



Clinical logbook for Simon Downes

Emergency Medicine,

Community First Medical Center, Chicago, 9/2020

Chief attending: Jared Marcucci, MD

Duration: Sept 9th to Oct 6th, 2020

Student details:

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As a novice medical student rotating during the COVID pandemic, the emergency department at Community First Medical Center seemed to be extremely busy. However, as Dr. Marcucci informed me, during the early days of the pandemic, the ED was much busier, and as they were instructed not to divert COVID patients elsewhere, they

developed a successful protocol for treatment.

Practicing in a "War Zone"



However, as the hospital beds filled up, patients sometimes stayed in the ED for as long as 10 days. During May, for example, they lost 250 patients to COVID in the hospital, with 60-80 pts/day presenting with COVID to the ED. Presently, 15 pts/month die from COVID in the hospital. During my stay, I witnessed one pass away following a CODE in the ICU, and it was an extremely sobering moment.

I felt honored to have been allowed to sit beside the physicians, PAs, nurses and technicians in the ED and learn so much as cases were discussed with me.

I benefited greatly from the direct teaching of ED director, Dr. Marcucci, and also Dr. Williams. I was personally guided me through cases, providing many teaching points that I am sure will make good use of in my medical career.

In addition to participating in the cases, I joined the code team during resuscitation efforts, and through hands-on experience, I realized the work that is done in the ED is like none other I had experienced in my rotations.

I came across an interesting article regarding the experiences of Dr. Marcucci during the hardest hit months of COVID.

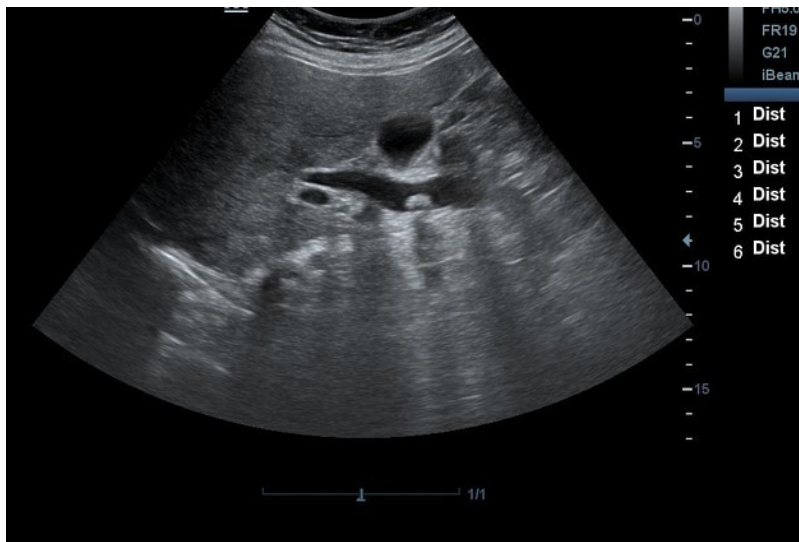
<https://www.rosalindfranklin.edu/news/practicing-in-a-war-zone/>

Clinical procedures performed/observed

**A 91 yo M with a PMHx of CHF and HTN, presented to the ED with vomiting and Afib.
A bedside procedure was initiated to R/O gallstones.*

Clinical procedure #1

**Name of the procedure: Bedside ultrasound, R/O
Cholelithiasis/Choledocholithiasis**



Principle of the procedure:

First, it is important to know the difference between Cholelithiasis and Choledocholithiasis.

Cholelithiasis is when you have gallstones in the biliary tract, eg the gallbladder. However, choledocholithiasis is when you have gallstones in the common bile duct (CBD).

In the ED, there is an US machine which is rolled into rooms for examinations. After placing lubricant on the body, a transducer is placed over the area to be assessed, and sound waves are sent through the body and back to the transducer (between the tissues and the beam path). The image is reflected on the screen.

Indication(s) for the procedure:

If there is an obstruction in the common bile duct, it can result in jaundice (obstructive jaundice). The patient in this case was non responsive – or at least we had difficulty communicating with him, so this procedure was necessary to rule out gallstones or cholecystitis.

Associated risk(s) with the procedure:

