GENPRO ROTATION AND MEDICAL CONSULTATION SYLLABUS

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TABLE OF CONTENTS

*** ITEMS MARKED WITH A ** ARE KEY TOPICS AND MUST BE READ IN THE FIRST 2 DAYS OF THE ROTATION ***

*** REVIEW CURRICULUM WITH YOUR ATTENDING ON DAY 1 OF YOUR ROTATION ***

** GenPro Rotation Curriculum ........................................................................................................4
Expectations .......................................................................................................................................9

** Medicine Consultation Service Basics .......................................................................................11

** After Hours Clinics (for General Medicine Clinic Patients) .......................................................13

** Basics of Medical Consultation .................................................................................................16

Case-Based Learning Cases
   Pulmonary ......................................................................................................................................20
   Liver ...............................................................................................................................................21
   Diabetes .........................................................................................................................................22
   VTE Prophylaxis ...........................................................................................................................24
   Infective Endocarditis Prophylaxis ...............................................................................................25

Reference Articles

General Topics

Principles of Effective Consultation: An Update for the 21st-Century Consultant ......................26

Anesthetics and anesthesia techniques: Impacts on perioperative management and postoperative outcomes .................................................................31

Preoperative evaluation and use of laboratory testing .................................................................36

Preoperative Cardiovascular and Pulmonary Evaluation

** ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation
   And Care for Noncardiac Surgery (complete guideline) .........................................................40
Coronary-Artery Revascularization before Elective Major Vascular Surgery. NEJM 2004..........................................................................................................................104

** Risk Assessment for and Strategies to Reduce Perioperative Pulmonary Complications for Patients Undergoing Noncardiothoracic Surgery: A Guideline from the ACP. Ann Intern Med 2006...............................................................113


Risk reduction: Perioperative smoking intervention. Best Practice & Research Clinical Anaesthesiology 2006....................................................................................................................130


Beta-Blockers for Reducing Perioperative Events: Randomized Trials with Clinical Outcomes (as of 10/12/07)

** Effect of Atenolol on Mortality and Cardiovascular Morbidity after Noncardiac Surgery. NEJM 1996 (Mangano).................................................................144

The Effect of Bisoprolol on Perioperative Mortality and Myocardial Infarction in High-Risk Patients Undergoing Vascular Surgery. NEJM 1999 (Poldermans)..........................................................151

The effects of perioperative beta-blockade: Results of the Metoprolol after Vascular Surgery (MaVS) study, a randomized controlled trial. Am Heart J 2006.................................................................................................157


Perioperative beta-blockade (POBBLE) for patients undergoing infrarenal vascular surgery: Results of a randomized double-blind controlled trial. J Vasc Surg 2005..................................................................................................171

Beta-blockers for Reducing Perioperative Risks: Other Key Articles

** Beta-Blockers and Reduction of Cardiac Events in Noncardiac Surgery: Scientific Review. JAMA 2002.................................................................................................178

Perioperative Beta-Blocker Therapy and Mortality after Major Noncardiac Surgery. NEJM 2005 (Lindenauer)..................................................................................187

Perioperative Evaluation and Management of Other Conditions

** Perioperative medication management. UpToDate 2007......................................................199
** Inpatient Management of Hyperglycemia and Diabetes in Non-Critically Ill Adults. UCDMC Guideline, July 2007

Management of patients with cardiac stents undergoing noncardiac surgery.
Current Opinion in Anesthesiology 2007

Perioperative Management of Hypertension. 2006

Medical Care of Elderly Patients with Hip Fractures. Mayo Clin Proc 2001


** Surgery in the Patient with Liver Disease. Med Clin N Am 2003

Risk Factors for Mortality After Surgery in Patients with Cirrhosis. Gastroenterology 2007

Perioperative management of patient with chronic kidney disease or ESRD. Best Practice & Research Clinical Anesthesiology 2004

Perioperative Stroke. NEJM 2007

Management of dementia and acute confusional states in the perioperative Period. Neurol Clin N Am 2004


** Prevention of Venous Thromboembolism. Chest 2004

Hyponatremia. NEJM 2000

GENPRO ROTATION CURRICULUM

Introduction:

The GenPro Rotation is a combination of education in 3 main areas:
(1) General Medicine Inpatient Consultation
(2) Outpatient General Medicine Urgent Care
(3) Common Outpatient Musculoskeletal Medicine and Office-Based Procedures.

In addition, residents will do Swing/Float for UC Wards for approximately 1 week in 4. Please refer to the UC Wards Curriculum for details.

This Curriculum Addresses the Consult Curriculum and Urgent Care/Procedures together, but separates items in places for clarity.

I. Educational Purpose, Goals, and Objectives.

A. General Medicine Consultation Section: the General Medicine Consultation Service aims to educate internal medicine residents in the broad field of inpatient and outpatient general medical consultation. Residents will learn how to evaluate medical problems and risks for patients who are under the care of non-medical services. The pre-operative assessment of risk is emphasized. The development of residents’ proficiency in interacting as a consultant with non-medicine specialists is also emphasized. Specific Goals and Objectives include:
   i. Learn methods to enhance the consultant’s effectiveness.
   ii. Develop proficiency in evaluation, risk assessment, and management of patients who are on non-medical services or who are scheduled for surgery.
   iii. Learn to optimize a patient’s medical condition prior to surgery and to manage common perioperative problems.
   iv. Learn to co-manage patients (specifically their medical problems) on surgical services in an efficient and effective manner.
   v. Learn to work effectively with other members of the healthcare team, providing leadership in coordination of patient care.
   vi. Learn principles of Telephone Medicine.

B. Urgent Care/Procedures Section: this portion of the rotation aims to educate internal medicine residents on common problems seen in urgent care, to give residents experience in evaluating musculoskeletal problems and in performing common office procedures. Specific Goals and Objectives include:
   i. Learn skills to perform focused, appropriate histories and examinations for urgent care general internal medicine
   ii. Learn skills for evaluating joint and musculoskeletal complaints
   iii. Understand the indications, contraindications, risks, and benefits for common office-based procedures.
iv. Gain proficiency for performing common office-based procedures.

