" -- interactive questioning of status/assumptions
☐	☐	Contigency Plans -- For every follow-up item, there is an If...then type statement

Third Reading

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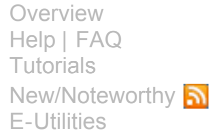

1: Curr Treat Options Gastroenterol. 2006 Jun;9(3):265-71.

Related Articles, Links

Update on Clostridium difficile.

Thorpe CM, Gorbach SL.

Department of Geographic Medicine and Infectious Diseases, Tufts-New England Medical Center, 750 Washington Street, Box 041, Boston, MA 02111, USA. cthorpe@tufts-nemc.org.

The most dramatic change in the past several years has been the increased incidence and severity of Clostridium difficile colitis reported from multiple countries. A number of factors have likely contributed to this. One major event has been the emergence of a fluoroquinolone-resistant clone of C. difficile with enhanced virulence properties that is associated with epidemic disease. Also noteworthy is the apparently decreasing effectiveness of the first-line agent metronidazole in treating this disease. Aggressive treatment of severe C. difficile colitis requires a multifaceted approach, including: 1) cessation of antibiotics where possible; 2) oral vancomycin; 3) if an ileus exists, intravenous administration of metronidazole and possibly intracolonic administration of vancomycin; 4) intravenous immunoglobulin if response to therapy is not rapid, or if there are signs of sepsis; and 5) early surgical consultation. Although it is likely that intravenous immunoglobulin contains antibodies against C. difficile toxins, its benefit remains unproven in rigorous clinical trials. Efforts to actively or passively immunize patients at risk are being explored to prevent the increasing morbidity and mortality associated with this disease. However, defining exactly who is at risk for severe C. difficile-associated disease is complex, as cases are being reported in populations not previously believed to be vulnerable.

PMID: 16901390 [PubMed - in process]

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1: Clin Infect Dis. 2002 Sep 15;35(6):690-6. Epub 2002 Aug 26.

Related Articles, Links

Comment in:

- Curr Surg. 2003 May-Jun;60(3):227-30.
- Rev Gastroenterol Disord. 2003 Fall;3(4):228-9.

Adjunctive intracolonic vancomycin for severe Clostridium difficile colitis: case series and review of the literature.

Apisarnthanarak A, Razavi B, Mundy LM.

Division of Infectious Diseases, Washington University School of Medicine, St. Louis, MO, 63110, USA.

Successful treatment of severe Clostridium difficile colitis has been reported with the use of adjunctive intracolonic vancomycin (ICV) therapy. We report a descriptive case series and review the literature on patients with C. difficile colitis who received adjunctive ICV therapy. Nine patients received antibiotics within 6 weeks prior to presentation. Complete resolution of the clinical presentation occurred in 8 patients (88.9%), and eradication of C. difficile cytotoxin production was documented in 3 (75%) of 4 patients who were tested after the completion of adjunctive ICV therapy. One patient (11.1%) died as a result of progressive multisystem organ failure. In the 6 weeks after the completion of treatment for C. difficile colitis, no patient had recurrent disease, required surgical intervention, or experienced complications from adjunctive ICV therapy. In this case series, administration of adjunctive ICV therapy appeared to be a safe, practical, and effective adjunctive therapy for severe C. difficile colitis.

Publication Types:

- Case Reports
- Review

PMID: 12203166 [PubMed - indexed for MEDLINE]

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