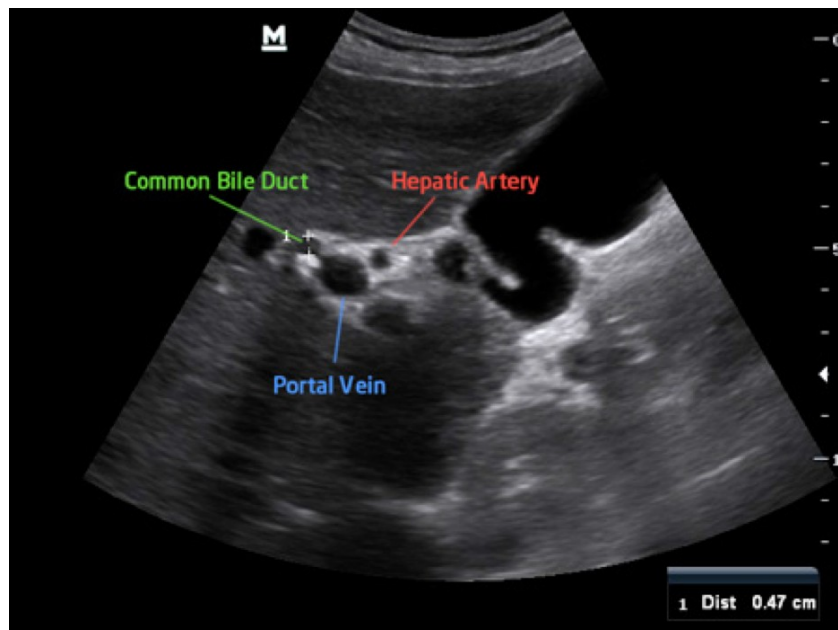
There are few risks of using ultrasound as it does not use radiation. However, one possible risk is overheating a certain area, and for this reason the patient may be asked if they feel any discomfort. Another way to put it is to say they may be exposed to 'ultrasound energy' for too long.

Method:

The purpose for using lubricant is to prevent friction, and to transmit the sound waves. One of the interesting things I noticed is that sometimes it is difficult to get the remaining lubricant out of the tube, so one must be prepared to have back-up tubes available.

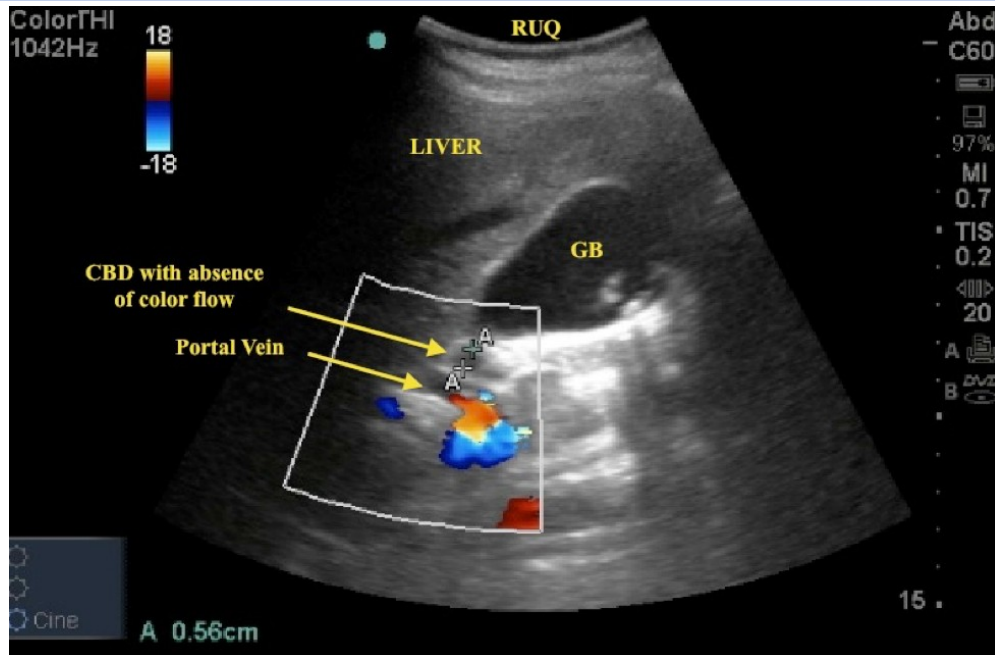
Reference: <https://coreem.net/core/biliary-ultrasound/>

One common method is called the 'subcostal sweep'. The practitioner will sweep the probe in a longitudinal orientation moving slowly under the costal ribs. He or she will identify structures such as the common bile duct, hepatic artery and the portal vein.

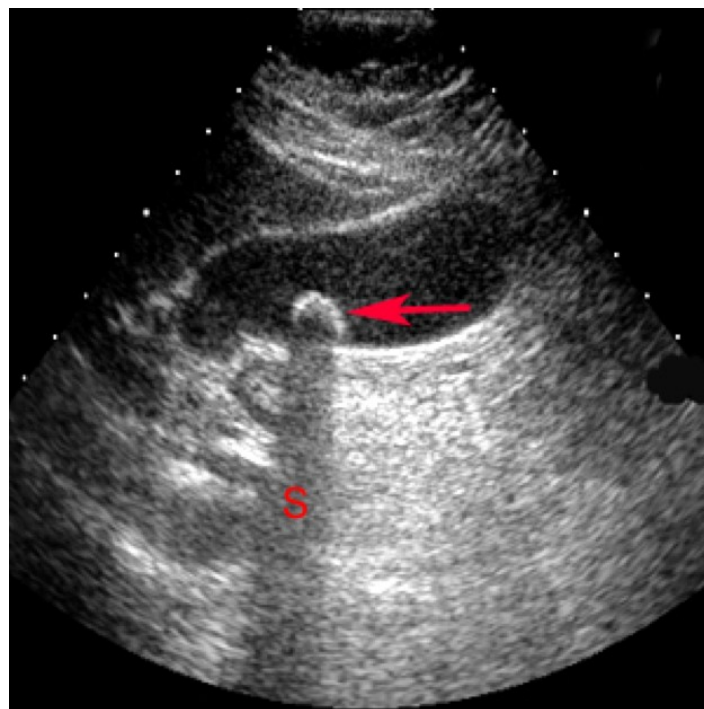


A 'Micky Mouse sign' should be visible. This is the portal triad (common bile duct, hepatic artery and portal vein). It is seen in the longitudinal view of the gallbladder.

