

Hospitalist

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Dr. Shoshana Herzig and colleagues

JAMES DEREK DWYER / BIDMC

New guidance for inpatient opioid prescribing

Exhaustive review will help hospitalists

By Kari Oakes
REPORTING FROM HM18

ORLANDO / A new guidance statement for opioid prescribing for hospitalized adults who have acute noncancer pain has been issued by the Society of Hospital Medicine.

The statement comes after an exhaustive systematic review that found just four existing guidelines met inclusion criteria, though none focused specifically on acute pain in hospitalized adults.

Among the key issues taken from the existing guidelines and addressed in the new SHM guidance statement are de-

termining when opioids – or a nonopioid alternative – should be used, as well as selection of appropriate dose, route, and duration of administration. The guidance statement advises that clinicians prescribe the lowest effective opioid dose for the shortest duration possible.

Best practices for screening and monitoring before and during opioid initiation is another major focus, as is minimizing opioid-related adverse events, both by careful patient selection and by judicious prescribing.

Finally, the statement acknowledges that, when a discharge medication list includes an opioid prescription,

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Hospitalist Movers and Shakers

By Matt Pesyna

Joshua D. Lenchus, DO, RPh, SFHM, has been named the president of the Florida Osteopathic Medical Association, FOMA announced at a gala on Feb. 24, 2018.



Dr. Lenchus

Dr. Lenchus is currently a hospitalist at Jackson Memorial Hospital, Miami, which is affiliated with the University of Miami. He is the first hospitalist to be named FOMA president in at least 20 years, FOMA confirmed.

Dr. Lenchus serves as the Society of Hospital Medicine's Public Policy Committee chair. He is noted for his work as a clinician, hospital administrator, educator, and researcher.

J. Kevin Shushtari, MD, FHM, recently was named chief medical officer at the New Britain (Conn.) Hospital for Special Care, where he will focus on managing the medical staff, admissions, credentials, infection prevention, and clinical affiliations.



Dr. Shushtari

Dr. Shushtari is the founder of the Mercy Inpatient Medical Service, which was one of the first fully staffed hospitalist services in the United States.

He comes to the Hospital for Special Care after spending nearly 3 years as executive medical director of post-acute services for the Sarasota (Fla.) Memorial Health Care System.

Tianzhong Yang, MD, has been selected as the new long-term care medical director for Van Dyk Healthcare in Montclair, N.J. Dr. Yang began his career 3 decades ago in China and has been a hospitalist at Hackensack University Medical Center Mountainside, also in Montclair, since 2013.

Dr. Yang has been an instructor at Brigham and Women's Hospital in Boston, specializing in anesthesiology. At Van Dyk, he will work with the nursing staff to help patients

recover their independence outside of the hospital setting.

Brent W. Burkey, MD, SFHM, a longtime hospitalist at the Cleveland Clinic, has been named the president of Fisher-Titus Medical Center in Norwalk, Ohio.

Dr. Burkey has been the chief medical officer at the Cleveland Clinic's Avon, Ohio, location the past 2 years. He helped the clinic open the Avon hospital in 2016 when he served as vice president of medical affairs.

Dr. Burkey has been a clinical hospitalist since 2004, and he has a master's degree in business administration from Cleveland State University. He will run all hospital and medical center operations at Fisher-Titus, including quality and safety.

Christopher Maiona, MD, SFHM, a longtime veteran of hospital medicine, has been named the chief medical officer for PatientKeeper, a physician-centered software company based in Waltham, Mass.



Dr. Maiona

Dr. Maiona will guide the company's product development, deployment, and optimization efforts.

Dr. Maiona has extensive experience as a practicing hospital physician and as an executive. Most recently, he served as national medical director for TeamHealth of Knoxville, Tenn. He also has been an instructor at Tufts University and Harvard Medical School, both in Boston.

Tom Cummins, MD, has been appointed chief medical officer at Bon Secours St. Francis Health System in Greenville, S.C. Dr. Cummins comes to Bon Secours from Catholic Health Initiatives St. Vincent, Arkansas, where he was senior vice president and CMO; he also first served as a hospitalist within that system.

At Bon Secours, Dr. Cummins will oversee the regional health system's 11 facilities, including St. Francis Downtown in Judson, S.C., and St. Francis Eastside in Greenville.

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Tower Health teams with SHM as first health system institutional partner

Pennsylvania health system to offer customized SHM benefits

Reading (Pa.) Health System has had a long-standing relationship with the Society of Hospital Medicine. Walter R. Bohnenblust Jr., MD, SFHM, the former medical director of hospitalist services at Reading Hospital in West Reading, had been an SHM member since 2002. He worked together with his dyad partner, who was trained in the SHM Leadership Academy curriculum, for 20 years. Together at Reading Hospital, they participated in several SHM Center for Quality Improvement Mentored Implementation programs on topics that included opioid management, care transitions, glycemic control, and VTE treatment.

Today, Reading Health System is known as Tower Health, which recently acquired five hospitals in the southeastern Pennsylvania region.

John K. Derderian, DO, FHM, director of hospitalist services, is leading the growth of the hospitalist programs and made the strategic decision to become an SHM institutional partner by enrolling his entire staff – which consists of 70 physicians and 20 nurse practitioners and physician assistants who provide acute care in a 711-bed hospital – as SHM members.

“I am proud to say the hospitalist group at Reading Hospital is committed to continuous improvement and the providers recognize that the partnership will be an effective tool to achieve their goals,” Dr. Derderian said. “The team at Tower Health is excited about the opportunity to partner with SHM and the potential for our providers to have a single source for all of their career needs – continuing medical education and profession-

al development, to name a few.”

Reading Hospital also has enrolled in SHM’s Optimizing Neurovascular Intervention Care for Stroke Patients Mentored Implementation program, which provides resources and training to equip practitioners with the skills needed to ensure continuous quality of care for stroke patients.

Defining the value of the hospitalist medicine program for Tower Health’s leadership is a topic that is important to Dr. Derderian also. “SHM’s State of Hospital Medicine [SoHM] Report provides exquisite detail of programs around the country, giving Tower Health’s providers invaluable insight into the changes of the hospitalist medicine landscape occurring across the country and the value of the hospitalist team,” he said.

Eric Howell, MD, MHM, who serves as senior physician adviser to SHM,

traveled to Reading Hospital to share his experience as chief of the division of hospital medicine at Johns Hopkins Bayview Medical Center, Baltimore. Dr. Howell shared his metrics dashboard with the Reading hospitalist medicine staff to provide insight into how to measure the effectiveness of the hospitalist team.

“This was an excellent example of how these institutional partnerships create important dialogue between SHM and our partner members, resulting in customized benefits,” said Kristin Scott, director of business development at SHM.

For more information about SHM’s institutional partnerships, please contact Debra Beach, SHM Customer Experience Manager, at 267-702-2644 or dbeach@hospitalmedicine.org.

SHM and Neurohospitalist Society partner on new program for stroke patients

The Society of Hospital Medicine recently partnered with the Neurohospitalist Society (NHS) to apply the neurology, stroke, and neurohospitalist expertise of NHS to the hospital and mentored implementation expertise of SHM for a uniquely positioned program for hospitals and health care systems: the Optimizing Neurovascular Intervention Care for Stroke Patients Mentored Implementation program.

This program aims to provide the resources and training to equip neurologists and hospitals with the skills to help ensure continuous quality in the care of stroke patients with large vessel occlusions. The program will help clinicians identify opportunities to engage multidisciplinary team members to implement evidence-based management practices in their hospital.

Reading Hospital–Tower Health, West Reading, Pa., was one of four hospitals selected to participate in the first wave of this program. Tower Health also recently became SHM’s first health system institutional partner.

The Hospitalist spoke with Reading Hospital staff about the program.

What led you to partner with SHM for this program?

Deepam Gokal, MD, is an associate director of hospitalist services and co-medical director of the stroke program, a member of SHM, and a

former member of NHS; he received an email regarding the Mentored Implementation program for continuous quality monitoring and improvement in the care of stroke patients with large vessel occlusions. Karen Hoerst, MD, is a vascular neurologist and stroke program co-medical director, and Ruth Bailey, RN, is the stroke program manager. Together, we reviewed the introductory webinar with Dr. Gokal and felt this program would be beneficial for our organization, in particular because of Reading Hospital’s recent acquisition of five hospitals to form Tower Health and to help fulfill our vision to become the hub facility and a comprehensive stroke center.

Did you have a history with SHM prior to this program and partnership?

Reading Hospital participated in Project BOOST, SHM’s care transitions Mentored Implementation program, from 2012 to 2013. The goal was to optimize the hospital discharge process and to mitigate and prevent known complications and errors that occur during transitions. This was championed by hospitalists Walter R. Bohnenblust Jr., MD, SFHM, former director of hospitalist services, and Binu Pappachen, MD, FHM.

The pain management provider team at Reading Hospital also championed an opioid management Mentored Implementation program in 2016-2017.

How might this program affect outcomes?

The aim is to provide better care for individuals, improve health strategies, and reduce health care costs. This mentorship program should support this commitment to value-based care and population health management. It should prove beneficial to Reading Hospital by optimizing neurovascular interventions, which will help it become the intended hub for the Tower Health Teleneurology Program.

What will success look like?

Future success for hospitalist services at Reading Hospital will include the fruition of a neurohospitalist subspecialty. Participation in this mentored implementation program should provide valuable resources for the development of this subspecialty that align with the vision of Reading Hospital’s Advanced Primary Stroke Center. This vision is to serve as the comprehensive stroke center of choice for the patients both in our community and the surrounding region and to provide them with 24/7 state-of-the-art complex stroke treatment with demonstrated optimization of quality patient outcomes throughout the continuum of care.

