Everything

And anything
Fill in IMR: Allergies. Diet. Old meds.
Fill inT&N: *x* hourly parameters. Trace old notes.

Passive things: From most to least important
(1)(a)Collapse,(b)Chest pain, (c)SOB: See below
(2)(a)Resite plug, (b)timed bloods/ECGs
(3)(a)Accompany DIL patient here and there for nonurgent stuff
(b)Pain here and there, fever, cannot sleep, etc
(4)Reviewing results: Scan for major abN: K+, Cardiac Enz(Cenz), Hb, Plt, XR reports. Leave exotic Ix for "team to note cm". Compare with previous Ix, check if team left instructions in casefile/IMR.
(5)(a)Talking to relatives(if you like, else ask them come cm), (b)AOR d/c – Need MO to sign. just do the prescription, TCU and memo. d/c summary only for coroner's case & interhospital/dept transfers.

Brainless blood taking
2 tubes = FBC, U/E/Cr. 3rd=PT/PTT. 4th=GXM.
Chest/SOB/Abd pain: Ck/CKMB/Trop T +/- Amylase, LFT
Consider LFT, Ca/Mg/PO4, drug levels
Fever: Blood C/S + Fever Ix(see fever)
SOB: ABG on whatever O2 pt looks comfortable on
2 plain and 1 PT/PTT(sterile fashion) for good measure.
-> PT/PTT can transfer to FBC/HBA1c, serology, GXM, C/S.

Cardio

AMI
Ix: 4tubes, CK, CKMB, Trop T+Bedside TropT, +/- LFT, +/- ABG. CXR, ECG: ST elevation +/- Q waves. R sided leads if ?Inf AMI.
NB: Trop T increased in CRF, recent AMI. CKMB/CK ratio > 5%.
Rx: O2. CRIB. Aspirin 300mg x1, then 100mg om [CI: BGIT, anemia ?cause], else Ticlid 250mg om. GTN '/' S/L or patch stat.[CI: low BP] ISDN 10mg tds. Atenolol 100mg om [CI:asthma]. Captopril 12.5mg bd if ant AMI. Major MI: add Morphine 5mg i/v + maxalon. Atenolol 5mg i/v over 5 min. ISDN 2-10mg/h i/v.
Urgent cardio r/v if good premorb & major MI.

CCF
Ix: 2tubes, CEnz, LFT, +/-ABG, ECG, CXR
Rx: Fluid restrict 1L/day. i/n O2, I/O chart, RIB
iv Lasix 40-80mg x1 + 40mg bd, spanK 0.6g om

Chest pain (on call)
Read case notes: PMH, current dx, recent ECG/CE.
Hx/PE: Nature of pain: cardiac/pleuritic/musculoskeletal
Ix: ECG(ST elevation, Q waves, then T inversion), cardiac enz.
Rx: as per AMI abv

Collapse/CPR
Determine "status" over phone. See stat anyway.
A,B : 100% O2 Bag, Dentures, Oral airway.Synchronize if breathing.
C: No pulse = pump 5:1. i/v access + 5mls bld & h/c. i/v N/S 1Θ fast.
- Asytole: 1mg adrenaline ("1 adrenaline") + 1 mg atropine x 3
- VT/VF: off GTN, defib pads, align apex. Clear. 200J, check rhythm, 360, check, 360 then adrenaline 1mg, lignocaine 70mg
- PEA/EMD: Tx as for K+ ↑. Excl pneumothorax, cardiac tamponade.
If still no response & no help: Check premorbid, case sheet.
- Intubate: Preoxy. Wear mask. ETT: Males: Size 8 to 22-24cm. Fem: Size 7.5 to 20-22cm. Visualize, intubate, check both lungs, SaO2.
- I/v HCO3 50mls after 5 mins.

DIM

Alcohol intoxication
Ix: 3 tubes, alc toxi (document no alcohol swab), +/- green tube.
Rx: Valium 2mg, 2mg, 5mg for Delirium tremors.
Folate 10mg om, Vit B Co '/' bd, Thiamine 30mg om

Allergic reaction (acute)
Stop offending medication (if identified), secure airway
Oral rx: Piriton '/' stat, predisolone 10-30mg
IV rx: Promethazine 25-50mg , Hydrocortisone 100mg stat

Cellulitis
Ix: 2 tubes, Bld C/S, wound swab. Hba1c(DM)/Fasting h/c
4 tubes, ref ortho for abscess, OM, necrotizing fasc, wet gangrene.
Rx: (1)i/v Clox 1g 6h, (2)i/v ampi 1g 6h or CP 2mU 6h. Paracet.