Color flow can be used to help identify the structures. It shows the speed/direction of blood flow.



The gallstones are said to be ‘hyperechoic – strong echoes’ and have shadows.



Gallbladder wall thickening is also a sign. It should be 3mm. If it is thicker, it could mean there is damage to the walls – caused by the gallstones.

Expected outcome/ advantage/ interpretation:

When you have a patient who is not able to communicate well, discovering something like Cholelithiasis could significantly improve their condition. Two ways to treat this condition are the stones could be extracted in surgery, or made into smaller stones (lithotripsy).

Clinical procedure #2

Name of the procedure: Chest compressions

**Although code blues are not uncommon in the ED or ICU, the opportunity to participate is a valuable experience. In the present case, a 37 yo M with a PMHx of suicidal ideations overdosed on tricyclic antidepressants. When he arrived in the ER, he had been unresponsive for about 30 min and had already received a few rounds of epinephrine. However, it is standard protocol to do all that can be done before pronouncing a person dead. As a student, I was afforded the opportunity to perform a few rounds of chest compressions, switching off with other members of the team, and I was the last person to compress his chest before he was pronounced dead.*



Principle of the procedure:

When the heart has stopped – cardiac arrest, there is no circulation of oxygenated blood. If chest compression can be performed, vital organs can live longer as a result of receiving blood flow.

Indication(s) for the procedure:

If an unconscious person has no pulse, this is the immediate indication to begin chest compressions. The fact that they are unresponsive and have no pulse may be reason enough to begin chest compressions. However, a pt. may also have ‘agonal breathing’ which is the body’s last attempts to gather air into the lungs.

Associated risk(s) with the procedure:

Some of the risks of performing CPR are: broken ribs, a collapsed lung, or a sore chest/sever pain. One other risk is that family members who are watching could later develop PTSD.



Method:

While it is optimal to have both breaths and chest compressions, recent changes in CPR guidelines say that for non-medical providers, chest compressions only is sufficient until EMS arrives. Ideally, if breaths can be given, the ratio is 30 compressions to 2 breaths.

The UK NHS says: *“After every 30 chest compressions at a rate of 100 to 120 a minute, give 2 breaths. Continue with cycles of 30 chest compressions and 2 rescue breaths until they begin to recover, or emergency help arrives.”*

<https://www.nhs.uk/conditions/first-aid/cpr/>

Expected outcome/ advantage/ interpretation:

Less than 1% of people who have a very serious illness survive the act of CPR.

More specifically, one study stated that about 15% who receive CPR survive until they are discharged from the hospital.

<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/485389>

From my perspective, these odds are very good. It is certainly worth attempting CPR on a patient who is pulseless and unresponsive.

In a related subject, a ‘precordial thump’ can be applied if a suddenly develops ventricular fibrillation or pulseless ventricular tachycardia in front of you. It is said that the thump delivers about 5-30 Joules can be enough to bring the heart back to a normal rhythm. I witnessed one successful result of a precordial thump in the ED here with a pt. brought in via EMS.

Seminars presented/attended

This rotation did not have any seminars. However, at the end of each shift, Dr. Marcucci reviewed the cases of the day, and suggested homework that would support the new cases I had seen on the shift.

As a learning experience, he suggested I watch ‘Code Black’ (2014) which is a documentary about the real experiences of a Los Angeles County Emergency Department.

Other activities*

The Emergency Department is a collection of cooperating professionals of many specialties. During my rotations, I was also able to observe and communicate with the Chicago Fire department, Paramedics, and the Police. It may go without saying but one of the defining features of the Emergency Department is that patients have no appointment. Accordingly, to be fully ready to receive the new patients, excellent communication between all the medical and non-medical professionals is paramount.

Case history #1: Diabetic foot ulcers



(Example images)

Diabetes that is not controlled causes many problems within the body, and diabetic foot is the result of PAD or peripheral arterial disease, also called sensory neuropathy. As arteriosclerosis worsens, diabetic patients are at risk of developing ulcers, chronic wounds and necrosis.

Patient details

Age: 49

Sex: M

Date: 9-22-20

Seen at: Community First Medical Center, Chicago

Chief complaint(S):

A 49 yo M with a past medical history of DM that is not controlled presented with foot ulcer on his left foot for two weeks. He described the pain as shooting pain from his knee down to his foot, relieved by taking naproxen.

History of present illness (HPI):

Past history:

Pt was not taking insulin and had similar foot ulcers on his right foot in the past.

Family history:

Mother has DM, father unknown history.

Personal and social history:

Pt. lives alone at home.