For more information about SHM’s Mentored Implementation programs, visit hospitalmedicine.org/qi.



SDOMINICK/STOCK/GETTY IMAGES

Inpatient opioid prescribing

Continued from page 1

there is potential risk for misuse or diversion. Accordingly, the recommendation is to limit the duration of outpatient prescribing to 7 days of medication, with consideration of a 3-5 day prescription.

An interactive session at the 2018 SHM annual conference presenting the guidance statement focused less on marching through the 16 specific statements in the guidance, and more on teasing out the why, when, how – and how long – of inpatient opioid prescribing.

The well-attended session, led by two of the guideline authors, Shoshana Herzig, MD, MPH, and Teryl K. Nuckols, MD, FHM, began with Dr. Herzig, director of hospital medicine research at Beth Israel Deaconess Medical Center, Boston, making a compelling case for why guidance is needed for inpatient opioid prescribing for acute pain.

“Few would disagree that, at the end of the day, we are the final common pathway” for hospitalized patients who receive opioids, said Dr. Herzig. And there’s ample evidence that troublesome opioid prescribing is widespread, she said, adding that associated problems aren’t limited to such inpatient adverse events as falls, respiratory arrest, and acute kidney injury; plenty of opioid-exposed patients who leave the hospital continue to use opioids in problematic ways after discharge.

Of patients who were opioid naive and filled outpatient opioid prescriptions on discharge, “Almost half of patients were still using opioids 90 days later,” Dr. Herzig said. “Hospitals contribute to opioid initiation in millions of patients each year, so our prescribing patterns in the hospital do matter.”

“We tend to prescribe high doses,” said Dr. Herzig – an average of a 68-mg oral morphine equivalent (OME) dose on days that opioids were received, according to a 2014 study she coauthored. Overall, Dr. Herzig and her colleagues found that about 40% of patients who received opioids had a daily dose of at least 50 mg OME, and about a quarter received a daily dose at or exceeding 100 mg OME (Herzig et al. *J Hosp Med.* 2014 Feb;9[2]:73-81).

Further, she said, “We tend to prescribe a bit haphazardly.” The same study found wide variation in re-

gional inpatient opioid-prescribing practices, with inpatients in the U.S. Midwest, South, and West seeing adjusted relative rates of exposure to opioids of 1.26, 1.33, and 1.37, compared with the Northeast, she said.

Among the more concerning findings, she said, was that “hospitals that prescribe opioids more frequently appear to do so less safely.” In hospitals that fell into the top quartile for inpatient opioid exposure, the overall rate of opioid-related adverse events was 0.39%, compared with 0.21% for hospitals in the bottom quartile of opioid prescribing, for an overall adjusted relative risk of 1.23 in opioid-exposed patients in the hospitals with the highest prescribing, said Dr. Herzig.

Dr. Nuckols, director of the division of general internal medicine at Cedars-Sinai Medical Center, Los Angeles, engaged attendees to identify challenges in acute pain management among hospitalized adults.

The audience was quick and prolific with answers, which included varying physician standards for opioid prescribing; patient expectations for pain management – and sometimes denial that opioid use has become a disorder; varying expectations for pain management among care team members who may be reluctant to let go of pain as “the fifth vital sign;” difficulty accessing and being reimbursed for nonpharmacologic strategies; and, acknowledged by all, patient satisfaction scores.

To this last point, Dr. Nuckols said that there have been “a few recent changes for the better.” The Joint Commission is revising its standards to move away from pain as a vital sign, toward a focused assessment of pain that considers how patients are responding to pain, as well as functional status. However, she said, “There aren’t any validated measures yet for how we’re going to do this.”

Similar shifts are underway with pain-related HCAHPS (the Hospital Consumer Assessment of Healthcare Providers and Systems) questions, which have undergone a “big pullback” from an emphasis on complete control of pain, and now put more focus on whether caregivers asked about pain and talked with inpatients about ways to treat

pain, said Dr. Nuckols.

Speaking about the process of developing the guidance statement, Dr. Nuckols said that “I think it’s important to note that the empirical literature about managing pain for inpatients ... is almost nonexistent.” Of the four criteria that met inclusion criteria – “and we were tough raters when it comes to the guidelines” – most were based on expert consensus, she said, and most had an outpatient focus primarily.

Themes that emerged from the review process included consideration of a nonopioid strategy before initiating an opioid. These might include pharmacologic interventions such as acetaminophen or an NSAID for nociceptive pain, pregabalin, gabapentin, or other medication to manage neuropathic pain, or nonpharmacologic interventions such as heat, ice, or distraction. All of these also should be considered as adjuncts to minimize opioid dosing as well, said Dr. Nuckols, citing well-documented synergy with multiple modalities of pain treatment.

Careful patient selection is also key, said Dr. Nuckols. She noted that she asks herself, “How likely is this patient to get into trouble?” with inpatient opioid administration. A concept that goes hand in hand, she said, is choosing the appropriate dose and route.

Dr. Herzig picked up this theme, noting that route of administration matters. A speedy route, such as intravenous administration, has been shown to reinforce the potentially addictive effect of opioids. There are times when IV is the route to use, such as when the patient can’t take medication by mouth or when immediate pain control truly is needed. However, oral medication is just as effective, albeit slightly slower acting, she said.

Conversion from IV to oral opioids is a potential time for trouble, said Dr. Herzig. “Always use an opioid conversion chart,” she said. Cross-tolerance can be incomplete between opioids, so safe practice is to begin with about 50% of the OME dose with the new medication and titrate up. And don’t use a long-acting opioid for acute pain, she said, noting that not only will there be a long half-life and washout peri-



LOU FERRARO, PARK SOUTH PHOTOGRAPHY

Dr. Teryl Nuckols said hospitalists are the “final common pathway” for hospitalized patients who receive opioids.

od if the dose is too high, but patient risk for later opioid use disorder is also upped with this strategy. “You can always add more, but it’s hard to take away,” said Dr. Herzig.

On discharge, consider whether an opioid should be prescribed at all, said Dr. Herzig. The guidance statement advises generally prescribing less than a 7-day supply, with the rationale that, if posthospitalization acute pain is severe enough to require an opioid at that point, the patient should have outpatient follow-up.

This approach doesn’t undertreat outpatient pain, said Dr. Herzig, pointing to studies that show that, at discharge, “the majority of opioids that patients are getting, they are not taking – which tells us that by definition we are overprescribing.”

The authors of the guidance statement wanted to address two important topics that were not sufficiently evidence backed, Dr. Herzig said. They had hoped to give clear guidance about best practices for communication and follow-up with outpatient providers after hospital discharge. Though they didn’t find clear guidance in this area, “We do believe that outpatient providers need to be kept in the loop.”

A second area, currently a hot-button topic both in the medical community and in the lay press, is whether a naloxone prescription should accompany an opioid prescription at discharge. “There just aren’t studies for this,” said Dr. Herzig.

The full text of the guidance statement may be found here: <https://www.journalofhospitalmedicine.com/jhospmed/article/161927/hospital-medicine/improving-safety-opioid-use-acute-noncancer-pain>.

Keep pushing the envelope

By Brian Harte, MD, SFHM

By the time this column is published, we will have wrapped up HM18 in Orlando, and I will have completed my year as past president, as well as my 6-year tenure on the Society of Hospital Medicine board of directors.

I can imagine that will feel like a relief and a milestone, and it also will feel like a loss to no longer be part of something that I have contributed my time, energy, passion, and emotion to for so long. I will retire at the ripe age of 48 years – a pretty typical age for ending SHM board tenure, and it's terribly important for SHM that I do so.

One of the great attributes of the society is that, despite turning 20 last year, it feels young. And by young, I don't just mean that the age of most board members is well under 50 years (although it is) or that the staff of the society is largely millennials (although they are). I mean that we do not feel beholden to or burdened by tradition or what a "typical" professional society does.

If you attended HM18, I hope you appreciated, as I do every year, the energy, enthusiasm, and youth – if not in years, then in spirit – of the event and of hospitalists. As a society and a profession, we take risks. We have set standards for excellence in hospital medicine programs. We have recognized a unique set of competencies and then not only attempted to expand them with education but also defined a specialty around them. We have welcomed practitioners and administrators as equals into our fold. These and many other accomplishments are the work of a board, committees, chapter leaders, and members who look for opportunities to expand our work into new and necessary domains and are not limited by precedent.

On the SHM board and committees, we tackle issues of governance and strategy. For most of us, the SHM board is our first exposure to nonprofit oversight. And, to be sure, there is a steep learning curve as new members discover the issues and substance of the work of the society. I recall that I barely spoke the first

year on the board, uncertain whether I understood items fully, and I also was burned once or twice by making suggestions that reflected my lack of knowledge. While ignorance slowly gave way to experience, we also ma-

tured as a group as we found ways to debate and resolve tough, sometimes ambiguous, issues.

I came to appreciate that the strength of the board – and of SHM – is that

we join the board naive to much of the past. After 6 years, while I may have come to understand issues with greater depth, I also see that the newer members bring fresher thinking, creative energy, and thoughts about how the group could function better. Over the last few years, I realized that we veterans had developed a cadence and predictability to our work and every year's new members disrupt that rhythm. This disruption forces us to challenge each other and

to be a better board and to represent and advocate for our membership better.

So it's time for me to move on. Even though I certainly feel like I still could contribute, it's time to retire my own way of thinking from the leadership of SHM. The fact that we term-limit out at a relatively young age is, I believe, an extraordinary aspect of our organization.