Fever (while on call)
< 38.0: sponge, paracetamol
38+, already on antibiotics: Paracet,
38+, no source, no ab: Hx, PE, kiv septic workup & ab.
- lungs, urine, gut, plug site, op site, DVT, bedsores, cellulitis
38+, post op D1-2. Excl DVT, observe. Don't open wound.

Hypotension (while on call)
Order 1Θ N/S(no K+) fast over phone. Confirm BP. Dx type of shock.
Ix: 4 tubes, +/- CK, CKMB, ECG, +/- DIVC screen, +/- lactate
Rx: O2, Fluids fast (> 2L unless in CCF). Call MO if still poor response. Kiv dopamin 1-10μg/kg/min. kiv CVP. Kiv PCT.

Poisoning
Ix: 4 tubes, LFT, toxicology (green tube, urine, sign 4 seals and fill form). ABG(Salicylates), levels(paracet/salicylate/etc)
police case, refer MSW, suicide precau
Rx: Lavage [<2h], charcoal. 50g 4h [<4h]
Paracet=n-ac (abv). Off later if 4h>200mg/L (1.3mM), 12h>50mg/L
Salicylate. If lvls > 3.6mM, give 1.26% bicarb +/- hemodi.
Cx=Fits(diazepam), Acidosis(bicarb)
Naloxone 2mg/2min max 10min then 2mg in 1Θ/titrate rate
Theophylline: Tx hypokalemia, diazepam for fits,

Potassium -Low:
Ix: +/- ECG(Inverted T,U wave, PR ↑, ST ↓), repeat K+ 6h/cm
Rx: <2.5 or < 3.0 with digoxin tox/AMI/IHD for op:
potassium 7.45% 10mls in 100ml N/S i/v over 1hr max 20mmol/h, (max 20mmol/Θ, do not flush)
Stop diuretics or add span K. Treat cause (eg vomitting)
High: Ix: ECG(Tall T,wide QRS, small P), repeat K+ in 6h/cm
More leeway(add ≈0.5) in: ESRF, recent AMI, "lysed"
> 5.0: Resonium 15g stat/30g fleet & 15g 8h po
> 5.5: add glucose 50% 40mls(dilute w/ N/S) + insulin 6U i/v
> 6.0: Calcium gluconate 10% 20mls slow i/v (cardioprotect), +/- neb ventolin: N/S 1:3 stat. ECG, Cardiac monitoring. +/- Hemodialysis.
Stop K+ sparing diuretics, treat ARF(eg hydration)

Sodium –Low (<125):
True Na+ = Na+ + gluc/4 (esp in DKA)
Dry: 0.9% N/S [(125-Na^+)*0.6*wt÷154] litres /24h
- 125=target Na(max ↑ by 10/24h). "514"(vs 154) for 3% N/S.
- stop diuretics.
Euvolemic: SIADH(malig,CNS,chest,metab,drugs), iatrogenic
- Ix: CXR, fT4, TSH, LFT, cortisol. Plasma osm. Urine osm, Na+. 8am: cortisol, renin-angiotensin ratio(2 FBC tubes), U/E.
- Fluid restrict 1L/d +/- Saline +/- Lasix . Stop D5% drip.
Overloaded: CCF, CRF, hypoalb. Diuretics.
High: Encourage plain water intake else D5% drip 3-5L/24h.
Large amt urine: ?DI. Low K+, high bicard: ?Aldosteronism.