Review of systems:

NEURO –no dizziness or Hx of neuro Dx, HEENT – No allergies, no glasses, no throat pain, RESP - No wheezing, CV – no hx chest pain or orthopnea, no PND, atypical chest pain, GI- no report of abnormalities, MSK – WNL, GU – WNL, Endo – normal function, hormonal HX of uncontrolled DM2, HEME/IMM– not anemic

Physical examination

General survey:

Pt. was very lethargic, endorsing pain in his right leg/foot.

Vital signs:

T: 98.6, **BP:** 125/70, **P:** 92, **RR:** 24, **O2:** 99, **Pain:** 7/10

Skin:

Clear skin on face, no scars, bruises, rash or edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx WNL, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged, no pain with turning

Back:

No discoloration or scars

Thorax and lung:

Lungs – clear, some wheezing, no crackles, rales, no rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Normal body habitus, not distended not tender. BS + in all quads. No bruits noted. No rebound tenderness. Liver WNL no hepatosplenomegaly, No Rovsing sign. Negative murphy sign. No CVA tenderness.

Extremities:

Skin on rt foot and toes ulcerative, erythematous, black.

Nervous system:

A&Ox3 (no pain), CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in hands only, right foot, left foot neuropathy. Motor 5/5 in all muscle groups, DTRs 2/4 and symmetric in all extremities B/L, Babinski could not be taken *fused toes, rt foot past peripheral neuropathy, now left foot too, and cannot move foot.

Other:

Glucose was 439

Differential diagnoses:

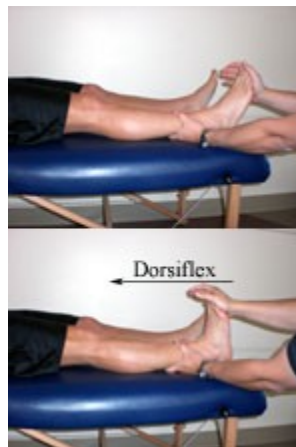
Gas gangrene, Vibrio vulnificus infection, osteomyelitis, blunt bone trauma.

Provisional diagnosis:

Diabetic foot ulcer

Investigations and result:

Homan's sign (dorsiflex foot to assess pain in calf) was negative, in order to rule out DVT.



X-ray of foot, showed no osteomyelitis, gas or gas gangrene.

Final diagnosis:

Diabetic ulcer



Treatment and follow-up:

While prevention of new infections can be achieved by controlling diabetes, this patient was not compliant, so the foot was treated in the ED. (Debridement, dressing, clean daily, keep covered, keep pressure off, use topical ointments)

Final outcome:

The pt was sent home with recommendation to follow up with his PCP.

Review of case:

Many patients coming to the ED with diabetic complications are either not willing to take insulin or make lifestyle changes or are non-compliant with their medications. The ED cannot make pts comply but will treat the pt and provide education.

1. Correct protocol:

Diagnosis and Management of Diabetic Foot Complications

https://professional.diabetes.org/sites/professional.diabetes.org/files/media/foot_complications_monograph.pdf

Protocol for treatment of diabetic foot ulcers

<https://www.medscape.com/viewarticle/453695>

How to Care for Diabetic Ulcers and Sores

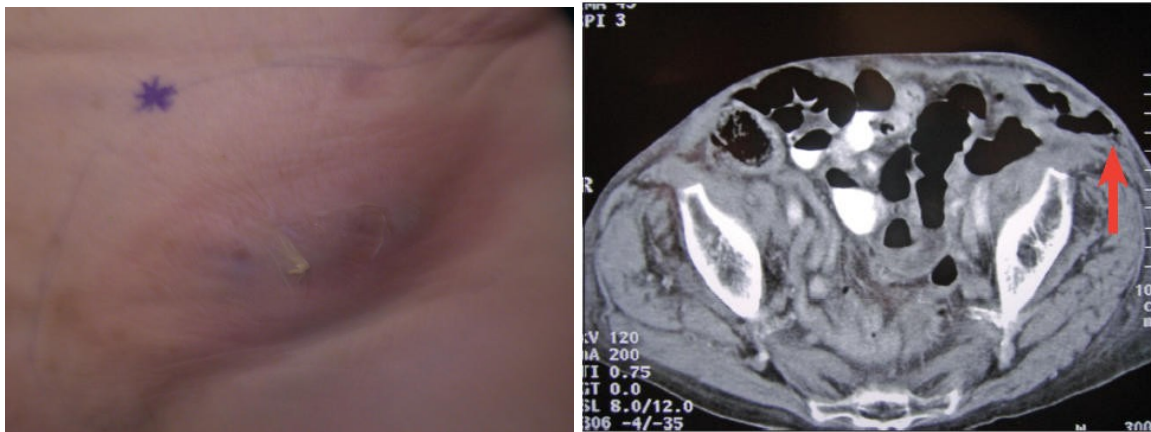
<https://www.webmd.com/diabetes/diabetes-sores-ulcers-care>

2. Relevant research articles:

Update on management of diabetic foot ulcers

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5793889/>

Case history #2: Diverticulitis presenting as inguinal hernia



EG: Diverticular Abscess Presenting as a Strangulated Inguinal Hernia

(example image)

Patient details

Age: 77

Sex: M

Marital status: M

Date: 9-10-20

Pediatric clinic: Community First Medical Center, Chicago

Admitted to Med/Surg ward: Yes

Chief complaint(S):

Pt had PmHx of Rt sided hernia 25 years ago, presenting to the ED with dizziness, and inguinal pain on the left side, relived with Tylenol.