II. Principal Teaching Methods

A. General Medical Consultation Section

1. Supervised Direct Patient Care:

   a. The General Medicine Consult section of GenPro is spread out over the 2 or 4 week GenPro rotation. Residents typically do GenPro during their PGY2 and PGY3 years. Residents perform inpatient consultations for the many non-medicine services at the UC Davis Medical Center (most commonly Orthopedic Surgery, Trauma Surgery, Surgical Oncology, Obstetrics and Gynecology, Gynecologic Oncology, Neurology, Neurosurgery, Otolaryngology, General Surgery, Cardiothoracic Surgery, Vascular Surgery, and Physical Medicine and Rehabilitation)

   b. Residents primarily learn through direct patient care with attending supervision in the inpatient and outpatient setting. Residents obtain histories, perform physical exams, review available studies and labs, make an assessment, and then present each patient to a dedicated attending for discussion and education. The attending then sees each patient in conjunction with the residents and confirms the history and physical exam, reviews the clinical data, and concurs with or revises the assessment and recommendations. This all occurs at UC Davis Medical Center.

   c. Management rounds will occur daily, and will include the Medicine Consult attending and the 1-3 residents on service during that day. Bedside teaching of physical examination skills (and to a lesser extent history-taking skills) are integrated into these management rounds, and emphasize physical examination skills development under the tutelage of the attending physician.

   d. Residents co-manage the patients on Orthopedic Surgery. This means that they will consult on many of their patients to manage their medical problems while they are in house. The residents will be first call for medical issues that they are following.

   e. Residents on this service handle patient calls from the General Medicine Residency Clinic from 5 PM to 7PM on Weekdays and from 7 AM to 7PM on Weekends and Holidays. These come from the UCD Operator. The General Medicine Consult Attending is available at all times for assistance with these calls, and reviews the documentation in EMR for all calls and provides direct feedback to residents where warranted.

2. Small Group Discussions:

   a. Dedicated teaching rounds are integrated with management rounds, and occur for a minimum of 4.5 hours per week. This teaching includes teaching directly related to problems being seen by the residents for patients on the service (including bedside history-taking and physical examination instruction) and case-based discussions. These case-based discussions revolve around a series of cases developed by the consult faculty that cover common perioperative management issues. They cover basic science, pathophysiology, and evaluation and management issues. Topics include assessment and management of patients with pulmonary disease, liver disease, and coronary heart disease; prophylaxis of patients for venous thromboembolism, management of
perioperative anticoagulation, and perioperative management of the diabetic patient. The syllabus provided includes literature that discusses each of these problems, and cases are written to emphasis the major points of management. The written cases concentrate on important issues that do not always come up during the course of the rotation.

3. Didactic Sessions

   a. Thursday Consult Conference: The consult residents will participate in the weekly Consult Conference which is attended by General Medicine Division Faculty. They will lead patient-based discussions and case-based didactics included in this conference in conjunction with the Consult Attending. These are held at 10 AM in the PSSB 2400 Conference Room.
   
   b. Medical Grand Rounds: The resident will attend Internal Medicine Grand Rounds each Thursday morning at 8 AM in the PSSB 0300 Auditorium.
   
   c. Residents will attend the weekly Monday afternoon didactic conference from 1:30 to 4 PM in PSSB G0300.

4. Ancillary Teaching Materials:

   a. Reference materials: All residents are given a syllabus which includes this curriculum and which covers major areas of consultation medicine in distinct sections, including the principles of Telephone Medicine. Selected supporting articles are also included for reference and review. Medicine Consultation textbooks are available in the general medicine division offices. Housestaff have access to on-line texts and literature searches via computers at multiple sites throughout the hospital and from home. The housestaff have access to a medical library 24 hours daily.

B. Urgent Care/Procedures Section

1. Supervised Direct Patient Care:

   a. Residents will work in the General Medicine Urgent Care Clinic approximately 4 times over a 4 week rotation. Here they will learn through direct patient care of patients with urgent care issues with attending supervision in outpatient setting. This all occurs at UC Davis Internal Medicine Clinic.
   
   b. Residents will work at the UC Davis Internal Medicine Procedure Clinic approximately 1-2 times over a 4 week rotation. This clinic is staffed by a faculty member who is expert in performing office-based procedures, and in performing musculoskeletal exams. Residents will obtain histories, perform physical exams, review available studies and labs, make an assessment, and then present each patient to a General Medicine Clinic attending for discussion and education. The attending then sees each patient in conjunction with the residents and confirms the history and physical exam, reviews the clinical data, and concurs with or revises the assessment and recommendations. The resident and attending will then perform any procedures together (resident performs under attending supervision).
   
   c. During these clinic sessions, attendings are responsible to teaching physical examination skills appropriate for the problem, reviewing indications, contraindications, risks and benefits for each procedure, teaching appropriate techniques, and teaching appropriate aftercare of patient and management of test results once the procedure is completed.
2. Ancillary Teaching Materials

d. Residents will review a written curriculum on common office based procedures. They will complete a post-test to document their knowledge competency. Residents are encouraged to review the on-line curriculum for the Urgent Care/Procedure Clinic that is available on the Internal Medicine section of the Clinical Resources Center (CRC) intranet site (this is available to all residents through the EMR). This includes didactic information about the musculoskeletal exam and procedures as well as video links for observing the exam and procedures being performed.

III. Educational Content

A. Patient Characteristics and Disease Mix:

a. The UC Davis Medical Center has a highly varied patient population, with great diversity of age, gender, occupation, culture, socioeconomic status, and ethnicity. On this rotation, residents will consult on patients on all of the surgical services, neurology, PM&R, and OB/GYN services. They will encounter patients with common medical problems (diabetes, hypertension, CHF, coronary heart disease, etc), hospital associated conditions (venous thromboembolism, nosocomial infections, delirium, etc), acute undifferentiated problems (chest pain, dyspnea), perioperative needs (perioperative risk assessment and optimization prior to surgery, management of medications around the time of surgery, etc), and common perioperative problems (ileus, bleeding, volume overload, hyponatremia, hypotensions, atrial fibrillation, etc).

B. Learning Venues

a. UC Davis Medical Center is a Level One trauma center and is a major hospital in the Sacramento area as well as a tertiary referral center for large areas of Central and Northern California.