Endocrine

Newly Dx DM
Ix: 2 tubes, LFT, HbA1c, Fasting lipids, fT4/Tsh ECG,CXR, Later: microalb kiv 24CCT & UTP. Dietician, DNE, Fundal photo
Rx: DM 1500-1800kcl, tds+10, SCSI accordingly

DKA/HHNK (H/C "HI", Acidotic, patient sick/drowsy)
Ix: 2 tubes, ABG, CXR, Urine ketones(stat dipstick). +/- 4 hour U/E/ABG (consider HD/ICU). +/- Cenz, ECG.
Rx: NBM, hourly(you do)-2 hourly h/c, hourly parm. I/O +/- catheterize. +/- CLC if drowsy. I/v actrapid(SI) 6U stat then infusion: 50U SI in 49.5ml N/S(1U/ml) at 6mls/hr then change N/S above to D5% at 3mls/hr once BSL<12. i/v N/S 2L/2h + add K^+ 20-40/hr if pu. Overlap SCSI with i/v insulin for 1-2h when converting iv to SCSI.

Hyperglycemia (while on call)
1)(a)8-12, (b)12-16 with DM meds due, (c)12-16 at 10pm: Watch.
2)12-16, no SCSI/oral meds due: SCSI 6-8U
3)16-20: SCSI 8-10U.
4)20-24: SCSI 10-12U. Recheck 2-4hrs, kiv urine ketones.
5)>24: Consider DKA workup.
Consider adjusting pt's oral meds (esp outside of Medical).

Hypoglycemia (while on call)
H/C: <2.5: I/v D50% 20-40mls (dilute with N/S). add i/v thiamine 100mg if alcoholic. <3.0: Glucose drink. Recheck hc 2-4h later.
Then: i/v D5 or D10% drip esp if NBM. Off OHGAs & insulin.
Newly dx:glucose(Li tube),toxicology,c-peptide,insulin before Rx
If admitted for workup: Write meds in casesheet. Any OD? Diet hx.
Stop DM meds. Ix: 2 tubes, HbA1c, excl infection. H/c 2-4 hrly.

Synacthen test
Ix: i/v 250μg synacthen (send IMR early in morning).Cortisol at 0, 30 and 60 min (can site plug in elbow). Any > 500 = responsive.

Gastro

Abdominal pan (while on call)
Causes: GI, HBS-Panc, KUB.Cardio, lung, AAA. DKA, Ca+, psych.
PE: +/- PR. Exclude acute abd.
Ix: 4tubes, LFT, amylase, Ca+, Po4. AXR/erect CXR, +/- cardiac enz & ECG. +/- Ufeme, C/S. Urine pregnacny.
Rx: NBM, PFO if surgical abdo. Else MMT/Mist carb/famot.

BGIT
On iron tabs? PR
Ix: 4tubes, LFT, Cenz, stool OB if no obvious bleed. anemia workup (2 plain + 1 fbc) before transufsion. +/- ECG. AXR if ?perf.
Rx: NBM, i/v drip, Off NSAIDS.
i/v pantoprozole 40mg bd then omeprazole 40mg bd/om po after scope
add i/v somatostatin if suspect varices (liver cirrhosis, alcoholic)

GE
Ix: 2tubes, LFT. AXR if?IO. Stool C/S, ova-parasites. +/- bld c/s, +/- Stool for leucocytes and C-difficile. NBM->Clear feeds->Non-milk diet. Rx: i/v 2-3Θ N/S + 2ΘD5%/24h. stat doses of i/v N/S if dry.
I/v maxalon 10mg tds/prn.Kaolin 10mls tds if severe diarrh.
Ciprofloxacin if septic.

Hepatitis
Ix: 3tubes,LFT. Acute Hep Sero, ?CMV, EBV. LFT/PT,PTT eod.
Rx: Vit B '/' om. Low fat diet. Stop hepatotoxic drugs.

Hepatic encephalopathy
Ix: 4tubes, Ca/Mg/P, ABG, Bld C/S. αFP.
Rx:i/v multivit 10mg, i/v thiamine 100mg, i/v vit k 10mg x 2/7.
Lactulose. Folic acid, vit b co, sangobion. Propranolol.
Low protein diet.

Heme-Onco

Anemia
Hx: Diet, Gastritis, NSAIDs, Menorrhagia
PE: PR, Postural BP
Ix: 4 tubes, LFT, ECG, Fe,TIBC/Ferritin(Plain tube), B12,Folate(Plain tube, FBC form), PBF, Retic.(FBC tube)
+/- Hb Electrophoresis, +/- Stool OB x 3/7. kiv OGD.
Rx: RIB, O2. 1Θ PCT/4 hours (after workup up) if Hb < 8-10.
Lasix 20mg with PCT if overloaded/phx IHD.