History of present illness (HPI):

Dizziness, pain to palpation of left LLQ.



Past history:

Inguinal hernia on Rt side, 25 years ago

Family history:

No significant FHx.

Personal and social history:

Married, two children, does not drink, no tobacco, no marijuana

Review of systems:

NEURO – endorses dizziness, never had any head issues, HEENT – Throat is clear, no infections, RESP – breathes with ease, not SOB, CV – no MI, no orthopnea, no PND, denies chest pain, GI- LLQ tenderness, MSK – no pain or abnormalities, no leg swelling, no numbness in toes, GU – BPH, Endo – WNL, HEME/IMM– no coagulopathies

Physical examination**General survey:**

Alert and oriented x 3, no difficulty communicating, normal body habitus

Vital signs:

T: 96, BP: 135/82, P: 95, RR: 22, O2: 99, Pain: 8/10

Skin:

Supple, no scars, no bruises, no rashes, no edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, no pharynx soreness, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

Denies any pain, no deformities

Thorax and lung:

Lungs – clear to auscultation, no crackles, rales, no rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Soft, non-distended. BS + in all quads. No bruits noted. Tenderness and masses on LLQ, pain with light and deep palpation. No rebound tenderness. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis clubbing or edema

Nervous system:

A&Ox3, CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L. Motor 5/5 in all muscle groups, DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

Dr. Marcucci was able to reduce the hernia by hand, which relieved the pt. of pain, and surgery may be needed to completely reduce the hernia.

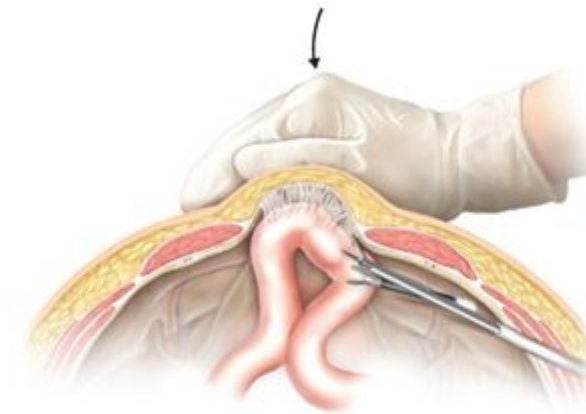


FIG 9 • External manual reduction. External pressure applied to abdominal wall can aid in intraoperative reduction of hernia contents.

Differential diagnoses:

- Diverticulitis
- Metastatic neoplasm
- Testicular torsion
- Femoral artery aneurysm
- Undescended testicle



Provisional diagnosis:

Inguinal hernia (r/o diverticulitis)

Investigations and result:

Cremasteric reflex – done by lightly stroking the superior and inner thigh. If the testicle moves up .5cm, it is a normal response. If it is absent, there may be a lesion of the corticospinal tract above L1. In addition, a CT was obtained to r/o diverticulitis.

Final diagnosis:

Diverticulitis with reducible inguinal hernia (may need surgery).

Final outcome:

Pt. was diagnosed with diverticulitis and admitted with possibility of needing surgery for his hernia.

Review of case:

This was an interesting case because the pt. presented only with symptoms of a hernia but Dr. Marcucci suspected he may also have diverticulitis, which was later confirmed. I watched Dr. Marcucci very carefully manually reduce the hernia which gave the pt. a great deal of relief reducing his pain from an 8/10 to 2/10.

1. Correct protocol:

Hernia reduction

<https://fpnotebook.com/surgery/gi/HrnRdctn.htm>

2020 update of the WSES guidelines for the management of acute colonic diverticulitis in the emergency setting

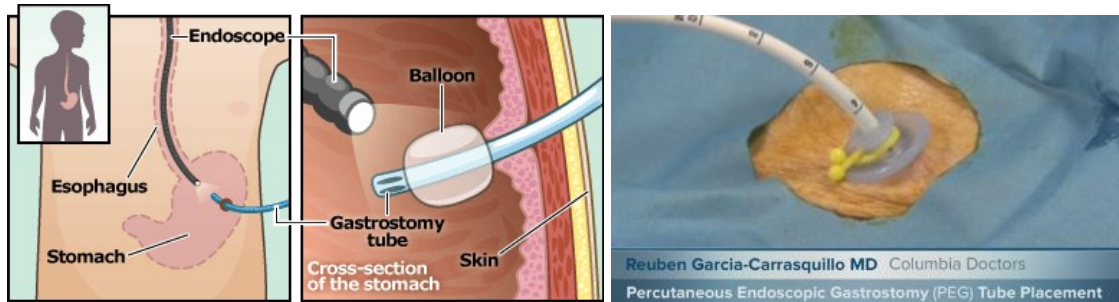
<https://wjeb.biomedcentral.com/articles/10.1186/s13017-020-00313-4>

2. Relevant research articles:

Diverticular Abscess Presenting as a Strangulated Inguinal Hernia

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2001137/#:~:text=Diverticulitis%20can%20present%20as%20left,as%20a%20strangulated%20inguinal%20hernia.>

Case history #3: G-tube replacement



Patient details

Age: 41

Sex: M

Date: 09-12-2020

Chief complaint(S):

Pt was brought in for G-tube replacement. A regular foley catheter was in the stomach at the time of presentation to the ED.