C. Procedures:

a. General Medicine Consultation Section:
   i. Procedures that may be learned or reinforced may include, but are not limited to: thoracentesis, arthrocentesis, arterial puncture, joint injection, paracentesis, and lumbar puncture, with supervision, instruction and feedback as indicated.
   ii. Interpretive skills which will be emphasized or learned include serum electrolytes and chemistry panels, CBC, LFTs, coagulation studies, rheumatologic studies, UA, ABG, ECG, CXR, spirometry or PFTs.

b. Urgent Care/Procedure Section:
   i. Procedures that may be learned or reinforced include, but are not limited to: arthrocentesis, therapeutic joint or bursa injection, skin biopsy (shave, punch), skin tag removal, paracentesis, thoracentesis, lumbar puncture, hemorrhoidectomy, endometrial biopsy, cervical polyp removal, incision and drainage of abscess or cysts, fracture evaluation, splint placement, suturing of lacerations, toenail removal, paronychia incision and drainage, plantar fascia injections, and cryotherapy of warts
D. Structure of Rotation:

   a. Review of Curriculum: on the first day of their 2 or 4 week rotation, the residents will review the curriculum and will have the opportunity to ask questions about it. This will begin at the start of the first management rounds.

   b. Daily Schedule: there are usually 3 residents on the GenPro Rotation at a given time. One resident is designated as the first-call resident each day. That person takes the consultation calls and performs many of those consults from 7 AM to 7 PM. One of the other residents will generally be on available for consults and teaching rounds in the morning, and then will be in clinics in the afternoon (urgent care, continuity clinic, or UC Procedure Clinic). The 3rd resident is usually doing the Dayfloat duties for the UC Wards rotation. From 7 PM to 7 AM the consults are performed by a covering night float resident, which are passed off to the first-call consult resident the following morning at 7 AM.

   c. Residents should keep a patient list in the FP Signout program, so that this information is available to the Resident Night Float. Residents should sign out all consult patients verbally to the Night Float each evening to facilitate cross-coverage, if needed, overnight. Patients that require extensive medical care and evaluation overnight should be transferred to a medical service—this is left to the judgment of the consult attending and the consult residents.

   d. Urgent Care/Procedure Clinics Schedules: UCD Procedure Clinics are on Friday afternoons. Urgent Care Clinics or Continuity Clinics may be scheduled on Tuesday – Friday afternoons in the UCD Internal Medicine Clinic.

   e. Each Resident usually does 5 session of Swing Float (1 PM to 1 AM) on the UC Wards.

   f. Duty Hours: There is no overnight call. Residents will log their work hours in E-value. All residents work under 80 hours per week, have no overnight call, and there are always more than 10 hours between shifts. Each resident has 4 assigned days off averaged over a 4 week rotation.

IV. Methods of Evaluation

A. Housestaff are formally evaluated with standard UC Davis evaluations using our E-Value online evaluation system. These are sent out at the end of the rotation to the attendings with whom they have worked. The evaluations are based upon core competencies of Medical Knowledge, Patient Care, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice. The attendings base their evaluation on direct observation of patient care, on the participation in the conferences, on chart audit and review, and on input from peers. Informal feedback is given to residents on an ongoing basis by faculty. For Procedures, the residents log them in E-Value and the supervising attending must then sign off on the procedure, which includes a formal evaluation of the resident’s performance on the procedure.

B. Residents will be required to complete a test of their knowledge and attitudes on common procedures and turn this in prior to their completion of the rotation.
C. Housestaff fill out standard UC Davis evaluation on E-Value of the GenPro rotation and attendings at the end of their rotation. Evaluations of the course are reviewed by the course director, program director, and UC Davis Department of Internal Medicine Clinical Competency Committee (CCC) as they are received.

**GENPRO SERVICE EXPECTATIONS**

This is a rotation for PGY2 and PGY3 residents, and the experience is spread out over 2 years in short blocks. Thus, there is no graded responsibility or expectations, and they are expected attain these competencies by the end of their 3rd year rotation on this service.

Rotation-specific competencies are noted with **.

### COMPETENy EXPECTATIONS OF RESIDENTS

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<thead>
<tr>
<th>COMPETENCY</th>
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<tbody>
<tr>
<td><strong>PATIENT CARE</strong></td>
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<tr>
<td>History</td>
<td>will personally obtain a detailed and accurate complete history, and review available clinical history and data.</td>
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<td>will include pertinent positives and negatives, particularly with respect to perioperative risks of bleeding, anesthetic reactions, and ischemia. **</td>
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<td>will use appropriate nonpatient sources of data if patient cannot give a complete history (i.e. outside physicians, outside records, patient chart review).</td>
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<td>will not rely solely on referring service for history. **</td>
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<td>Physical Exam</td>
<td>will do a thorough physical exam, tailored to patient’s problems.</td>
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<td>will be able to identify and characterize the PMI, identify and characterize murmurs, assess the JVP, and identify S3 and S4.</td>
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<td>will be able to perform a basic shoulder and knee physical exam. **</td>
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<tr>
<td>Documentation</td>
<td>will have initial consultation note on chart on the day consult is obtained (after discussion with the attending) and daily notes thereafter. **</td>
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<td>will document assessment and recommendations in discrete, explicit lists (see Basics of Medical Consultation handout). Notes will be legible. **</td>
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<td>Clinical Judgment</td>
<td>prioritizes diagnostic and therapeutic decisions based on patient’s severity of illness, and proceeds in an orderly manner.</td>
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<td>understands limitations of knowledge and seeks assistance from supervising physicians when diagnostic or therapeutic dilemmas arise.</td>
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<td>Medical Care</td>
<td>addresses in a timely manner abnormal vital signs, labs, x-rays, and other tests.</td>
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<td>identiﬁes all major problems</td>
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<td>ensures/recommends appropriate follow-up after discharge from hospital on medical issues for patients seen in consultation (includes contacting primary MD when appropriate). **</td>
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<td><strong>MEDICAL KNOWLEDGE</strong></td>
<td>will understand epidemiology, pathophysiology, differential diagnosis, and management of common perioperative illnesses, including hyponatremia, delirium, CHF, thromboembolic disease, diabetes, pneumonia, myocardial</td>
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ischemia, hypertension, atrial fibrillation, and alcohol and drug withdrawal.
• will understand evaluation, risk assessment, and risk reduction for patient scheduled to undergo surgery. **
• will understand diagnostic criteria for common knee and shoulder problems, as well as indications and contraindications for knee arthrocentesis and therapeutic shoulder and knee corticosteroid injections. **

PRACTICE-BASED LEARNING

• Locate, appraise, and assimilate evidence from the scientific literature to answer questions about the care of patients’ health problems, where appropriate.
• Use computers to manage information and access on-line information for the care of their patients.