Blood reaction
Ix: Fill form. GXM tube, Grey tube. Hourly parm, +/- O2.
Rx: Hydrocort, Piriton.

Blood transfusion/call BTS MO (on call)
Know: Hb, blood group, Dx, symptomatic/bleeding? pre-op?
Call 62238793(office hr)/97342721. Document reply.
Check blood: Num on tag vs packet. Name on tag vs pt. Sign.
Lasix?

DIVC screen (PT/PPT tube & form)
Ix: Fibrinogen(↓), D-dimer >0.5, soluble fibrin monomer

DVT
Ix: Leg circumference. d-dimer, Anticardio lipin Ab. Duplex scan.
Rx: S/C clexane 1mg(0.1ml)/kg bd

Neutropenic sepsis
Ix: 3tubes, LFT, Bld C/S, ECG, CXR, Ufeme & C/S
Rx: i/v cetriaxone 1g om + i/v genta 80mg tds OR i/v fortum 2g bd + i/v amikacin 7.5mg/kg bd if nosocomial

PT/PTT raised (pre-op)
No i/m injections, fall precautions, RIB.
Ix: LFT, +/- DIVC screen (see above). Recheck pt/ptt <when>.
Rx: i/v vit k 10mg om x 3/7 for raised PT. 500mls FFP 8 hourly if for invasive procedure. Inform surgeon. Not for spinal/epidural.

ID

Dengue
PE: Bleeding, Postural BP
Ix: 4tubes, LFT, Dengue Sero, BFMP, +/- Bld C/S
Ufeme, Stool OB, Daily FBC, CRIB, Notify. No i/m inj (if plt low)
Rx: Paracet

Malaria
PE: Cerebral, pulmonary cx, Postural bp (hypovol)
Ix: FBC (Hb < 8), PBF (for schizonts), BFMP. LFT (Cr > 205, Bil > 50). PT/PTT kiv DIVC screen. Bld C/S. G6PD level(FBC tube). Kiv Dengue, wwF. +/- BFMP x2 12 hourly (finger prick & smear)
H/c 6h (hypoglyc).
Rx: Chloroquine 600mg stat and 300mg om x 3/7
If toxic, above criteria +ve, or BFMP falciparum: Quinine: Load (wt x20) in 1Θ D5% i/v over 4h then (wt x 10) in ½Θ D5 over 4-8h bd-tds

PUO
Ix: CT Abdo-pelvis. 4 tubes, LFT, Bld C/S, wwf, dengue, BFMP. CMV, EBV, HIV, Meliodosis. TB, Mantoux. ESR, ana, Anca, dsDNA. β2-μglob, LDH, CRP. FT4, TSH. Ufeme, C/S. Sputum.

Sepsis ?source – see also Fever (DIM)
Ix: 3 tubes, Bld C/S(1-1,2-2,1-1-1(fungal)). CXR. Ufeme, C/S(or dipslide if strong suspicion UTI after office hours). Sputum gram stain +C/S if coughing. Rx: Paracet, i/v antibiotics afrer C/S up.
Guidelines:
Cellulitis: Cloxacillin 0.5-1g 6h + CP 2mu 6h/Ampicillin 500mg 6h
GE, severe: >6x, fever, toxic: Ciproflox 500mg bd po/400mg bd i/v
Meningitis: ceftriaxone 2g bd i/v after bld c/s but before LP
Neutropenic sepsis: (1)Ceftriaxone 1g om + Gentamycin 120mg om Or (2)Imipenem 0.5g 6h i/v or cefepime 2g om or Fortum 2g bd i/v + amikacin 7.5mg/kg bd i/v or . Regime varies by dept/hsptl.
Peritonitis - SBP: ceftriaxone 2g om i/v
Peritonitis - perf: Ciproflox 400mg i/v 12h + Flagyl 500mg i/v 6h
Pneumonia, mild: Amoyxcillin/Augmentin po + EES. Alt: Clarithro.
Pneumonia, CAP: ceftriaxone 1g om i/v + EES 800mg bd po
Pneumonia, CAP, severe: above + cloxacillin 1g 6h i/v
Pneumonia, nosocomial: imipenem 500mg 6h or pip-tazo 4.5g 6h
Pneumonia, aspiration: ceftriaxone + metronidazole 500mg 8h i/v
Septic arthritis: tap, i/v ceftriaxone 1-2g qds + ?cloxacillin 1g 6h
Septic shock: imipenem 0.5mg 6h i/v or meropenem 1g 8h
Thrombophlebitis: cloxacilln 500mg 6h x 2/7, GMS dressing
UTI: urine dipslide, i/v ceftriaxone1g om, or po ciprofloxacin 250mg bd or po bactrim ‘’/’’ bd or po augmentin 525mg bd