History of present illness (HPI):

Pt. was a resident of a nursing home, with a brain tumor, responsive to voice, but unable to move.

Family history:

Unknown

Personal and social history:

Living at care facility.

Review of systems:

NEURO – responsive to voice, but not commands, HEENT – no nodules, pain erythema, RESP – no lung abnormalities, CV – no Hx of chest pain, GI- G-tube (now with temporary



foley catheter), MSK – no pain or abnormalities, B/Lleg swelling, no numbness in toes, GU – Catheter placed, Endo – UNKNOWN, HEME/IMM– no coagulopathies

Physical examination:

General survey:

Pt appears lethargic, with no apparent skin lesions, or discoloration of skin. Able to respond to voice, but not commands, presumably due to brain tumor.

Vital signs:

T: 98.0, BP: 135/90, P: 85, RR: 20, O2: 99, Pain: 0

Skin:

No bruises, no rash cyanosis, edema B/L legs

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx WNL, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

WNL, no masses

Thorax and lung:

Lungs – clear to auscultation, no rales, no rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Soft, slightly distended. BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative Murphy sign. No CVA tenderness.

Extremities:

Edema in legs 2+

Nervous system:

Responsive only to voice and touch, could not assess CN1. CN2-CN4, CN6 – eyes responsive to stimulation and light, CNs 5-12 intact. B/L. vibration and proprioception not intact in all extremities B/L. Motor 2/5 in all muscle groups, DTRs not responsive B/L, Babinski not measurable.

Others:

No other labs were taken

Differential diagnoses:

None, as presenting for replacement of tube only

Investigations and result:

No further investigations undertaken.

Final diagnosis:

G-tube replacement

Treatment and follow-up:

The patient's G-tube was replaced after removal of the foley catheter.



Final outcome:

The new G-tube was inserted, and the balloon was filled to keep it in place. There were no complications.

Review of case:

The patient was not responsive because of his brain tumor but did seem to be aware of what we were doing. I noticed that when I adjusted his mask so that he could see better, he seemed appreciative. I saw two G-tube replacements during my ED rotation, one



with Dr. Marcucci, and the other with Dr. Williams. Both were replaced within 10 minutes, and the pt. was taken back to the care facility. I wondered why this procedure could not have been done at the care facility, but I imagine it is because there may be dangerous complications with the procedure.

1. Correct protocol:

Gastrostomy acute replacement of displaced tubes

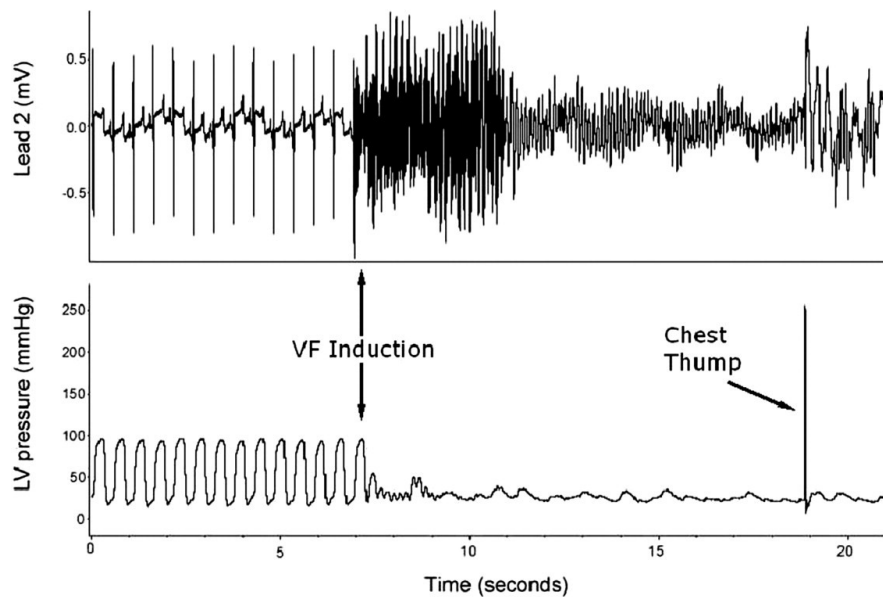
[https://www.rch.org.au/clinicalguide/guideline_index/Gastrostomy acute replacement of displaced tubes/](https://www.rch.org.au/clinicalguide/guideline_index/Gastrostomy_acute_replacement_of_displaced_tubes/)

2. Relevant research articles:

Percutaneous endoscopic gastrostomy tube replacement: A simple procedure?