SHM is an organization that, from the top down, embraces change in ways that few others do. I believe we owe it to you to keep pushing the envelope of creativity. I ask all of you to continue challenging the SHM leadership to be disruptive, to push the profession to better places, and to always strive to be more diverse, inclusive, communicative, visible – and to stay young. In spirit and attitude if not in age. Thank you for giving me the opportunity to work on your behalf. It has been the greatest privilege of my career.

Dr. Harte is a past president of SHM and president of Cleveland Clinic Akron General and Southern Region.



Dr. Harte



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Physician learning must evolve as industry transforms

Training addresses communication challenges

By Eric Barna, MD

In medical school, students are trained on skills that will make them better future physicians, team members, and care givers. It's a curious thing: Once we make headway into our medical careers and our days are filled with patient visits and paperwork, we rarely have the opportunity to assess our skill sets in the same way, despite the fact that new technologies and approaches to treatment have emerged since many of us attended medical school.

As a hospitalist at Mount Sinai Hospital in New York, I'm part of a team that cares for moderately to severely ill patients at a major academic institution. I'm also a physician advisor, and I have the pleasure of teaching some of the brightest medical students, interns, and residents at various stages of their careers. I consider this the best part of my work, so I'm sure it comes as no surprise

that I'm a firm believer in the importance of continuous learning.

That's why I was so excited when I had the chance to participate in three standardized patient encounters training scenarios designed for me and my 22 hospitalist colleagues to improve our communication skills; this training was funded by a grant from the Doctors Company Foundation. A standardized patient encounter is essentially a live simulation in a clinical setting with trained actors.

To start the simulation, a physician is given a short prompt about the patient scenario. They may also be provided with some basic information, such as a diagnosis or a relevant imaging study, prior to entering the room. Once the testing center provides a signal, physicians are allowed to enter the room. An introduction of our role on the medical team is provided, and a discussion ensues. The actors provide relevant

history, incorporate true emotional response to questioning, and display any behavioral or physical prompts that a real patient would. This al-



Dr. Barna

lows physicians to react in real time to the needs of the patient. The use of standardized patients can also be adapted to desired testing scenarios, which might deal with

issues like communication, clinical reasoning, or establishing a differential diagnosis.

Like many hospitals, we have a program in place aimed at assessing how we educate students and younger physicians. But Mount Sinai is the first hospital in New York that has established a program designed specifically to assess and address some of the unique communication challenges we face as hospitalists to improve patient care.

As hospitalists, we've never met patients or families before beginning conversations at critical points of care. It takes sensitivity and a particular thoughtfulness to create rapport and share substantial information with a patient even without having a prior relationship.

During the training, my colleagues and I each encountered three different standardized patients in key scenarios: one at daily rounds, one upset over a missed diagnosis, and one at discharge, when the potential for errors and miscommunication is greatest. We were videotaped during the encounters for our personal review, and we received direct feedback afterward from the patient.

We discovered that we as physicians have become great at taking care of patients, but we also discovered that we don't have enough opportunities to investigate which elements of our day-to-day communication needs adjustment – or what good behaviors need reinforcing.

It was extremely helpful to be able to watch the videos and ask ourselves, "Do I use medical jargon that's hard for the patient to understand? Do I say things that aren't warm and welcoming?" Then, by adding in patient feedback, we learned how we performed across core domains, such

as treating patients with courtesy and respect, using listening skills, and explaining complex topics in an understandable way.

Strengthening these individual communication skills is paramount to improving patient comprehension, which in turn can improve patient follow-through on discharge instructions and reduce risk of re-admission. And as educators, our takeaways from the training can empower others in the health care system at large to better communicate with their patients.

Mount Sinai is proud to have spearheaded this innovative training effort in New York. In fact, since the initial date of the training, the three modules have expanded into a program run by the Morchand Center for Clinical Competence at the Icahn School of Medicine at Mount Sinai. So far, the Morchand Center has adapted the standardized patient methodology used for hospitalists to train 1,845 additional residents in various specialties across New York.

Nationwide, the entire medical community stands to benefit from continuous physician learning and the partnerships that facilitate it. At a time of tremendous change for health care, having a well-trained physician workforce is more important than ever before. Our patients deserve to be cared for by physicians whose knowledge evolves alongside the transformation of care delivery.

Physician learning must keep pace with our industry's transformation. By setting expectations higher for patient communication, we increase patient safety and levels of satisfaction and drive quality care – no matter what the future of health care delivery looks like.

This column was provided by the Doctors Company, the exclusively endorsed medical malpractice carrier for the Society of Hospital Medicine. Neither SHM nor Frontline Medical Communications was involved in its production.

Dr. Barna is an associate residency program director for inpatient medicine in the Division of Hospital Medicine/Samuel Bronfman Department of Medicine in the Icahn School of Medicine at Mount Sinai, New York.

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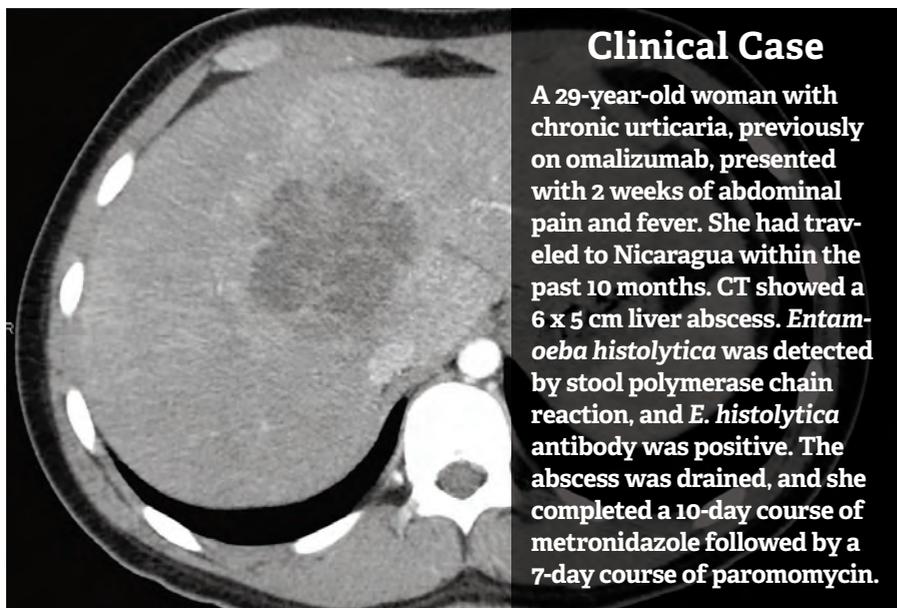
Key Clinical Question

What is the microbiology of liver abscess?

Identify risk factors and mechanism of infection

By Pooja Mehra, MD, and Andrew Parsons, MD, MPH

University of Virginia, Charlottesville



Clinical Case

A 29-year-old woman with chronic urticaria, previously on omalizumab, presented with 2 weeks of abdominal pain and fever. She had traveled to Nicaragua within the past 10 months. CT showed a 6 x 5 cm liver abscess. *Entamoeba histolytica* was detected by stool polymerase chain reaction, and *E. histolytica* antibody was positive. The abscess was drained, and she completed a 10-day course of metronidazole followed by a 7-day course of paromomycin.

JAMES HEILMAN, MD/CC BY-SA 4.0

Brief overview

Bacterial, parasitic, and fungal organisms can cause liver abscess. Worldwide, bacteria are the most common cause of liver abscess. Infection is usually polymicrobial, though *Klebsiella* and the *Streptococcus milleri* group are the most common organisms identified.

Entamoeba histolytica is the most frequent cause of amoebic liver abscess and should be strongly considered in a returning traveler, a visitor from another country, or those on monoclonal antibody therapy directed against IgE such as omalizumab. *Candida* species are the most common fungal etiology; an example being hepatosplenic candidiasis in hematologic malignancies.

Liver abscesses not only cause local symptoms but can cause sepsis and can rupture into the pleural and peritoneal space. The aim of treatment is to control the local response, prevent rupture, and eradicate the pathogen.

Overview of the data

Pyogenic liver abscess. A variety of bacteria have been isolated from pyogenic liver abscesses (PLA) because of differences in mechanism of infection (such as biliary tract interventions, postoperative complications, and hematogenous spread), immunocompromised states, and geographical variation. The literature is not robust for pyogenic liver

abscesses, and the microbiology isolated via epidemiologic studies are confounded by the mechanism of infection and thus difficult to generalize.

Initially, the Enterobacteriaceae including *Klebsiella pneumoniae* and *Escherichia coli* were the most common cause of PLA in the United States. The emergence of improved culturing techniques, which has improved the yield of facultative anaerobes such as the *Streptococcus milleri* (also known as *Streptococcus anginosus*) group, has led to an increased incidence and wider assortment of bacteria, with a more recent study of 38 patients in the Cleveland Clinic system showing that about half of the PLA were polymicrobial and with the predominant organism when monomicrobial being of the *Strep milleri* group in 9/22 patients (Chemaly et al.).

Biliary tract disease, whether from choledocholithiasis, stricture, or malignant obstruction, is the most common etiology of PLA. Much of the PLA-focused literature is from Asia, where *Klebsiella* is more commonly a cause of liver abscess. In a study of 248 Taiwanese patients with PLA, *Klebsiella* was responsible for 69% of PLA (Yang et al.). In a study of 79 patients hospitalized in New York, *Klebsiella* was the most common bacteria isolated, although more than half of the patients studied were Asian, and *Klebsiella* was

more common among Asian patients than the other groups studied. An 8-year analysis of patients admitted to a university hospital in Taiwan with cryptogenic PLA showed that the etiology was *Klebsiella* in 46/52 patients (Chen et al.). Most patients with *Klebsiella* liver abscess have documented bacteremia.