INTERPERSONAL AND COMMUNICATION SKILLS

• Communicate with referring physicians after completing consult (after rounding with attending) to relay assessment, recommendations, and critical recommendations. **
• will learn and use methods to enhance consultant’s effectiveness. **
• Effectively communicate with referring physicians on an ongoing basis regarding major treatment recommendations or with concerns at any time during the care of the patient. **
• Communicate regularly with families and patients.
• Contact primary care outpatient physicians to appraise them of urgent or critical follow-up issues on the patients after discharge.
• will use the EMR to effectively communication to physician PCPs regarding telephone calls after hours (document all calls in EMR and route to PCP).**

PROFESSIONALISM

• Make a strong commitment to carrying out professional responsibilities, and thus will be reliable, committed to patient care, responsive to other services.
• Place care of the patient above self-interests
• Make a commitment to excellence and ongoing improvement
• Demonstrate sensitivity and responsiveness to patients’ age, culture, gender, and disabilities.
• Demonstrate integrity, respect, and compassion in all interactions and actions.
• Resident shows regard for opinions and skills of professional colleagues.
• Resident treats team members with respect, including nurses and other nonphysician healthcare providers.

SYSTEMS-BASED PRACTICE

• Recognize how their patient care and professional practices affect other healthcare professionals and the healthcare system
• Recognize how types of medical practice (HMO, Medicare, Medicaid) and delivery systems differ from one another.
• Where appropriate, utilize the individual delivery systems to help improve
Medicine Consult Service Basics

1. **Formal Curriculum:** Please review the formal curriculum in full (attached), which outlines the basic structure of the service and the goals and duties. Please ask any questions you have of the attending on your first day of service.

2. **Rounds:** Rounds are held daily with the General Medicine Consult attending. The exact time of rounds is negotiated each day, taking into account clinic duties of residents and attendings.

3. **New Consults:** Call the attending immediately with all new consultations once you have completed your evaluation. You can wait until rounds if you do this in the day before team rounds, unless there are urgent issues to be attended to.

4. **Sick Patients:** Call the attending when you see a new or old patient that is quite ill, that has a major change in clinical status, that may need transfer to a unit or to a medical team, or anytime that you have questions or need help.

5. **Orthopedics Patients:** We co-manage the medical problems of orthopedic surgery patients that we are caring for, in order to improve their overall care. That means that we take calls from nursing in managing the medical problems for patients we are actively following. We write orders related to medical problems. The only exceptions are anticoagulation, antibiotics related to bone or surgical infections, wound care, bowel care, usual post-operative pain medications, and IV access. If there are issues related to this that you are called for, you should refer them back to the Ortho service. Also, if you would like to recommend changes to those issues, you should communicate directly with the Ortho personnel on the specific Ortho service. We do NOT write admission, discharge, or transfer orders. We can sign off of the case once the patient’s medical problems are stable (i.e. not adjusting medications). In the front of the syllabus is a list of the contacts for each of the subservices for Ortho, to help you contact the correct person when needed. You should ALWAYS communicate major changes in patient orders or patient condition to the Ortho team.

6. **Consult Team List and Sign-Out:** Please keep the list of patients on the communal CONSULTS_GEN MED list in the EMR. It should be in your Shared Lists file. If not, have someone add you (your attending should be able to do so, or the resident on before you). You should also keep a list of patients in the IM Signout program so that Night Float has access to patient information in case they are called with questions on consult service patients. If you have an active patient that you expect Night Float to be called on, please verbally sign out to them as well. One caveat – if your patient requires frequent checks due to a very active medical condition (e.g. hypoxia, DKA), he/she should probably be transferred to the medicine service for stabilization. Don’t leave such patients for the busy night float to cover.

7. **Transfers to Medicine:** You often will get called to transfer patients to the medicine ward service. If it is very obvious that the patient needs a transfer after a quick chart review, call the consult attending to let them know of the case and then call the hospitalist on call. The hospitalist will distribute the patient to a medical team. Please contact the accepting team (R2, R3, or
hospitalist) to discuss the case with them. Sometimes, a complete formal consult on the obvious cases is not necessary. If the patient is followed by a medical subspecialty, they should be able to help in assessing if the patient is appropriate for transfer to medicine, and you may not need to do a full formal consult if they feel it is appropriate. Call the attending to review the case after doing a chart review and/or discussing with the consulting medicine subspecialty team. Depending on the situation, you may need to do a formal consult in order to make the appropriate decision on whether to transfer or not, or to simply follow as a consultant.

8. General Medicine Clinic Telephone Calls. During this month, you are responsible for taking outside phone calls for the Residents General Medicine Clinic and Geriatric Clinic on weekdays from 5 PM to 7 PM and weekends and holidays from 7 AM to 7 PM. The Nightfloat Resident takes calls from 7 PM to 7 AM. Patients often have clinical concerns or need refills on their medications.

You must document all calls on a Telephone Encounter in the EMR. CC your note to the patient’s primary provider, and put your Med Consult attending down as the co-signing attending. This is an important medico-legal and clinical care issue for both you and the patient. If you have any questions about how to manage these patients, contact the Medicine Consult attending at any time for assistance.

If you get calls on the IM Faculty Practice patients (i.e. patients of Michael McCloud, Katie Newell, Maya Mitchell, Joe Melendres, Jorge Garcia, Patrick Romano, Craig Keenan, Rich White, Heather Vierra, Suzanne Sweidan), do not take them. They cover their own calls.

If you get calls on patients who have PCPs in the Primary Care Network (PCN), do not take them. They cover their own calls.

If you get calls from patients of subspecialty services, refer them to the subspecialty service’s person on call. You should not handle these calls.

It is established General Medicine clinic policy that we do not refill narcotics for patients by telephone—leave it for the clinic to manage during regular business hours. This avoids abuses of our system. Have them call back first thing in the morning and talk to the Triage Nurse (4-2737).