Neuro

Bell’s palsy (usu not admitted unless to excl stroke)
Ix: EBV, HSV, CMV, ESR. Blink reflex.
Rx: Pred 40mg om x 2/7 -> 20mg om x 5/7. Eyedrop/shield.

CVA
Ix: +/- CLC 4 hourly. NBM/NG feeds if dysphagia. PT/OT/ST.
3 tubes, LFT, Ca/P. ESR, VDRL, fasting lipids & glucose. ECG, CXR U/S carotids, CT head (usu already done, non-contrast)
Rx: Aspirin 100mg om + famotidine 20mg om-bd, after excl. CI.
BP up to 160/100 normal post-CVA: don’t treat.

Drowsy/Confusion
Causes: Structural, infective, metabolic, drugs, any organ failure
Ix: h/c stat. +/- CLC. Off sedatives.
Ix as for provisional dx: Struc: CT head + CVA workup. Infective: septic workup +/- LP. Metab/drugs: 4 tubes, SpO2, ABG, toxi.

Epilepsy/Fits
Ix: h/c stat. 100% O2. I/v plug 2 tubes, anti-epileptic levels (send all if unsure), LFT, CK, CKMB, aldolase. Later: ABG, bld C/S. CT head.
Rx(Pt fitting):Diazepam 5mg slow bolus max 15mg. 2nd line: phenytoin 20mg/kg (undiluted, or in a line running N/S) with BP and cardiac monitor.
If h/c < 4: i/v D50% 40mls (with thiamine 100mg i/v if ?alcoholic)
Maint: Phenytoin 300mg 6h x 3 then 300mg om

Giddiness, postural hypotension
Causes: CNS, Vestibular, Cardiac, Metab/drugs
PE: Nystagmus, cerebellar s/s, postural BP, Hallpikes, gait
Ix: 4 tubes, Cenz, h/c, ECG,
Rx: Stugeron ‘/’ tds/prn, Stemetil 10mg tds/prn

LP/Meningitis
Ix: Consent, CT head, h/c, Plt & PT/PTT. Opening P. Fluid for: (1-clearest)Feme(tw/gluc), (2)G Stain and C/S, (3)AFB and TB C/S, (4)Fungal smear and C/S. kiv for (5)Latex agglutination, (6)Neurotrophic viruses, (7)VDRL, (8)Cytology
Rx: i/v ceftriaxone 2g stat & bd after bld c/s, before LP/CT.

Renal

Diet
Pre-HD: Cr < 300: Prot 1g/kg/d. >400: 0.6-0.8g/kg/d
HD: Prot 0.8-1g/kg/d, low K, Na+,fluid 500+urine
CAPD: Normal Prot(60-80g), K. Na and fluid restrict.

Dialysis pt
Hx: Dialysis days/center. Last HepB/HIV. Fluid restriction.
Ix: 3tubes, ABG, ECG, CXR. Inform Renal MO cm. No BP/blood taking L/R arm.
Rx: Fluid restrict. DM/low salt diet. O2. i/v lasix 120-240mg if overloaded and still having PU. Urgent HD if SOB++/K+ high.

Nephrotic syndrome
Ix: 3 tubes, Hep B,C, ANA, dsDNA, ANCA, RF, F Lipids. Ufeme, C/S, 24UTP, CCT. ECG. CXR, XR T/L spine. IO chart, daily wt. U/S kidneys.
Rx: Fluid restrict 500. i/v lasix 80mg tds + span K. Don’t start pred.