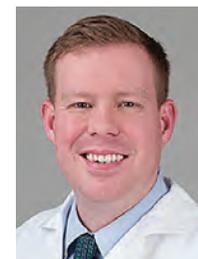
The second most common mechanism is bacterial translocation through the portal venous system. *Escherichia coli* is commonly isolated and is frequently spread from intra-abdominal infections, such as appendicitis leading to pylephlebitis. As the diagnosis and management of appendicitis has improved, the incidence of PLA caused by appendicitis has decreased.

Hematogenous spread is also possible, and the presence of endocarditis or endovascular infection should be considered if streptococcal or staphylococcal species are identified. Staphylococcal species can be seen following recent instrumentation, such as endoscopic retrograde cholangiopancreatogram. The *Strep milleri* group have an association with colorectal malignancy and PLA.

PLA should be cultured to guide therapy, and catheter drainage may be required. However, common organisms causing liver abscess should also be considered when selecting initial antibiotic therapy because cultures are frequently affected



Dr. Mehra



Dr. Parsons

by previous antibiotic exposure or imprecise culturing techniques. Blood cultures should be obtained, and empiric therapy with a beta-lactam/beta-lactamase inhibitor or third-generation cephalosporin plus metronidazole should be started thereafter.

Entamoeba histolytica. This anaerobic parasite can lead to amoebic dysentery and liver abscess and affects

Continued on following page

Quiz



Microbiology of liver abscesses

Bacterial, parasitic, and fungal organisms can all cause liver abscesses. History, including travel history, is very important in deciphering which organisms are present.

Question 1: What is the most common cause of an amoebic liver abscess worldwide?

- A. *Echinococcus*
- B. *Klebsiella pneumoniae*
- C. *Entamoeba histolytica*
- D. *Escherichia coli*

The best answer is choice C.

Entamoeba histolytica causes amoebic dysentery and liver abscess. This anaerobic parasite affects 50 million people worldwide, with the highest prevalence in India, sub-Saharan Africa, Mexico, and parts of

Central and South America. Travelers spending a month or more in endemic areas are at highest risk, but cases have been reported with less than 1 week of exposure.

Question 2: Which type of parasitic cyst should not be aspirated?

- A. *Echinococcus*
- B. *Entamoeba histolytica*
- C. *Schistosomiasis*
- D. *Paramoeba*

The best answer is choice A.

Aspiration of an echinococcal cyst carries a risk of anaphylaxis and spread of infection and should be done only if there is serologic and radiographic uncertainty. Imaging typically shows a well-defined cyst with calcifications and budding daughter cysts.

Continued from previous page

upwards of 50 million people worldwide, predominantly in India and sub-Saharan Africa. Travel to an endemic area for longer than 1 month carries a high risk of transmission, although cases have been described with less than a week of exposure.

Infection occurs following consumption of affected food or water and can lead to dysentery within 3 weeks. Fever and right upper quadrant pain develop later, anywhere from 3 months to years following initial exposure. To diagnose, both serologic and stool testing for *Entamoeba histolytica* are recommended because of the high sensitivity and low specificity of the serologic antibody test and because of the low sensitivity and high specificity of the stool antigen test. Imaging may reveal a single cyst with surrounding edema, which is characteristic.

Effective treatment is a two-step process. Metronidazole targets trophozoites that cause liver abscesses, then paromomycin or diloxanide furoate eradicates luminal oocysts and prevents reinfection. Aspiration and catheter drainage is necessary if the microbiology or etiology of the liver abscess remains uncertain, patients are not responding to antibiotics, or

Key Points



- Risk factors and mechanism of action will suggest the most likely organisms and guide antibiotic choice.
- *Entamoeba histolytica* is the most common cause of liver abscess worldwide.
- Stool PCR and antibody testing for *E. histolytica* should both be ordered in the work-up of a liver abscess.
- Calcifications and daughter cysts budding off the main cyst can distinguish echinococcal cyst from *E. histolytica* abscess radiographically.

there is concern about impending rupture with cyst size greater than 6 cm (Jun et al.).

Hydatid cysts. Serologic testing via enzyme-linked immunoassay and radiographic characteristics are used to diagnose cysts caused by *Echinococcus*, of which there are many species. Imaging typically shows a well-defined cyst with calcifications and budding daughter cysts. Aspiration of an echinococcal cyst carries

a risk of anaphylaxis and spread of infection and should only be undertaken if there is serologic and radiographic uncertainty.

Three options exist for treatment: medication, surgical excision, and percutaneous drainage. Currently, standard treatment is careful surgical excision and a course of albendazole. A new technique, PAIR, involves *puncture, aspiration, injection* (with a scolicidal agent like hypertonic saline), and *reaspiration* (Smego RA Jr et al.). Patients are treated with albendazole before and after this procedure.

Fungal abscesses. Fungal abscesses are most commonly caused by *Candida* species. The typical patient presentation includes high fever and elevated alkaline phosphatase, usually during the count recovery phase of patients with hematologic malignancies undergoing chemotherapy.

Fungal abscesses are frequently too small to aspirate. Fortunately, serum and radiographic results, as well as the clinical setting, make diagnosis more straightforward. Serum fungal markers can be checked, and empiric treatment with amphotericin B or an echinocandin is recommended, followed by narrowing to oral fluconazole. Treatment should continue until abscesses resolve.

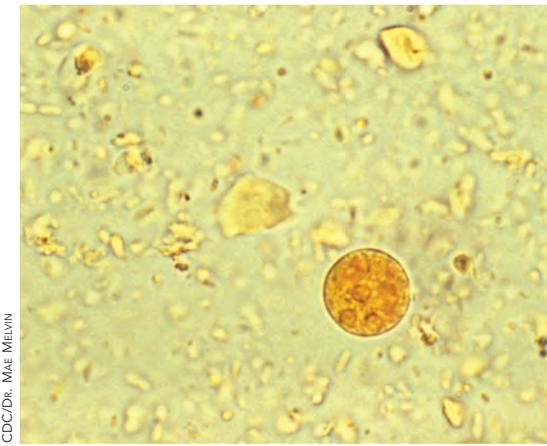
Interestingly, if patients become neutropenic during their antifungal course, the microabscesses may disappear on CT or MRI only to reappear once neutrophils return. Once patients have a stable neutrophil count and imaging shows no abscesses, antifungal treatment can be discontinued, but it must be restarted if patients are to undergo additional chemotherapy with expected neutropenia.

Back to the case

While impossible to state with certainty, infection with *Entamoeba histolytica* while in Nicaragua was thought most likely in this case. This patient was on omalizumab for chronic urticaria immediately prior to acquiring the infection and this anti-IgE monoclonal antibody likely predisposed her to a parasitic infection. Because of this epidemiology, she may not have required catheter drainage; however, the cyst was causing pain, and drainage provided decompression. She was treated with antibiotics followed by paromomycin.

Bottom line

Entamoeba histolytica is the most common cause of liver abscess worldwide, but identifying risk



CDC/DR. MAE MELVIN

This iodine-stained photomicrograph reveals the presence of an *Entamoeba histolytica* amoebic parasitic cyst.

factors and mechanism of infection can lead to finding the most likely infecting organism.

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In the Literature

Clinician reviews of HM-centric research

By Bryan Huang, MD, FHM; Maryann T. Ally, MD, MPH, FACP; Arkady Komsoukaniants, MD; Ali Farkhondehpour, MD; and Supraja Thota, MD

Division of Hospital Medicine, UC San Diego Health

IN THIS ISSUE

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By Bryan Huang, MD, FHM

1 Prompting during rounds decreases lab utilization in patients nearing discharge

CLINICAL QUESTION: Does prompting hospitalists during interdisciplinary rounds to discontinue lab orders on patients nearing discharge result in a decrease in lab testing?

BACKGROUND: The Society of Hospital Medicine, as part of the Choosing Wisely campaign, has recommended against “repetitive complete blood count and chemistry testing in the face of clinical and lab stability.” Repeated phlebotomy has been shown to increase iatrogenic anemia and patient discomfort. While past interventions have been effective in decreasing lab testing, this study focused on identifying and intervening on patients who were clinically stable and nearing discharge.

STUDY DESIGN: Prospective, observational study.

SETTING: Tertiary care teaching hospital in New York.

SYNOPSIS: As part of structured, bedside, interdisciplinary rounds, over the course of a year, this study incorporated an inquiry to identify patients who were likely to be discharged in the next 24-48 hours; the unit medical director or nurse manager then prompted staff to discontinue labs for these patients when appropriate. This was supplemented by education of clinicians and regular review of lab utilization

data with hospitalists.

The percentage of patients with labs ordered in the 24 hours prior to discharge decreased from 50.1% in the preintervention period to 34.5% in the postintervention period ($P = .004$). The number of labs ordered per patient-day dropped from 1.96 to 1.83 ($P = .01$).

BOTTOM LINE: An intervention with prompting during structured interdisciplinary rounds decreased the frequency of labs ordered for patients nearing hospital discharge.

CITATION: Tsega S et al. Bedside assessment of the necessity of daily lab testing for patients nearing discharge. *J Hosp Med.* 2018 Jan 1;13(1):38-40.

2 Steroids do not reduce mortality in patients with septic shock

CLINICAL QUESTION: Among patients with septic shock undergoing mechanical ventilation, does hydrocortisone reduce 90-day mortality?