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3547115/>

Case history #4: Precordial thump



Patient details

Age: 73

Sex: M

Marital status: M

Date: 09-22-20

Chief complaint(S):

Chest pain, radiating to shoulder

History of present illness (HPI):

The patient was at home when the paramedics met him and noticed him lose consciousness in the ambulance, become pulseless and go into ventricular tachycardia. EMS gave him a precordial thump which brought him back into a sinus rhythm.

Past history:

Heart failure, DM, and hyperlipidemia

Family history:

Both parents died of heart-related chronic conditions

Personal and social history:

Married with no children, no tobacco, no drugs, no alcohol



Review of systems:

NEURO –not dizzy, normal mentation, HEENT – no neck problems or hoarseness, RESP – lungs clear CV – WNL, no PND, chest pain radiating to shoulder, GI- WNL, MSK – no weakness in legs, GU – WNL, Endo – denies abnormalities, HEME/IMM– no coagulopathies

Physical examination

General survey:

Looks pale, but awake and lucid

Vital signs:

T: 99, BP: 160/80, P: 100, RR: 27, O2: 99, Pain: 4/10

Skin:

No dryness, no scars, no marks on arms or legs, no bruises, rash or edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx WNL, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

WNL, no scoliosis, no masses

Thorax and lung:

Lungs – clear, no wheezing on expiration, no crackles, rales, or rhonchi

Cardiovascular system:

S1 & S2 WNL, slight thrill while supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses wnl and equal B/L

Abdomen:

Soft, non-distended. BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis clubbing or edema, no marks from needles or erythema



Nervous system:

A&Ox3, CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L, Motor 5/5 in all muscle groups, DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

Troponin level: .65 (example – do not have actual result)

Differential diagnoses:

Acute coronary syndrome, aortic dissection, esophageal rupture, PE, pericarditis

Provisional diagnosis:

STEMI

Investigations and result:

STEMI – EKG showed >1-2mm of ST elevation in two contiguous leads, ischemic chest pain and LBBB.

Final diagnosis:

ST elevation myocardial infarction, LBBB

Treatment and follow-up:

Pt. was given O2 therapy, antiplatelet therapy, anticoagulation therapy (heparin), and pain relief medicine for angina with nitrates and morphine, and beta-blockers.

Final outcome:

The patient was admitted for observation and continued medial therapy.

Review of case:

I remember hearing the EMS announcement and being ready in the ambulance bay to receive the pt. expecting there would be a full code including chest compressions. I was surprised to see him sitting up and talking when he came in. It was then that I learned he had been given a precordial thump by the EMS staff.

1. Correct protocol:

Precordial thump

<https://www.firstaidtrainingbangkok.com/info/cpr-precordial-thump>

1. Witnessed arrest

2. No pulse detected
3. No AED immediately available

2. Relevant research article:

Precordial thump for cardiac arrest is effective for asystole but not for ventricular fibrillation

<https://pubmed.ncbi.nlm.nih.gov/19968931/>

Case history #5: Head laceration



(sample image)

Patient details

Age: 44

Sex: M

Date: 9-04-20

Chief complaint(S): Laceration of left hand

History of present illness (HPI):

Pt. was working in a construction area and broke a glass pane over his hand.

Personal and social history:

Pt lives at home with family. No alcohol, drugs or tobacco.



Review of systems:

NEURO – no mental abnormalities, no dizziness or bumps on head, HEENT – sore throat, no nodules, RESP no history of asthma or breathing diff / trauma, CV – orthopnea, sleeps with no difficulties, no chest pain, GI- WNL, MSK – no numbness or difficulty with gait, GU – WNL, Endo – no reported abnormalities, HEME/IMM– no coagulation or bleeding problems

Physical examination:

General survey:

Pt is alert and talkative.

Vital signs:

T: 98.6, BP: 120/90, P: 89, RR: 22, O2: 99, Pain: 4/10

Skin:

no scars, bruises, or edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx WNL, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

WNL, no scars or masses. No scoliosis

Thorax and lung:

Lungs – clear, no wheezing, crackles, rales, or rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Soft, non-sensitive, BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.



Extremities:

No cyanosis clubbing or edema. Hand is swollen and erythematous around the laceration.

Nervous system:

A&Ox3 (no communication difficulties), CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L. Motor 5/5 in all muscle groups (no difficulty with gait), DTRs 2/4 and symmetric in all extremities B/L, No numbness or tingling in his fingers as a result of the laceration. Babinski downward pointing toes.

Differential diagnosis:

Self-inflicted cut, attempted suicide

Final diagnosis:

Laceration due to trauma

Treatment and follow-up:

Pt. was given 8 sutures, interrupted mattress.

Final outcome:

Pt. was given a tetanus shot, and left the ED.

Review of case:

This pt had a cut that had a central section that needed sutures on both sides. The pt. was interested in the procedure and the physician explained why he was adding sutures to each section. I was interested to notice that for head lacerations that do not involve the hair, only staples are used.