If you feel that a patient needs to be seen acutely for evaluation of their pain after speaking to them, and it cannot wait until the next business day, you have two options -- send them to an ER or to an After Hours Clinic (The list is attached AND the CRC has a listing of these and instructions on how to access them -- look on the IM page, and under the CURRICULUM heading there is a link termed "After Hours Clinic Referrals"). If you are EVER not sure of what do to, (e.g. extenuating circumstances such as a hospice patient out of pain medications), PAGE THE GENERAL MEDICINE CONSULT ATTENDING OR PAGE THE PRIMARY CARE PHYSICIAN for the patient to discuss it further. You can do this at any time of day or night. You can also page the clinic director, Craig Keenan, at 762-9004 for any questions.
9. **Medicine Consult Conference:** Each Thursday from 10-11 am, the Division of General Internal Medicine meets for Consult Conference in the conference room in PSSB Suite 2400. We discuss 1-3 interesting consult cases, which you will present in conjunction with your attending.

**DOCUMENTING CLINIC PHONE CALLS**

On Consults, you will receive phone calls via the operator from the General Medicine & Geriatrics Clinic patients from 5 to 7 PM on weekdays & 7 AM to 7 PM on weekdays

- You should document these phone calls in the EMR as follows:

1. To document a phone call, select “Telephone Encounter”, then select the patient, and you will open a visit navigator for your call.
2. Enter a reason for call. *(This is essentially the title for the note).*
3. Enter contact information, etc as you see fit.
4. You can write orders, if needed, from within this encounter.
   a. If the computer makes you select a routing option, click the routing button and select IMB REMOTE ORDERS
5. Document your discussion in the Progress Notes section.
6. You can send a copy to the patient’s PCP using the Routing Section.
7. Close the Encounter when you are done.
8. It will ask you for a Co-Signer – select your Med Consult Attending as the attending *(or directly supervising attending if more appropriate).*

- You can call the General Medicine Consult attending at any time if you have questions on how to handle a problem.

- For most calls with clinical questions, you should document the HPI, brief medical history, current medications, your assessment and plan, and reasons to call back or to seek immediate medical attention

**UCD GENERAL MEDICINE CLINIC**

**AFTER HOURS CARE OPTIONS**

This memo is for those residents that take after hours calls (i.e. M-F 5 pm to 8 am and Sat/Sun) for the UCD General Medicine Clinic. After speaking to patients by telephone, you must decide if they need to be seen acutely, or if it can wait until the next business day, when they can be seen in the clinic as usual. If it can wait, have the patients call the GenMed Clinic Triage nurses first thing in the morning at 734-2737 to arrange to be seen.

If you feel that they need to be seen right away, there are generally two options, which are dependent upon severity of the problem and insurance. If the patient seems severely ill or needs high-level or monitored evaluation, they should be referred to the nearest emergency room. If it is something that you think can be seen in an outpatient setting, there are some after-hours clinics available, listed below. These clinics generally have a shorter wait for patients to be seen and are less expensive to UCD than an ER visit, and thus are appropriate for those patients needing evaluation for noncritical
issues. Some patients may not be eligible for those based upon their insurance. Please see below for details.

This can take some time and some phone calls, but with your hard efforts, appropriate and efficient medical care can be provided to our patients.

Be sure to document all of your phone discussions in the EMR on a Telephone Encounter (and cc: the note to the patient’s PCP and put your supervising attending or Dr. Keenan as the cosigning attending). If you have any questions about patient management, the General Medicine Consult Attending on-call is available at all times to discuss issues with you.

AFTER-HOURS CLINIC REFERRAL GUIDELINES

CAPITATED PATIENTS
Patients with insurance capitated to UCDMC may be referred to the following facilities for urgent care after hours. A good way to find out the patient’s insurance, if the patient is not sure, is to have them read off their blue patient ID card.

Common capitated insurance plans are include: PACIFIC CARE, HEALTH NET, HEALTHNET SR, WHA COMMERCIAL, CIGNA, AND ANY HEALTH INSURANCE CARD THAT HAS UCD/INSURANCE PLAN NAME. You should call the clinic and let them know that the patient is coming in, and confirm that they can be seen with their insurance plan.

Doctor’s Medical Center Group
4948 San Juan Avenue
Fair Oaks, CA
916-966-6287
MED 7 Urgent Care-- Roseville
1101 Smith Lane
Roseville, CA
916-772-6337

MEDCARE Medical Center
1907 Douglas Boulevard #70
Roseville, CA
916-783-0101

MED 7 Urgent Care—Carmichael
4156 Manzanita Avenue
Carmichael, CA
916-488-6337

MEDI-CAL CAPITATED
We have many patients who have MediCal capitated to us via the WHA or Blue Cross insurance program. Their card will have WHA/GMC or GMC B/C on it in some way. GMC means Geographic Managed Care Medi-Cal, which is the same thing as Medi-Cal capitated. **WE HAVE NO CONTRACT**
FOR MEDI-CAL CAPITATED PATIENTS. IF THEY HAVE TO BE SEEN AFTER HOURS THEY NEED TO BE SENT TO AN EMERGENCY ROOM.

STRAIGHT MEDI-CAL
These cards just say MediCal on them.
WE HAVE NO CONTRACT FOR NON-CONTRACTED MEDI-CAL PTS, IF THEY HAVE TO BE SEEN AFTER HOURS THEY NEED TO BE SENT TO ER.

STRAIGHT MEDI-CARE
These patients have no supplemental insurance or HMO-MediCare coverage. We do not have any special contracts. Have the patients call the above clinics to see if there is appointment availability and if they can be seen. If that fails, or if they prefer, they can go to the ER.
BASIC PRINCIPLES OF MEDICAL CONSULTATION

Medical consultation is the rendering of an opinion to another physician regarding diagnosis or management. On a general medicine consultation service, there are two main types of consultations requested: (1) assisting in the diagnosis and management of a condition out of the scope of expertise of the requesting physician; and (2) assessing perioperative risk, making recommendations to reduce this risk, and anticipating, monitoring for, and managing medical problems in the perioperative period.

Medical consultation can be broken down into four steps: (1) initial contact with the physician requesting consultation; (2) the consultation; (3) communication of recommendations to the requesting physician; and (4) follow-up after the initial consultation. The following discussion goes into these four steps more explicitly, and is applicable to any consultations that you will provide in your career.