BACKGROUND: Septic shock is associated with a significant mortality risk, and there is no proven pharmacologic treatment other than fluids, vasopressors, and antimicrobials. Prior randomized, controlled trials have resulted in mixed outcomes,

and meta-analyses and clinical practice guidelines also have not provided consistent guidance.

STUDY DESIGN: Randomized, controlled, double-blinded trial.

SETTING: Medical centers in Australia, Denmark, New Zealand, Saudi Arabia, and the United Kingdom.

SYNOPSIS: Over a 4-year period from 2013 to 2017, 3,658 patients with septic shock undergoing mechanical ventilation were randomized to receive either a continuous infusion of 200 mg/day of hydrocortisone for 7 days or placebo. The primary outcome, death within 90 days, occurred in 511 patients (27.9%) in the hydrocortisone group and in 526 patients (28.8%) in the placebo group ($P = .50$).

In secondary outcome analyses, patients in the hydrocortisone group had faster resolution of shock (3 vs. 4 days; P less than .001) and a shorter duration of initial mechanical ventilation (6 vs. 7 days; P less than .001), and fewer patients received blood transfusions (37.0% vs. 41.7%; $P = .004$). There was no difference in mortality at 28 days, recurrence of shock, number of days alive out of the ICU and hospital, recurrence of mechanical ventilation, rate of renal replacement therapy, and incidence of new-onset bacteremia or fungemia.

BOTTOM LINE: Administering hydrocortisone in patients with septic shock who are undergoing mechanical ventilation does not reduce 90-day mortality.

CITATION: Venkatesh B et al. Adjunctive glucocorticoid therapy in patients with septic shock. *N Engl J Med.* 2018 Jan 19. doi: 10.1056/NEJMoa1705835.

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Diego Health and an associate professor of medicine at the University of California, San Diego.

By Maryann T. Ally, MD, MPH, FACP

3 Chest Pain Choice tool decreases health care utilization

CLINICAL QUESTION: What effect does the Chest Pain Choice (CPC) decision tool have on health care utilization?

BACKGROUND: Patients who complain of chest pain make up over a quarter of annual hospital admissions, but not all chest pain is attributable to acute coronary syndrome. The one-page CPC document was developed to facilitate joint decision making between low-risk patients and providers regarding the work-up for chest pain.

STUDY DESIGN: Parallel, randomized, controlled trial.

SETTING: Six U.S. medical centers.

SYNOPSIS: After reviewing the CPC tool, patients with low cardiac risk who presented to the ED with chest pain were given the option either to be admitted to the hospital for cardiac testing or to not be admitted and instead follow up with their primary care doctor or a cardiologist within 3 days to determine what further cardiac work-up might be warranted.

Upon reviewing data obtained from 898 patient diaries regarding use of health care services, as well as from billing data from the medical centers, the researchers found no statistically significant difference between patients who used the CPC tool and those treated under usual care with regard to hospital readmission rates, length of stay in the ED, repeat ED visits, or clinic visits.

However, at the 45-day follow-up mark, those in the CPC group had undergone fewer tests and cardiac imaging studies (decrease of 125.6 tests/100 patients; 95% confidence interval, 29.3-221.6).

BOTTOM LINE: Shared decision making between providers and patients with low cardiac risk factors that used the Chest Pain Choice tool decreased some health care utilization without worsening outcomes.

CITATION: Schaffer JT et al. Impact of a shared decision-making intervention on health care utilization: A secondary analysis of the Chest Pain Choice multicenter randomized trial. *Acad Emerg Med.* 2018 Mar;25(3):293-300.



Dr. Ally



Dr. Huang

Continued from page 13

4 Low risk of complications from sedation-associated GI endoscopies

CLINICAL QUESTION: What types of sedation and risk factors lead to sedation-associated complications in patients undergoing GI endoscopic procedures?

BACKGROUND: Most GI endoscopies use sedation to keep patients comfortable during procedures, but sedation puts patients at increased risk of complications. Most of the available studies reporting sedation-related complications are retrospective and dated. There is a lack of prospective studies investigating sedation-related complications and their associated risk factors.

STUDY DESIGN: Prospective study.
SETTING: Thirty-nine hospitals in Germany.

SYNOPSIS: Using data collected from 314,190 adult endoscopies in which sedation was used, this study identified that there was only a 0.01% rate of major complications. Major complications for this study included intubation, ICU admission, resuscitation, or death. Propofol was the most commonly used sedative (61.7% of cases) and had the lowest risk of complications (odds ratio, 0.7509; $P = .028$). The top risk factors for complications were an American Society of Anesthesiologists class greater than 2 (OR, 2.2998; P less than .001), emergent need for the endoscopy (9 of the 13 fatal cases), and longer procedure length (P less than .001).

BOTTOM LINE: GI endoscopic procedures with sedation are tolerated well in the general population and have low risk of complications.

CITATION: Behrens A et al. Acute sedation-associated complications in GI endoscopy (ProSed 2 Study): Results from the prospective multicentre electronic registry of sedation-associated complications. *Gut*. 2018 Jan 3. doi: 10.1136/gutjnl-2015-311037.

Dr. Ally is a hospitalist at UC San Diego Health and an assistant clinical professor at the University of California, San Diego.

By Arkady Komsoukaniants, MD

5 Myeloproliferative neoplasms increase risk for arterial and venous thrombosis

CLINICAL QUESTION: What are the risks for arterial and venous thrombosis in patients with myeloproliferative neoplasms (MPNs)?

BACKGROUND: Myeloproliferative neoplasms include polycythemia

vera, essential thrombocythemia, and primary myelofibrosis. Prior studies have investigated the incidence of arterial and venous thrombosis in patients with myeloproliferative neoplasms, but the actual magnitude of thrombosis risk relative to the general population is unknown.

STUDY DESIGN: Retrospective matched-cohort study.

SETTING: Sweden, using the Swedish Inpatient and Cancer Registers.

SYNOPSIS: Using data from 1987 to 2009, 9,429 patients with MPNs were compared with 35,820 control participants to determine hazard ratios for arterial thrombosis, venous thrombosis, and any thrombosis. The highest hazard



Dr. Komsoukaniants

ratios were seen within 3 months of MPN diagnosis, with hazard ratios of 4.0 (95% confidence interval, 3.6-4.4) for any thrombosis, 3.0 (95% CI, 2.7-3.4) for arterial thrombosis, and 9.7 (95% CI, 7.8-12.0) for venous thrombosis. Risk decreased but remained significantly elevated through follow-up out to 20 years after diagnosis. This decrease was thought to be caused by effective thromboprophylactic and cytoreductive treatment of the MPN.

This study demonstrates significantly elevated risk for thrombosis in patients with MPNs, highest shortly after diagnosis. It suggests the importance of timely diagnosis and treatment of MPNs to decrease early thrombosis risk.

BOTTOM LINE: Patients with MPNs have increased rates of arterial and venous thrombosis, with the highest rates within 3 months of diagnosis.

CITATION: Hultcrantz M et al. Risk for arterial and venous thrombosis in patients with myeloproliferative neoplasms. *Ann Intern Med*. 2018 Mar 6;168(5):317-25.

6 High users of CT pulmonary angiograms have lower diagnostic yields

CLINICAL QUESTION: What physician characteristics are associated with CT pulmonary angiogram (CTPA) diagnostic yield?

BACKGROUND: Overuse of CTPAs for pulmonary embolism evaluation exposes patients to unnecessary testing and harmful ionizing radiation. Physician characteristics influence ordering practice. Identifying specific

SHORT TAKES

Preoperative physiotherapy reduces postoperative pulmonary complications in patients undergoing elective abdominal surgery

A randomized, controlled trial showed that, in patients having elective abdominal surgery, a 30-minute preoperative physiotherapy session – that focused on breathing exercise training and education – reduced postoperative pulmonary complications, including hospital-acquired pneumonia, by half (hazard ratio, 0.48; number needed to treat, seven).

CITATION: Boden I et al. Preoperative physiotherapy for the prevention of respiratory complications after upper-abdominal surgery: pragmatic, double-blinded, multicenter randomized controlled trial. *BMJ*. 2018 Jan 24;360:j5916.

Severity of thrombocytopenia does not predict bleeding risk in patients with cirrhosis

A subgroup analysis of a prospective cohort study showed that, although platelet counts worsened with progression of liver disease, platelet counts were similar in patients with and without a bleeding event.

CITATION: Basili S et al. Platelet count does not predict bleeding in cirrhotic patients: Results from the PRO-LIVER study. *Am J Gastroenterol*. 2018 Mar;113(3):368-75.

characteristics can provide an intervention for reducing overutilization.

STUDY DESIGN: Retrospective analysis.

SETTING: Academic teaching hospital in Montreal, Canada.

SYNOPSIS: Investigators reviewed 1,394 CTPAs ordered by 182 physicians at an academic teaching hospital during 2014-2016, with 199 (14.3%) positive studies and 1,195 (85.7%) negative studies. Physician years of experience, physician sex, and emergency medicine specialty were not associated with diagnostic yield. However, the diagnostic yield decreased with the total number of scans ordered per physician. For every 10 additional scans ordered, the odds of a positive test were reduced (odds ratio, 0.76; 95% confidence interval, 0.73-0.79). For physicians who ordered more than 50 studies, the percentage of positive studies was only 5%.

This study's results show that overuse of CTPA is associated with decreased diagnostic yield. A limitation of the study was that pretest

SHORT TAKES

Patent foramen ovale closures are superior to medical therapy in patients with medium to large PFOs

A meta-analysis of four randomized, controlled trials found that patients with cryptogenic stroke who underwent PFO closure had decreased rates of stroke and transient ischemic attack, compared with medical therapy alone, but had increased incidence of atrial fibrillation or atrial flutter.