1. Correct protocol:**Suturing, Knots and Wound Care**

[https://emergencypedia.com/2013/06/10/suturing-knots-and-wound-care/#::~text=Essentially%20the%20procedure%20is%20done,2%20throws%20in%20each%20direction\).](https://emergencypedia.com/2013/06/10/suturing-knots-and-wound-care/#::~text=Essentially%20the%20procedure%20is%20done,2%20throws%20in%20each%20direction).)

Laceration Repair: A Practical Approach

<https://www.aafp.org/afp/2017/0515/p628.html>



2. Relevant research articles:

Is there a relationship between wound infections and laceration closure times?

<https://intjem.biomedcentral.com/articles/10.1186/1865-1380-5-32>



Date	Activity / ED topic	Details & Cases
9/8	Registration, meet staff	Paperwork
Week 9/9 – 9/15	Topics	Example cases
9/9	Orientation and start	Tour of the ED with Dr. Marcucci, explanation of activities, expectations
9/10	Resuscitation, basic & advanced airway management	- 75yo F with COPD, HF - MVA, 28yoF, 40yoM
	O2 therapy, Mechanical ventilation	- Intubation using US - Diverticulitis presenting as inguinal hernia
9/12	anaphylaxis, mental state assessment	- Testicular pain - COVID, full code
	deliberate self-harm, acute psychosis	R/O PE, COVID infection
9/13	principles of pain management	- R/o COVID, low blood sugar
9/14	heat related illness	- Elbow pain, tendinopathy
	drowning, electrical injuries	- Homeless/shelter - MVA, LOC, arm, back pain, shoulder
	procedural sedation, bedside, US, CT, MRI	- ETOH intox, withdrawals
9/15 Homework: diverticulitis, inguinal hernia, alcohol withdrawal	disaster management, altitude sickness	- Blue toe syndrome - PEG/G tube replacement
Week 9/16 – 9/22	Topics	- MVA, shoulder injury
9/17		- Stage 4 lung cancer, SOB
		- Drug seeker, leg pain
		- ETOH, head lac
9/19		- Dementia, Nausea, V
		- Palpitations, STEMI, CHF
9/20	STI, Diabetic emergencies	- 14 yo F, anxiety - LOC
	Using US to see gallbladder	- Opiate intox
9/21	Chest pain assessment & management	- ETOH, man on street

9/22	HTsive emergencies, Asthma, COPD	- 57 yo M, Diabetes, SOB - Altered 20 yo m
		- DOA, full code, PEA
Week 9/23 – 9/29	Topics	- Liver failure, SBP
9/23	Acute coronary syndrome, Arrhythmias, pulmonary embolism	- 47 yo M, syncope - r/o fracture hand/MVA - Leg pan, hip fractures
		- 32 yo M, Head Lac
9/24	PID, drug overdose, poisoning, sexual assault, ETOH illness, ethics/privacy in ED	- Edematous line with ultrasound, anasarca vs edema
		- NSTEMI, Chest pain, headache, r/o dissection
9/25	Emergency Department	- Sleep apnea
	Critical Care Unit	- 17 yo M, seizure - 102 yo m, vomiting, a-fib, choledolithiasis
	Comm aqu. Pneumonia, hemoptysis,	- ETOH - Food allergy to Tilapia
		- HTN, cocaine use
		- Bee sting, anaphylaxis
		- Diverticulitis
	Headache, stroke	- HTN, Abdominal and chest pain
9/27	Syncope, seizures	- RLQ pain, r/o appendicitis/stone
	Pneumothorax, acute abdomen	- DM, foot ulcer, r/o osteomyelitis, Homans sign
9/28	Dysphagia, GI bleed	- Swollen neck glands, r/o mono, strep throat, peritonsillar abscess, epiglottitis
		- Lac of 2 nd , 3 rd digits, sutures - OVERDOSE code
9/29	Bowel obstruction	Example cases
	Electrolyte emergencies, acid-base, ectopic pregnancy	- Stroke, leg pain, swelling, r/o H failure - Fall from bed - Headache, miscarriage - HF, chest pain



	Fever, needle-stick, UTI, meningitis, HIV	- Altered, blind - AB pain, r/o MI - Ulcers, squeezing chest pain
		- A-fib, diltiazem
Week 9/30 – 10/6		
9/30	Trauma burns, fracture ID & management,	- R/o boerhaave syndrome - 30 yo, Human bite,
10/1	Acute kidney injury, acute scrotal pain	- CODE, PEA - G-tube replacement - High BP - CODE – precordial thump, recovered
10/3	Renal colic	- Postictal seizure
	Conjunctivitis, vision loss, glaucoma	- Spontaneous bacterial peritonitis
		- Pre-eclampsia
	Ocular trauma	- L bundle branch block
		- Syncope
		- 13 cm leg laceration
		Example cases
		- Chest pain
		- Forward fall, on Eliquis
	ENT emergencies, epistaxis	- Fall, L hip pain
	Hearing loss, otitis media/externa	- Heroin OD, pain relief, r/o drug seeker *this actually turned out to be a real pain issue as the pt had a lesion in her lung – Dr. Marcucci found it on a CT