1. **Initial Contact**

   The consultant and referring physician should both be clear on the main reason for consultation. The referring physician should give you a distinct question. If you are unsure of the main question is, you should contact the referring physician to clarify the reason for consultation. By doing so, satisfaction with your consultation will be greater, patient care will likely be more efficient (i.e. more timely, less costly, and with less duplication of services), and patient care will likely be improved. Sometimes the consultant is not clear on a specific question, particularly in complex patients. This should be regarded as a call for help in managing the patient as a whole. Lastly, “Pre-op clearance” is a common request, but really what we offer is a perioperative risk assessment and recommendations to reduce that risk.

2. **The Consultation**

   In general, non-urgent consultations should be performed within 24 hours from the time the request is received. On the General Medicine Consult Service at UC Davis, they should be seen on the same day as the request, and immediately if the clinical situation is urgent. In general, if a consult cannot be performed in a timely fashion, that information must be relayed to the requesting physician.

   When you first see the patient, it is important to clearly identify your role to the patient. Tell them your name, that you are a consultant requested by the attending/primary team, which service that you represent, and the reason for consultation. At UC Davis, you should also let the patient know that there are other members of the consulting team that will also be coming to evaluate them.

   The consultant should personally thoroughly interview and examine the patient as well as reviewing the patient’s primary data from the chart and prior medical records. Do not rely on the chart notes or summaries for full details of the history, as important data may be missing. You may need to request outside records to adequately complete your consultation. Do not rely on the primary team to obtain pertinent outside records—by doing it yourself, you can be sure that you get the correct information in a timely fashion.
3. Communicating Your Recommendations to the Referring Physician

Once you complete your evaluation, complete a written consultation note. It is best to create a problem list, with discussion, followed by an explicit list of your recommendations. Don’t mix your recommendations in with your discussion, as they are hard to find, and are thus much less likely to be followed. By creating an organized problem list, it can easily relay information and can aid referring physicians in understanding a complex patient. An example of a proper format is as follows:

<table>
<thead>
<tr>
<th>Assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perioperative risk assessment: Based on ACP guidelines, Mr. Jones falls into a low risk group (&lt;3%) for perioperative cardiac events. Given his underlying dementia, he is at high risk for perioperative delirium, and care must be taken to reduce this risk.</td>
</tr>
<tr>
<td>2. HTN: under control.</td>
</tr>
<tr>
<td>3. Dementia: stable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Continue his atenolol 50 mg po daily. Take with sip of water on day of procedure.</td>
</tr>
<tr>
<td>2. Discontinue the prn Tagamet and Benadryl and avoid anticholinergic and other CNS acting agents, as these can cause an acute delirium in susceptible patients.</td>
</tr>
<tr>
<td>3. Avoid sensory deprivation, keep hearing aid in, keep near window, re-orient frequently to help prevent delirium.</td>
</tr>
</tbody>
</table>

Some key points to your consultation report, which will improve compliance, communication, and patient care:

1. Be sure to specifically answer the questions of the referring physician in a clear and concise manner.
2. Limit your recommendations to 5 or less to improve compliance. Studies show that if you make more than 5, many are often ignored. Sometimes it is not possible to make such a limitation.
3. List recommendations in order of severity, if possible. Also, clearly indicate which recommendations are the most critical (circling, block letters, highlighters, colored pens can all do this).
4. Be very explicit with your recommendations—be short and to the point. Take particular care with medication recommendations--include dosages, timing, route, and duration of therapy.
5. References can be helpful in a teaching program.

For pre-operative consultations, be sure to include the following:

1. Clear, concise evaluation of the medical risks of the procedure.
2. Measures to improve or stabilize the patient pre-operatively.
3. Management strategies to reduce perioperative risk (e.g. beta-blocker, incentive spirometer).
4. Post-operative considerations (especially what complications to watch for) to allow early intervention.
5. Role that you will assume post-operatively (i.e. will you follow). Note that most patients should be seen in follow-up after surgery. It allows you to identify any missed recommendations and is helpful in identifying complications after surgery.

Contact the referring physician either personally or by telephone once you have completed the consult in order to review your assessment and recommendations. You should always verbally relay critical issues. This contact is very effective at improving compliance, and is good consult etiquette—thus, always call after completing the initial consultation.

- It is often a good idea, when you contact the team with your recommendations, to ask if they would like you to write the orders for them. That often expedites their implementation, and may reduce mistakes.

- Co-management, where the medicine consultant actively manages medical problems, by writing orders daily, taking calls from nurses, etc, is much more common now. If this is done, the consulting and referring teams/physicians must communicate clearly what each is responsible for. We currently are doing this to a small degree with the Orthopedic Surgery service at UCD.

It is often a good idea to wait to discuss your recommendations with the patient and family after you discuss them with the referring physician, to avoid conflicts over differing opinions on the management plan. This way, a unified plan that has been agreed upon can be presented to the patient.

4. Follow-up

The frequency and duration of your follow-up after the initial consultation depends upon the severity of the illness. When you stop your consultations, provide a clear written note to that effect in the chart, otherwise the primary service may assume that you are still following the patient when in fact you are not.

Be sure to keep abreast of other consulting services’ recommendations so that conflicting recommendations are not made. If there are conflicting ideas, discussion with the other services can help to come to an agreement on a care plan.

You do not necessarily need to verbally contact the referring physician each day, as your note should suffice. You should, however, contact the referring physician if you have new major or urgent recommendations or if you have concerns over the status of the care plan. Have a low threshold for calling--good communication is a key to good consulting.

As an internist, be sure that the patient who is being discharged has appropriate follow-up for his medical problems, so that ongoing problems are addressed and not overlooked. It is good practice to call the patient’s primary physician to discuss any complex or outlying management issues that will need to be followed up after discharge.