CITATION: De Rosa S et al. Percutaneous closure versus medical treatment in stroke patients with patent foramen ovale: A systematic review and meta-analysis. *Ann Intern Med*. 2018 Mar 6;168(5):343-50.

Short-run atrial tachyarrhythmias increase the risk of stroke

A retrospective, observational study showed that patients with short-run atrial tachyarrhythmias (more than three consecutive supraventricular ectopic beats lasting less than 5 seconds) have an increased risk of stroke (11.4% vs. 8.3%; P less than .001) over a 9-year follow-up period.

CITATION: Yamada S et al. Risk of stroke in patients with short-run atrial tachyarrhythmia. *Stroke*. 2017 Dec;48(12):3232-8.

Even one cigarette is too many

A meta-analysis of 55 publications containing 141 cohort studies demonstrated that even those that smoked one cigarette per day were at increased risk of developing coronary artery disease and stroke.

CITATION: Hackshaw A et al. Low cigarette consumption and risk of coronary heart disease and stroke: Meta-analysis of 141 cohort studies in 55 study reports. *BMJ*. 2018 Jan 24;360:j5855.

probabilities for pulmonary embolism could not be calculated because of inadequate charting, which would have determined whether CTPA was the appropriate test (as opposed to D-dimer).

BOTTOM LINE: Physicians who order higher numbers of CTPAs have lower diagnostic yields.

CITATION: Chong J et al. Association of lower diagnostic yield with high users of CT pulmonary angiogram. *JAMA Intern Med*. 2018 Mar 1;178(3):412-3.

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By Ali Farkhondehpour, MD

7 EUS and MRCP as complementary studies in the etiologic diagnosis of idiopathic acute pancreatitis

CLINICAL QUESTION: Should endoscopic ultrasound (EUS) and magnetic resonance cholangiopancreatography (MRCP) both be used in the diagnostic work-up of idiopathic acute pancreatitis (IAP)?

BACKGROUND: Approximately 10%-30% of patients with acute pancreatitis do not have an established etiology after routine investigation with imaging. These patients are classified as IAP. Less invasive tests, such as EUS, MRCP, and secretin stimulation MRCP (S-MRCP) have been used to further explore IAP, but their comparison in the etiologic diagnosis of idiopathic acute pancreatitis is lacking.

STUDY DESIGN: Meta-analysis involving 34 studies that investigated the etiology of IAP with MRCP and/or S-MRCP and/or EUS.

SETTING: Brazil, Canada, China, France, Hong Kong, India, Italy, Ko-

rea, Spain, the United Kingdom, and the United States.

SYNOPSIS: When EUS was compared with MRCP, the diagnostic yield of EUS (153/239 patients; 64%) was higher than that of MRCP (82/238 patients;



Dr. Farkhondehpour

34%; P less than .01). Specifically, EUS seemed to have a significant benefit in detecting biliary disease, compared with MRCP. In the subgroup analysis, the diagnostic yield of EUS was higher than that of MRCP for detecting parenchymal changes suggestive of chronic pancreatitis (10% vs. 1%). S-MRCP was superior to EUS and MRCP (12% vs. 2% vs. 2%, respectively) in diagnosing pancreatic divisum, a congenital anomaly that is prevalent in 5%-14% of the population and an etiology of IAP.

A limitation in this meta-analysis was that EUS was used in seven times as many studies as was MRCP, which may have influenced the overall results.

BOTTOM LINE: Less invasive modalities, such as EUS and S-MRCP,

used together could improve the diagnostic yield in evaluating the etiology of AIP.

CITATION: Wang J et al. Comparison of EUS with MRCP in idiopathic acute pancreatitis: A systemic review and meta-analysis. *Gastrointest Endosc.* 2017 Dec 7. doi: 10.1016/j.gie.2017.11.028.

8 ICH: Recent NOAC use associated with lower risk of in-hospital mortality, compared with warfarin

CLINICAL QUESTION: Among patients presenting with an intracerebral hemorrhage (ICH), what is the association between recent anticoagulant use and in-hospital mortality?

BACKGROUND: Previous studies comparing NOACs with warfarin have demonstrated a lower incidence of ICH in patients receiving NOACs. Data have been limited, though, regarding ICH with recent anticoagulant use and in-hospital mortality.

STUDY DESIGN: Retrospective cohort study.

SETTING: More than 1,600 U.S. hospitals that participate in the Get With The Guidelines–Stroke national registry.

SYNOPSIS: Of 141,311 patients admitted with ICH, 10.6% were receiving warfarin and 3.5% were receiving NOACs prior to hospitalization. Prior use of warfarin or NOACs, compared with no anticoagulant use, was associated with higher in-hospital mortality. However, use of NOACs, compared with use of warfarin, was associated with lower in-hospital mortality risk (adjusted risk difference, -5.7% ; adjusted odds ratio, 0.75). Among patients with prior NOAC use, 54% of them were using rivaroxaban.

A limitation to this study is that reversal strategies, such as the use of vitamin K, fresh frozen plasma, or intravenous factor concentrates, were not available in the database. In addition, since rivaroxaban accounted for more than half the NOACs used, it may be difficult to apply the overall findings to all other available NOACs.

BOTTOM LINE: In patients admitted for ICH, prior use of NOACs, compared with warfarin, was associated with lower risk of in-hospital mortality.

CITATION: Inohara T et al. Association of intracerebral hemorrhage among patients taking non-vitamin K antagonist vs. vitamin K antagonist oral anticoagulants with in-hospital registry.

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pital mortality. JAMA. 2018 Feb 6;319(5):463-73.

Dr. Farkhondehpour is a hospitalist at UC San Diego Health and an assistant clinical professor at the University of California, San Diego.

By Supraja Thota, MD

9 Long-term follow-up of monoclonal gammopathy of undetermined significance

CLINICAL QUESTION: What is the expected clinical progression of patients with monoclonal gammopathy of undetermined significance (MGUS)?

BACKGROUND: There are few studies showing the risk of malignant transformation and survival in patients with MGUS. Additionally, there is limited data risk stratifying between the two subtypes of IgM and non-IgM MGUS.

STUDY DESIGN: Prospective, observational cohort study.

SETTING: Single institution in Minnesota.

SYNOPSIS: Investigators identified 1,395 patients with MGUS during 1960-1994, with a median follow-up of 34 years. Progression to multiple myeloma, plasma cell disorders, or

lymphoid disorders was noted in 147 patients (11%), which represents a 6.5-times higher risk for these disorders, compared with the age/sex-adjusted control population.

Two risk factors were associated with progression of disease: elevated serum M protein (greater than 1.5 g/dL) and an abnormal serum free light chain ratio. Risk of progression at 20 years in patients with both of these risk factors was 55% in patients with IgM subtypes and 30% in patients with non-IgM subtypes. With a single risk factor, risk of progression at 20 years was 41% and 20%, respectively. With no risk factors the risk of progression at 20 years was 19% and 7%. Overall expected survival was shorter in patients with MGUS versus that in the age/sex-matched control population.

BOTTOM LINE: Patients with MGUS have a shorter life expectancy than the general population, and the IgM subtype is associated with a greater risk of progression at 20 years, compared with the non-IgM subtype.



Dr. Thota

Citation: Kyle RA et al. Long-term follow-up of monoclonal gammopathy of undetermined significance. N Eng J Med. 2018 Jan 18;378(3):241-9.

10 Rebleeding and mortality after lower-GI bleeding in patients taking antiplatelets or anticoagulants

CLINICAL QUESTION: Is there a difference in lower GI rebleeding risk in patients on antiplatelet medications versus those on anticoagulation medications?

BACKGROUND: It is estimated that 29%-37% of patient with GI bleeds are also on antiplatelet or anticoagulation medications. Minimal research has looked at outcomes for these populations and the comparative risk of rebleeding.

STUDY DESIGN: A retrospective study.

SETTING: Multicenter study in the United Kingdom.

SYNOPSIS: The study followed 2,528 patients with lower GI bleeds, 917 of whom were on antiplatelet or anticoagulation medications. Of these, 504 were on single-antiplatelet therapy, 79 on dual-antiplatelet therapy, 232 on warfarin, and 102 on direct-acting oral anticoagulants (DOACs). Patients on single-an-

tiplatelet agents had a threefold increased risk of rebleeding (hazard ratio, 3.57), those on dual-antiplatelet agents had a fivefold increased risk of rebleeding (HR, 5.38), and patients taking warfarin or DOACs had no increased risk of rebleeding.

In addition, the authors concluded that there was no significant difference in rebleeding risk if antiplatelet medications were held for less than 5 days during hospitalization versus if they were continued. The risk of rebleeding with antiplatelet agents is likely caused by the relatively long half-lives of these therapies. In contrast, warfarin and DOACs have available reversal agents, and DOACs have comparatively shorter half-lives.

BOTTOM LINE: The risk of rebleeding from a lower-GI bleed is higher in patients on antiplatelet medications than it is in patients on warfarin or DOACs.

CITATION: Oakland K et al. Rebleeding and mortality after lower gastrointestinal bleeding in patients taking antiplatelets or anticoagulants. Clin Gastroent Hepatol. 2017 Dec 23. doi: 10.1016/j.cgh.2017.12.032.

Dr. Thota is a hospitalist at UC San Diego Health and an assistant clinical professor at the University of California, San Diego.