Pyelonephritis
Ix: 3tubes, Bld C/S, Ufeme + C/S. Genta levels
Rx:Cefzolin 1g 6h + Genta OR i/vCiprofloxacin 250mg 12h OR
Renal impair: Ceftriaxone 1g stat+om

UTI
Ix: 4tubes, Bld C/S, Ufeme & dipslide before ab
Rx: ceftriaxone x 5/7/ Bactrim(nephrotox)/ Cipro/Augmentin
Catheter assoc + S/S: kiv trial off catheter, ab x 14/7.

Respi

Asthma(Reversibility)/**COPD**
Ix: 2tubes, ABG(on *x* l/min), ECG, CXR, Peak Flow. (asthma)
Rx: i/n O2 2L/min, +/- rib. Off β-blockers.
Neb ventolin:N/S 1:3(asthma) or ventoline:atrovent:n/s 1:1:2(COPD) 2-6 hourly, i/v hydrocort 100mg 6h or pred 10-30mg x 3/7. Rx any pneumonia.

Hemoptysis
Ix: 4tubes, LFT, hemoptysis chart(>25 x1 or >300/24h). Sputum C/S. +/- cytology. +/-TB ix. +/- blood C/S if ?pneumonia. CXR(Bronchiec). Kiv E-bronch
Rx: procordin 10mls tds. If massive(die from asphyxia, not blood loss): Lie on affected side(see CXR). 100% o2. Suction. Intubate (kiv w/ 2 lumen ETT). E-bronch.. kiv pulmonary art. embolization.

PE
Ix: 4 tubes, ABG + A-a gradient. Spiral CT. V/Q scan if spiral CT contraindic. Duplex LL.
Rx: 100% O2, Clexane bd

Pleural tap
Consent. Ix: Serum: LDH, LFT, +/- tumour markers
Fluid: 1 + ABG tube: Feme, protein, LDH, pH 2:G stain and C/S. 3: Cytology. 4:AFB, TB C/S 5:Fungal 6:Cryptococal Ag
Lights: Any of: Pl/serum: TP>0.5, LDH>0.6. Pl abs: LDH>200.

Pneumonia
Ix: 3tubes, ABG, Bld C/S, +/- mycopl/leg/chlamydia sero
Ufeme + C/S, Sputum stain + C/S, AFB smear + C/S
kiv laryngeal swab for AFB & TB C/S x 2/7, mantoux
Rx: i/n O2 2L/min. Chest physio
Ceftriaxone 1g stat+om, EES 800mg bd/tds, paracet
Hsptl acq: cefepime/pip-taxo (Pseudomonas)
Aspiration: Metronidazole
Allergy to penicillins: EES/Doxycyclin/Clarithromycin

Pneumothorax
Ix: 4 tubes(2 if small), SpO2/ABG, CXR (in full inspiration), ECG
Rx: 100% O2(even if not SOB) -> Chest tap -> Chest tube (4 tubes, consent, repeat CXR post tube).

Shortness of breath (on call)
Get dx , increase O2 over phone except COPD. Read casesheet.
Ix: 3tubes, SaO2/ABG, +/- Cenz & ECG, +/- CXR. +/- PE ix.
Rx: O2 (keep < 4L/min if known Type 2 RF), tx cause

Pre/Post op / procedure

Pre-op prep. “PFO – Prepare for op**”**
All: Listing, OT chit, consent. NBM 12mn(except under LA).
Premeds “on call to OT”: Eg i/v cefazolin 2g
<40, minor: Hb
>40, minor: FBC, U/E, ECG, CXR
major: FBC, U/E, CXR. if > 40, +ECG
Rheumatoid Art going for GA: C-spine (Flex/Ext)
Bronchoscopy: FBC, ECG. PT/PTT if for TBLB. I/m pethidine 30mg + i/m atropine 0.6mg(CI: Tachycardia, phx AMI) on call to ot
OGD: NBM 12mn.
Bowel Prep (colonoscopy): Low residue x 3/7, feeds only x 1/7, PEG 2L/Oral fleet 45ml bd x 1/7 before +/- Fleet enema few hours before.

Post-op review
Read op findings, post-op instructions and copy.
Check: VS stable. Dressing not soaked? (don’t open!), drain unclamped, drain not excessive. Distal perfusion & neuro ok.
Order: Hourly parm, O2, pain relief, 1st dose of stuff, Feeds->DOC, STO *x* POD.