IMPROVING THE EFFECTIVENESS OF YOUR CONSULTATIONS

Studies show that in medical consults to nonmedical services at academic centers, only about 55-75% of recommendations are carried out. This can be very frustrating for a consultant. Thus, follow-up is essential to ensure that important recommendations are followed.
Other studies have evaluated how compliance with recommendations can be improved. Key techniques are as follows:

1. Have a clear understanding of the reason for consultation. Studies show that 14-36% of the time, the referring and consulting physician disagree on the reason for consultation. One way to ensure that recommendations are not followed is to not address the problem for which you were consulted! Thus, be sure you know the question and that you answer it.
2. Perform the consult promptly.
3. Make frequent follow-up visits, including written notes.
4. Discuss recommendations with the referring team.
5. Limit recommendations to 5 or less. In one study, compliance fell from 70 to 50% if there were more that 5 recommendations.
6. Be very specific in your recommendations.
7. Write orders for the primary team. Do this only after discussing your assessment and recommendations, and obtaining permission from the referring physician, unless you have a pre-existing agreement with that physician or service to write orders (i.e. co-management agreement).

If there are disagreements in the care plan, these should be discussed among the referring and consulting physicians. Do not use the medical record as a place to wage arguments over disagreements, nor should disagreements be discussed with patients without the consent of the referring physicians. A good method to settle disputes is to obtain a second consultation from a third party. In rare cases of irreconcilable differences in opinion, you may need to sign off of the case. In that situation, you may wish to explain to the patient the difference of opinion, but this should be done in the presence of the referring physician.
CASE-BASED LEARNING TOPICS

PERIOPERATIVE PULMONARY MANAGEMENT: PULMONARY CASES

Case 1:
You are asked by General Surgery to perform a pre-op evaluation on Mr. G in Pre-Op Clinic. He is a 57 year-old carpenter who is scheduled for a partial gastrectomy next week for gastric cancer. His only symptoms are those of some gastric outlet obstruction (bloating after meals). He denies fever, chills, or chest pain. He has baseline dyspnea on exertion at 2 blocks, but states he is at his baseline.

PMH:
1. COPD. Chronic DOE, chronic cough in am. PFTs 18 months ago showed an FEV1 1.2L, FVC 2.4 L TLC 6.2 L. No hospitalizations or intubations.
2. CAD: hx inferior MI 4 years ago. No angina since.
3. PUD
4. BPH s/p TURP
5. HTN
6. Tobacco abuse—100 pack year history, still smoking 1 ppd.

SocH: no etoh, drugs. Lives with wife.

All: none

PE: 98.2 158/98 70 20 93% RA
HEENT unremarkable.
Chest bilateral scattered wheezes. I:E 1:2
Cor RRR nl s1s2 no m/r/g. JVP normal.
Abd: soft, nd, mild epigastric tenderness
Ext: no edema

Questions:
1. What is his cardiac risk?
2. What are his pulmonary risks?
3. What labs would you order?
4. What other studies would you order pre-operatively?
5. Is this patient’s hypertension enough to hold off on surgery? Would you do anything about it today?
6. Should any interventions be made pre-operatively to lower his perioperative risks?

Case 2:
One of your patients has been admitted to the surgical service for acute gallstone pancreatitis. They plan to do an open cholecystectomy and ask for your pre-operative evaluation.
He is an 85 year old man with COPD, HTN, Type II Diabetes, morbid obesity.
He has no chest pain, but does note that over the last 3 days he has been more short of breath with increased wheezing and cough productive of green sputum. His chest x-ray does not reveal a pneumonia

Meds: Atrovent 4 puffs four times daily, Albuterol 2 puffs four times daily and prn, Diltiazem CD 240 mg daily, ASA 81 mg daily, Simvastatin 40 mg qhs, Insulin 70/30 30 U am, 20 U pm.

PE: 99.0 145/90 100 28 92% on 2L
Mild respiratory distress.
Chest diffuse wheezes with I:E 1:3
Cor RRR, no JVD
Abd: epigastric tenderness
Ext: no edema.

EKG: ST 102 no ST/T changes
CXR: flat hemidiaphragms, no infiltrates.

Questions:
1. What are his cardiac risks?
2. What are his pulmonary risk factors?
3. How would you characterize his pulmonary risk, and what are the potential peri-op pulmonary complications?
4. What would you do to minimize his risks?

PERIOPERATIVE LIVER DISEASE: LIVER DISEASE CASES

Case #1:

55 year-old man with history of chronic alcoholism and cirrhosis. Found to have large (7 cm) left renal mass on ultrasound, done for evaluation of hematuria. CT confirmed mass, very suspicious for renal cell carcinoma. You are asked to provide pre-operative “clearance”.

PMH
Cirrhosis due to chronic alcoholism
Chronic ascites
History of variceal hemorrhage, s/p sclerotherapy.
Alcoholism, in remission

SocH: lives with mother. Smokes 1 ppd tobacco.
Meds: Propranolol 20 mg bid. Ciprofloxacin 750 mg q week. Spironolactone 100 mg daily. Lasix 40 mg daily.
ROS: negative except easy bruisability.

PE: Disheveled man in NAD.
96.7 98/58 65 16 98% RA
NAD
Chest CTA
Cor RRR without m/r/g
Abd: + moderate ascites, + caput. No hsm.
Ext: trace edema

1. In general, what are his perioperative risks?
2. What further information would you like to assess those risks?

CBC normal except platelets 100. Chem 7 normal.
Albumin was 2.7 INR 1.35 Bilirubin 2.4 AST/ALT normal. Alk phos 137

3. How would you classify his risk from his liver disease? What do persons with liver disease die from in the perioperative period?
4. How would you counsel/inform your patient?
5. How would you manage him in the perioperative period?

Case #2:
JB is a 65 year old man with long-standing compensated liver disease due to chronic hepatitis C. He does not drink, has no symptoms. Very active, runs daily.
After discussion with the patient you perform an AFP to screen for hepatocellular carcinoma. It returns at 11.2 (normal to 6).

6. What would you do now?

Your evaluation reveals no significant abnormality, so you get a repeat AFP in 6 months. It is now 75. CT scan reveals a 2 cm mass in the posterior dome of the liver. Not amenable to CT or ultrasound guided biopsy.
The surgery service is consulted and they plan on surgical resection of the lesion. They ask you to do a pre-operative assessment.

7. What further information do you need?

PMH notable for CAD with no angina, on atenolol and aspirin.
Labs with CBC normal except platelets of 95. Chem 7 normal. LFTs normal ALT of 111 AST 120. Bilirubin 1.4 INR 1.4
CXR normal. EKG SB 56 old inferior Q waves.

8. What is his cardiac risk?
9. What is his risk from liver disease?
10. What would you pre-operatively to reduce his risk?