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Society of Hospital Medicine

A clinical pathway to standardize use of maintenance IV fluids

Reducing the risk of hyponatremia in hospitalized children

By Weijen W. Chang, MD, SFHM, FAAP

Clinical question

Can an evidence-based clinical pathway improve adherence to recent recommendations to use isotonic solutions for maintenance intravenous fluids in hospitalized children?

Background

The traditional teaching regarding composition of maintenance intravenous fluids (IVF) in children has been based on the Holliday-Segar method.¹ Since its publication in Pediatrics in 1957, concerns have been raised regarding the risk of iatrogenic hyponatremia caused by giving hypotonic

Figure 1: Risk factors for increased antidiuretic hormone secretion

1. Uncontrolled pain
2. Uncontrolled nausea or vomiting
3. Recent surgery
4. Acute CNS disorders
5. Acute pulmonary diseases (pneumonia)

fluids determined by this method,² especially in patients with an elevated risk of increased antidiuretic hormone secretion.³ Multiple recent systematic reviews and meta-analyses have confirmed that isotonic IVF reduces the risk of hyponatremia in

hospitalized children.⁴

Study design

Interrupted time series analysis before and after pathway implementation.

Setting

370-bed, tertiary care, free-standing children's hospital.

Synopsis

A multidisciplinary team was assembled, comprising physicians and nurses in hospital medicine, general pediatrics, emergency medicine, and nephrology. After a systematic review of the recent literature, a clinical algorithm and web-based



Dr. Chang is a pediatric hospitalist at Baystate Children's Hospital in Springfield, Mass., and is the pediatric editor of *The Hospitalist*.

training module were developed. Faculty in general pediatrics, hospital medicine, and emergency medicine were required to complete the module, while medical and surgical residents were encouraged but not required to complete the module. A maintenance IVF order set was created and embedded into all order sets previously containing IVF orders and was also available in stand-alone form.

study period, 11,602 pathway-eligible encounters in 10,287 patients were reviewed. Use of isotonic maintenance IVF increased significantly from 9.3% to 50.6%, while use of hypotonic fluids decreased from 94.2% to 56.6%. Use of potassium-containing IVF increased from 52.9% to 75.3%. Dysnatremia continued to occur due to hypotonic IVF use.

Bottom line

A combined clinical pathway and training module to standardize the composition of IVF is feasible, and results in increased use of isotonic and potassium-containing fluids.

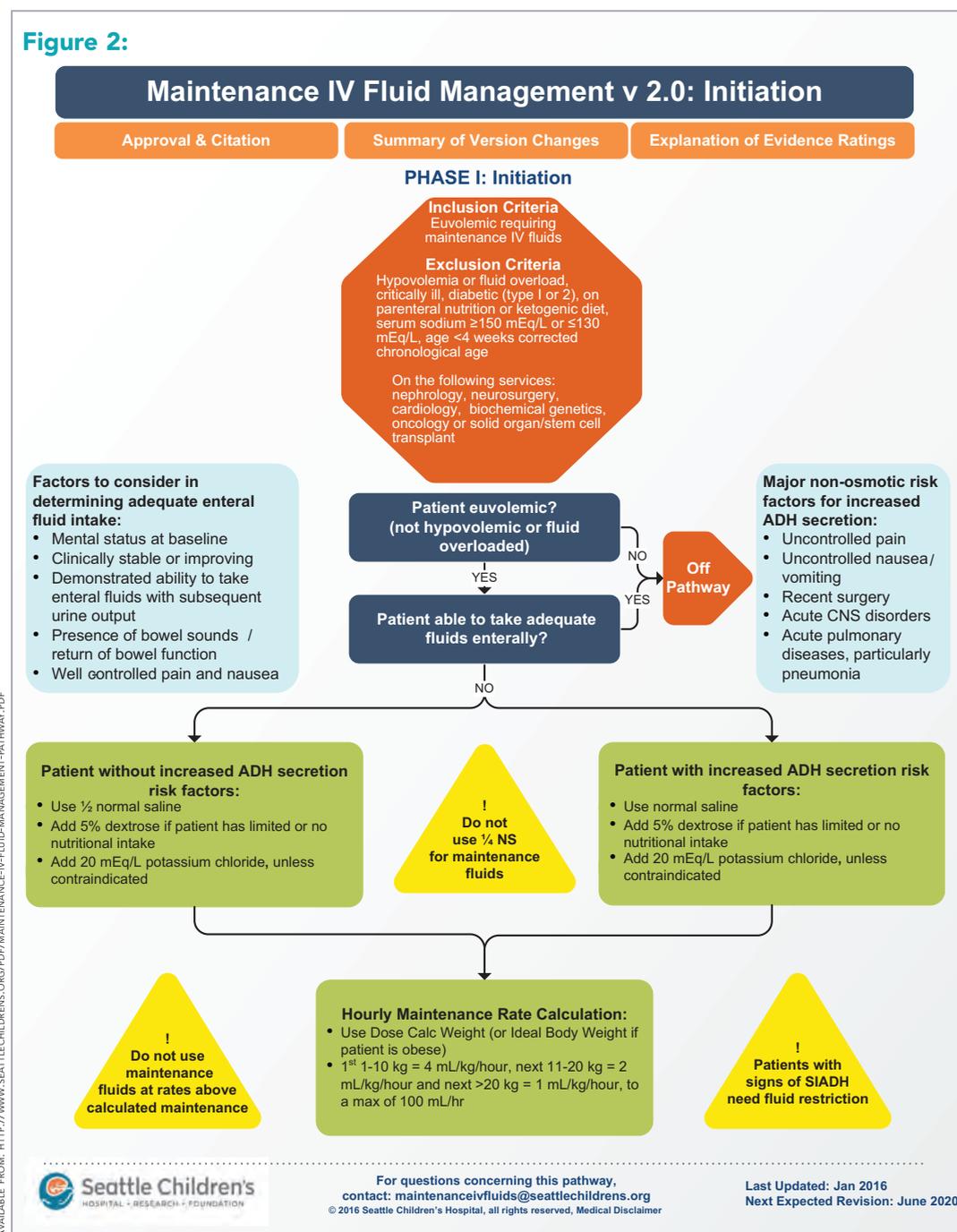
Citation

Rooholamini S et al. Outcomes of a clinical pathway to standardize use of maintenance intravenous fluids. *Hosp Pediatr*. 2017 Dec;7(12):703-9.

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2. Friedman JN et al. Comparison of isotonic and hypotonic intravenous maintenance fluids: A randomized clinical trial. *JAMA Pediatr*. 2015;169:445-51.
3. Fuchs J et al. Current issues in intravenous fluid use in hospitalized children. *Rev Recent Clin Trials*. 2017;12:284-9.
4. McNab S et al. Isotonic versus hypotonic solutions for maintenance intravenous fluid administration in children. *Cochrane Database. Syst Rev* 2014;CD009457.

Figure 2:



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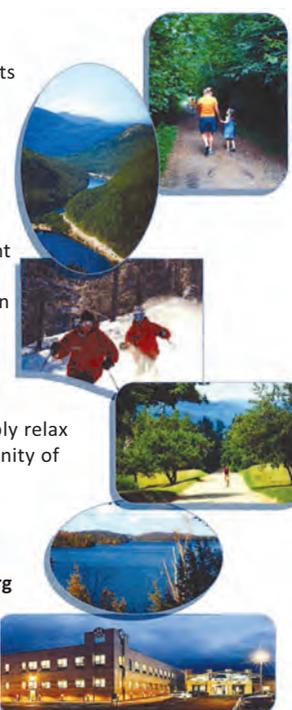
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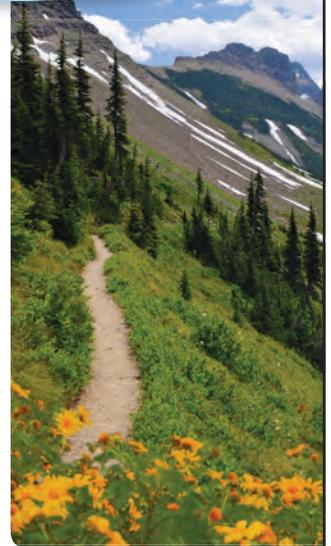
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Penn State Health is a multi-hospital health system serving patients across central Pennsylvania seeking exceptional physicians to join our Penn State Health family to provide patient care as a Hospitalist.

What we're offering:

- Faculty positions as well as non-teaching hospitalist positions within our multi-hospital system as well as our outpatient practices;
- Network with experienced hospitalist colleagues and collaborative leadership;
- Ability to develop quality improvement projects in transition of care and other scholarly pursuits of interest;
- Commitment to patient safety in a team approach model;
- Potential for growth into leadership roles;
- Competitive salary, comprehensive benefit package, relocation, and so much more!

What we're seeking:

- Collaborative individual to work with diverse population and staff;
- Medical degree - MD, DO, or foreign equivalent;
- Completion of an accredited Internal Medicine or Family Medicine program;
- BC/BE in Internal or Family Medicine;
- Must have or be able to acquire a license to practice in the Commonwealth of Pennsylvania;
- No J1 visa waiver sponsorships available.

What the area offers:

Located in a safe family-friendly setting in central Pennsylvania, our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Our communities are rich in history and offers an abundant range of outdoor activities, arts, and diverse experiences. We're conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington DC.

For more information please contact: Heather Peffley, Physician Recruiter at: hpeffley@pennstatehealth.psu.edu



Penn State Health is committed to affirmative action, equal opportunity and the diversity of its workforce.
Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.