Interventional radiology (TACE, Angiogram, Hickman’s, etc)
PE: Femoral pulse
Ix: Consent, 4 tubes, LFT, Cr Θ, Hb>8, Plt > 100k, PT/PTT
Pre: +/- n-acetylcysteine 600mg bd if Cr raised
Post-op: Examine wound site. RIB. Hourly parm, circulation chart x 6h. Pain relief.

Tap/tubes/Cope loops
Consider sedation and LA.
Send for:1)Cytology 2)C/S, Gstain 3)TB C/S, AFB.
4)Biochem: FEME, TW, glucose,
Pleural: 5)LDH, TP, SG, pH(ABg tube) 6) Serum h/c, LDH, TP.
LP: 5)Cryptococcus stain & Ag. 6)Specialized tests as ordered
Joints: 5)Crystals
Document: <Time>. <Procedure> and complications explained to pt. Performed by <Dr> under aseptic technique at <location>. Successful first attempt. <opening pressure>. 20mls of straw coloured fluid obtained and sent for <ix>. No cx, patient tolerated procedure well. Lie flat, hourly parm x 6 and CXR. <sign>

GS

Acute abd
Ix: PR. 4 tubes, amylase, LFT, Ca+, Cenz. H/C. Urine diastase, pregnancy test. Ufeme, C/S. ECG, AXR, CXR(sitting/erect/L lat decub AXR). Hourly parm, NBM. Kiv CT abdo-pelvis. PFO.
Rx: i/v fluids. Pain relief(strong relief only if confirm op). Ciproflox 400mg 12h i/v or Ceftriaxone 2g om, Metronidazole 500mg 8h i/v.

ARU / BPH / Catheterization
Ix: PR, Ufeme, C/S, FBC, U/E/Cr, +/- PSA +/- KUB
Rx: Catheterize if pain/UTI/ARU. 12 small, 16 big. Replace foreskin.
C/I: Pelvic #, prostatitis.
“In-out cath”: Cath, measure amt, if < 300mls, remove cath.
Suprapubic cath falls out: Use normal foleys, insert through track as per normal ASAP before track distorted. Call uro ASAP if can’t cath.

Cholecystitis/ biliary colic/ cholangitis.
Ix: 4 tubes, amylase, LFT, Cenz, Bld C/S. Urine diastae. AXR(10% gallstones). U/S HBS. NBM.
Rx: i/v fluids. Pain relief. Ciproflox 400mg 12h i/v or Ceftriaxone 2g om, Metronidazole 500mg 8h i/v.

IO
Ix: PR +/- flatus tube. 4 tubes, LFT, Cenz. H/C. ECG, AXR, CXR(sitting/erect/L lat decub AXR). Hourly parm, NBM. I/O chart. Kiv CT abdo. PFO esp if large bowel(haustra incomplt cross) >8cm , RIF tender, BS ++.
Rx: drip & suck(NG tube on intermittent suction). Fleet enema. Ciproflox 400mg 12h i/v or Ceftriaxone 2g om, Metronidazole 500mg 8h i/v.

Testicular torsion
D/dx: Epididymitis(>30yrs old usu), UTI, tumour, trauma, hydrocoele.
Ix: 4 tubes. +/- urgent U/S testes. PFO. Consent for kiv orchidectomy & *bilat* orchidopexy.
Rx: Pain relief, PFO.

Ortho/Eye

Eye emergencies
Redness + Pain + decreased Va + = glaucoma/keratitis/iritis
Blindness(sudden) + RAPD + white fundus & pale disc = CRAO
Peripheral vision loss +/- “curtain” +/- floaters = retinal detachment

Head injury(Stable)/”Patient fell down”
Hx, PE: VS, Scalp, pearl, GCS, joint ROM, bony pain.
Ix: Xrays/CT head. 1-6 Hourly parm, CLC. Need incident report? Need police case?

Fractures
Xrays. Only emergency # needing op tonight are: (1)Spine with cord compression/instability (2)Hip # if pt <60 years. (3) # with neurological defecit. Traction / backslab everything else, refer cm.
ABG for long bone # to excl fat embolism.

Septic arthritis
Ix: Tap knee before starting Ab.
Rx: Clox (Staph), Ampi(Strep), +/- Roc 2g/d(Gonorrhoea)

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Updates/corrections please submit to / get from:
http://www.geraldtan.com/school