National Recognition:
The program has the potential to expand its influence beyond the University of Missouri Health Care Sciences (UMHCS) with regional and national recognition. We anticipate that each fellow will present at professional meetings with travel funds provided for this purpose. Each fellow will be expected to attend at least one professional meeting. Fellows are expected to present their research and projects in a nationally recognized forum such as the society of hospital Medicine, the Society of General Internal Medicine, the Society of Teachers of Family Medicine, the Association of American Medical Colleges annual and regional meetings, American Geriatric Society and other professional specialty groups.

References:

1. Wachter, R. (2006). "The hospitalist movement 10 years later: life as a Swiss army knife." MedGenMed: Medscape general medicine 8(3): 30
2. Baker, S. (2006). "Hospitalists No Longer Novel." Managed Care.
3. Hatt, K. (2013). "Hospitalists: A Worthy Investment." Executive Insight Vol. 4 (April): Page 47.
4. Natarajan, P., et al. (2009). "Effect of hospitalist attending physicians on trainee educational experiences: a systematic review." Journal of Hospital Medicine 4(8): 490-498.
5. Parker, R. M., et al. (2003). "Health literacy, a policy challenge for advancing high-quality health care." Health Affairs 22(4): 147-153.
6. Pham, H. H., et al. (2005). "Health care market trends and the evolution of hospitalist use and roles." Journal of General Internal Medicine 20(2): 101-107.
7. Soong, C, et al. (2010). "Hospitalist physician leadership skills: perspectives from participants of a leadership conference." Journal of Hospital Medicine 5(3): E1-E4.
8. Whitcomb, W. F. and J. R. Nelson (1999). "The role of hospitalists in medical education." The American journal of medicine 107(4): 305-309.
9. Institute of Medicine *"Bridging the Quality Gap"*, April 8, 2003, *Health Professions Education*
10. http://www.hospitalmedicine.org/Content/NavigationMenu/Education/HospitalMedicinePrograms/Hospitalist_Fellowsh.htm

Diagnostic Dilemma

Sudharshan Balla, MD
Chief Fellow, Division of Cardiovascular Diseases, University of Missouri Health Care

Questions:

1. 65-year-old male with history of CAD was referred by orthopedic surgeon for pre-operative risk stratification. He had h/o severe osteoarthritis of his right knee joint preventing him from having an active lifestyle. He is unable to walk beyond a block. Right knee arthroplasty is planned. He has a history of recent myocardial infarction and underwent drug eluting stent (DES) placement to his LAD five months ago. His other medical comorbidities included hypertension, hyperlipidemia and obesity. Medications included aspirin, clopidogrel, metoprolol, pravastatin and Lisinopril. Your recommendation with regard to the next course of action:

    a. Perform stress testing
    b. Obtain echocardiogram
    c. Discuss about deferring surgery
    d. Proceed with surgery; no further testing required

2. 57-year-old female is admitted for severe right lower quadrant abdominal pain. Evaluation revealed a ruptured appendix. Past medical history is significant for CAD with PCI to the RCA with a DES four months ago, history of Type 2 Diabetes Mellitus on insulin, chronic kidney disease with a creatinine of 2.2 mg/dl. To manage the multiple comorbidities, medicine service is consulted for preoperative risk assessment. Your recommendation to the surgeon would be:

a. Obtain stat echocardiogram
b. Start heparin drip and proceed to surgery
c. Proceed with surgery
d. Antibiotics and defer surgery

3. 45 year old male with history of aortic valve replacement with a bi-leaflet mechanical valve on anticoagulation with coumadin is admitted with abdominal pain and jaundice. Evaluation reveals obstructive jaundice with stone in the common bile duct. Acute cholangitis is diagnosed. ERCP is planned. He has no other medical conditions. INR is 2.2. Next step in the management:

a. Stop Coumadin and bridge with UFH
b. Stop Coumadin and bridge with LMWH
c. Administer Vitamin K and proceed when INR <1.5
d. No bridging needed, stop Coumadin and proceed when INR < 1.5

Answers on page 12

ID Corner

William Salzer, MD
Professor, Division of Infectious Diseases, University of Missouri Health Care

The NEJM is running a series of review articles on Critical Care Medicine- here is one on sepsis:

Angus DC, T van der Poll. Severe sepsis and septic shock. N Engl J Med 2013;369: 840-851.
http://www.nejm.org/doi/pdf/10.1056/NEJMra1208623

ASK A PATHOLOGIST

Emily Coberly, MD, Jack Campbell, PSF, and Richard Hammer, MD
University of Missouri Health Care

QUESTION: I took care of a patient with Disseminated Intravascular Coagulation (DIC), but the pathologist did not see schistocytes on the patient's peripheral blood smear. What is the role of peripheral smear in diagnosing DIC?