PERIOPERATIVE DIABETES MANAGEMENT – CASES

Case 1:
62 year old woman undergoing total vaginal hysterectomy for endometrial cancer. She has no cardiopulmonary symptoms and walks 1 mile daily. She has diabetes and her glucose levels are controlled on metformin 1000 mg bid and glipizide 10 mg bid.
PMH: Type 2 diabetes for 5 years without no nephropathy or neuropathy. Hypertension controlled on ACEI. Hyperlipidemia controlled on statin. Appendectomy age 21. No complications.

Meds: metformin, glipizide, ASA 81 mg daily, lisinopril 40 mg daily, simvastatin 40 mg daily.

SocH: nonsmoker (never), no alcohol. Works as administrative assistant.

PE BP 130/76 HR 92 RR 12 O2 sat 98% RA. Otherwise normal exam.

Pre-op labs: CBC with hgb 11.9 otherwise normal. Chem 7, lfts, albumin and coags normal. Last A1c 7.2 1 month ago.

EKG NSR and normal. CXR not done.

Questions:
1. What is your pre-operative risk assessment?
2. What would you recommend to reduce her perioperative risks? What medication instructions would you give her, be specific.
3. What are your goals of diabetic therapy and why?
4. How would you manage her diabetes in the pre-op and post-op periods?
5. Specifically, what sliding scale would you use?

Case 2:
Same patient. But, she is a Type 2 that is on metformin 1000 mg BID, Lantus 40 units at bedtime and insulin lispro 15 units before each meal.
1. How would you manage her diabetes in the perioperative period?
2. What would your sliding scale be?

Case 3:
Same patient. Taking insulin NPH/Regular 70/30 32 unit in am and 20 with dinner.
1. How would you manage this diabetic patient?

Case 4:
Same patient, going for Whipple procedure for pancreatic cancer – a long and bloody procedure. She is on the 70/30 insulin at the same dose as in Case 3.
1. How would you manage this case?

Case 5:
Same patient going for hysterectomy, but is a Type 1 diabetic on an insulin pump.
1. How would you manage this patient?

Case 6:
Same patient as Case 5, but not on a pump. Instead, on Lantus 12 units qhs and lispro insulin 4 units (on average) with meals. Adjusts based on carb counting.
1. How would you manage this patient?
PERIOPERATIVE VTE PROPHYLAXIS – CASES

Read the Chest supplement on VTE prophylaxis to assist you in answering these questions.

Case 1:
45 year old man due to undergo gastrectomy for gastric cancer. No prior history of DVT or PE. Smoker, otherwise health.
1. What is his risk for VTE?
2. What would you recommend for VTE prophylaxis? (what are your options)
3. How long would you continue the VTE prophylaxis?

Case 2:
22 year old man sustains a C5 neck fracture with resulting quadraparesis. No other medical problems.
1. What is his risk for VTE?
2. What are your options for VTE prophylaxis and what would you recommend?

Case 3:
82 year old white woman with HTN, diabetes, CAD, hyperlipidemia who is admitted with acute hip fracture after a fall, due to undergo a hemiarthroplasty.
1. What is her risk for VTE?
2. What are your options for VTE prophylaxis and what would you recommend?

Case 4:
67 year old man with severe hip osteoarthritis. Due to undergo a total hip arthroplasty. No prior VTE. Stable HTN, hyperlipidemia.
1. What is his risk for VTE?
2. What are your options for VTE prophylaxis and what would you recommend?
3. How long would you continue the prophylaxis for?

Case 5:
67 year old man with severe knee osteoarthritis. Due to undergo a total knee arthroplasty. No prior VTE. Stable HTN, hyperlipidemia.
1. What is his risk for VTE?
2. What are your options for VTE prophylaxis and what would you recommend?
3. How long would you continue the prophylaxis for?

Case 6:
72 year old woman with spinal stenosis. Due to undergo decompressive laminectomy and probable fusion.
1. What is her risk for VTE?
2. What are your options for VTE prophylaxis and what would you recommend?
3. How long would you continue the prophylaxis for?

Case 7:
28 year old woman with a large brain tumor. Due to undergo neurosurgical excision.
1. What is her risk for VTE?
2. What are your options for VTE prophylaxis and what would you recommend?
**Case 8:**
68 year old man scheduled to undergo radical prostatectomy for prostate cancer.
1. What is his risk for VTE?
2. What are your options for VTE prophylaxis and what would you recommend?

**Case 9:**
62 year old woman with probably ovarian cancer. Due to undergo laparoscopic TAH/BSO, tumor debulking, and lymph node sampling. History of VTE at age 38 while on birth control pills.
1. What is her risk for VTE?
2. What are your options for VTE prophylaxis and what would you recommend?
3. How long would you continue the prophylaxis for?

**Case 10:**
28 year old man arrives after MVA with multiple trauma, including femur fracture, rib fractures, splenic rupture. Underwent surgery for femoral rod placement and had splenectomy.
1. What is his risk for VTE?
2. What are your options for VTE prophylaxis and what would you recommend?
3. When will you start the prophylaxis?
4. How long will you continue the prophylaxis?

**INFECTIVE ENDOCARDITIS PROPHYLAXIS – CASES**
Read the 2007 Guidelines for Prevention of Infective Endocarditis

**Case 1:** 55 year old woman with mitral valve prolapse with 1+ MR. Going to dentist for tooth extraction.
1. Does this patient need IE prophylaxis? If yes, what regimen would you choose?
2. What cardiac conditions now are recommended for IE prophylaxis?

**Case 2:** 55 year old man with prosthetic aortic valve (metallic) for bicuspid aortic valve. Going for colonoscopy with possible biopsy.
1. Does this patient need IE prophylaxis? If yes, what regimen would you choose?

**Case 3:** 55 year old man who had endovascular repair of ASD 3 months ago. Going for deep tooth cleaning.
1. Does this man need IE prophylaxis? Why or why not? If yes, what regimen would you use? What if he is PCN allergic with anaphylaxis?

**Case 4:** 55 year old man with metallic prosthetic aortic valve. Has large abscess on back and going to OR for I&D.
1. Does he need IE prophylaxis? Why or why not? If yes, what regimen would you choose?
2. List the procedures for which IE prophylaxis is now recommended.