Internal Medicine Division: Hospital Medicine

Job Title: Hospitalist

The University of New Mexico, Health Sciences Center, Department of Internal Medicine, seeks faculty members to join the Division of Hospital Medicine. **These positions** are open rank and open track with the opportunity of full time or part time faculty positions. Salary and rank will be commensurate with experience and education. Minimum Requirements: 1.) Must be board certified or board eligible in Internal Medicine by date of hire; 2.) Must be eligible to work in US (not a J-1 opportunity); and 3.) Minimal teaching experience requirements: candidate must have attended a US Medical school as a third and fourth year medical student OR served at least two years in a residency that provides education to US medical students during their core clerkship in internal medicine OR served on the faculty of a medical school. Preferred Qualifications: 1.) Experience/interest in hospital medicine; 2.) Experience/interest in medical education; 3.) Experience/interest in quality improvement activities; and 4.) Preference will be given to current and former New Mexico Residents. Applicants will be required to obtain New Mexico licensure and be eligible for DEA licensure and NM State Board of Pharmacy narcotics license. This position may be subject to a criminal records screening in accordance with New Mexico law.

The positions are open until filled.

For complete description and application requirements for Posting Req555

Please see the UNM jobs application system at: <https://unmjobs.unm.edu>

Inquiries may be directed to Deepti Rao, MD, Associate Professor, Division of Hospital Medicine, Department of Internal Medicine, University of New Mexico, MSC 10 5550, 1 University of New Mexico, Albuquerque, NM 87131, Attn: (DRao@salud.unm.edu).

UNM's confidential policy ("Disclosure of Information about Candidates for Employment," UNM Board of Regents' Policy Manual 6.7), which includes information about public disclosure of documents submitted by applicants, is located at <http://policy.unm.edu/regents-policies/section-6/6-7.html>

The University of New Mexico is an Equal Employment Opportunity/Affirmative Action Employer and Educator.

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Hospitalist Opportunity Available
Join the Healthcare Team at
Berkshire Health Systems!

Berkshire Health Systems is currently seeking BC/BE Internal Medicine physicians to join our comprehensive Hospitalist Department

- Day, Evening and Nocturnist positions
- Previous Hospitalist experience is preferred

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- A major teaching affiliate of the University of Massachusetts Medical School and UNECOM
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- 7 on/7 off 10 hour shift schedule

We understand the importance of balancing work with a healthy personal lifestyle

- Located just 2½ hours from Boston and New York City
- Small town New England charm
- Excellent public and private schools
- World renowned music, art, theater, and museums
- Year round recreational activities from skiing to kayaking, this is an ideal family location.

Berkshire Health Systems offers a competitive salary and benefits package, including relocation.



Interested candidates are invited to contact:

Liz Mahan, Physician Recruitment Specialist, Berkshire Health Systems
725 North St. • Pittsfield, MA 01201 • (413) 395-7866.
Applications accepted online at www.berkshirehealthsystems.org



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For more information, please contact:

Joan Humphries

Director, Physician Recruitment
p 314.364.3821 | f 314.364.2597
Joan.Humphries@mercy.net

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'You are what kind of doctor?'

Remembering hospital medicine's early years

By Brad Flansbaum, DO, MPH, MHM

Editor's note: The Hospitalist is pleased to introduce a new recurring column: "The Legacies of Hospital Medicine." This will be a recurring feature submitted by some of the best and brightest hospitalists in the field who have helped shape our specialty into what it is today. It will be a series of articles that will reflect on hospital medicine and its evolution over time from a variety of unique and innovative perspectives. We hope you enjoy this series, and we welcome any feedback as it evolves!

Hearkening back to my early time as a hospital-based physician, I recall the pleasure of waking every day and feeling like I belonged to an exclusive club. I felt passion for my work, along with a tiny cohort of similarly situated docs. We lacked a kinship with other medical organizations, however. We had no union of our own and were invisible upstarts.

While some folks might have perceived our splintering from the mainstream as a liability, back then, we wore it like a badge of honor. No home office. No funds. No central hub to tap into when a notice needed dispatching. We were setting the world ablaze. Or so it was our delusion.

And the question always came: "Tell me again ... you are what kind of doctor?"

The response changed every week. Ditto for my job responsibilities and charges. The memories are wonderful, though, and I have great affection for the early years.

Initially, I recall networking and attending national meetings – SGIM and ACP in particular – spreading the faith and talking up our bona fides. In addition to the registration fees, there came an earful of guff from irate physicians about this new breed of doctors, yet unnamed, who were destroying medicine. Likewise, I recall opinion columns from newspapers and peer-reviewed journals from a spate of "simple country docs." The writing had a pretense of politeness but with a hint of disdain, predicting nothing less than the destruction of health care as we knew it. And to be standing next to them in conversation: "How dare you hospital docs exhale CO₂!" We might as well have had "KICK ME" signs on our backs.

Inpatient medicine was upending the status quo – or so we believed – while also overturning a generations' worth of dogma on how hospitals should do their business. Fate also played a role, and we could not have anticipated the arrival of health care

consolidation, "To Err Is Human," managed care, and payment reform – all of which upset practice conditions that had been in existence for decades. We walked a line between old and new, down a path whose purpose we felt but toward a destination we could not entirely envision.

That transformed with time.

Like most hospitalists, my ticket in began after some sleuthing and calls to Win Whitcomb, MD, MHM, and John Nelson, MD, MHM – still trusted friends today. They will make their marks in future columns, but as I am the inaugural contributor, let me be the first to state they both had a sixth sense steering our group of disciples. They became the obvious chiefs, along

with Bob Wachter, MD, MHM, and took the lead in articulating what we aspired to be. Sounds saccharine now, but it did not then.

Without support, we arranged summits, assembled work groups, passed the hat for loose change, fashioned a newsletter (see accompanying photo), and formed a countrywide network. Our efforts predated the Internet by several years, so it was mail, faxes, pagers, and answering machines only. The hours we would have spared ourselves if we had had Doodle, Web Connect, and Skype.

But lucky for us, hospital medicine took off. Our wise choices laid the groundwork for what is now a discipline in repose. "Hospitalist" no longer sounds like a neologism, and the term entered Merriam-Webster to seal our fate.

Twenty years out, hospital medicine still feels like a figurative case of Moore's law. I cannot keep up with the strange faces at annual meetings and membership size, the throng of published articles (I used to pride myself on knowing all the hospitalist studies – no longer), and the lengthy list of initiatives and Society of Hospital Medicine resources on hand.

Without question, SHM has been the most rewarding part of my professional life. Hospital medicine mates sustain and keep me in good stead and have done so since training. Their insights teach me more than journals or any day on the job could impart and have given me a learning windfall for the cost of a song.

I initiated my hospitalist path as a 20-something tenderfoot, but from my interactions with colleagues both liberal and conservative, urban and rural, corporate and academic, and specialist and generalist, I developed into a seasoned craftsman.

Countless times I strode into an SHM activity thinking one way and, through the intellect and conviction of my peers, I got smart. Working in the same setting for most of my career, unchallenged, I could have assimilated a sclerotic worldview, but my hospital medicine colleagues would have none of that – kudos and thanks to them for it.

I could cite endless anecdotes – and they are swirling as I write. Crucial positions discussed and adopted, roads taken and those not, specialties angered and appeased, wonderful meals had, and on and on. They are



Dr. Flansbaum works for Geisinger Health System in Danville, Pa., in both the divisions of hospital medicine and population health. He began working as a hospitalist in 1996 and is a founding member of the Society of Hospital Medicine.

and were the building blocks of a journey – and a joyful one.

As truly notable memories go, however, for me, there is only one.

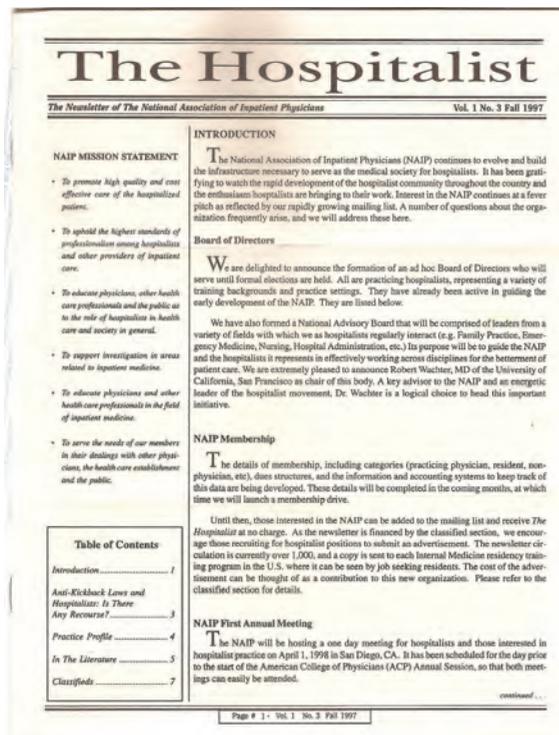
By far, watching and absorbing the lessons of how an organization develops – goes from 0 to 60 – has been a master class in enterprise and execution.

A PGY4 sees a president, CEO, board, ad hoc committees, staff, big budgets, and capital outlays make things happen and assumes it just is. But an operational charter with an instruction manual in-tow didn't just drop from on high; that's not how things go down. The right personnel selections, value choices ("SHM is a big tent" was not an accident), affiliate alliances, assessment of risks, and strategies pursued occurred for a reason; keen minds had the vision to set the board right.

The privilege of participating in the SHM project has been an education no grant or scholarship could equal. To say I had a tiny role in all of that is just reward.

Through SHM I have made lifelong friends, advanced my perspective and development as a healer, acquired a nifty board certification (one of 1,400 with a Focused Practice in Hospital Medicine), gained a mastership, and yes, met President Barack Obama.

As odysseys go, how many docs can make such lofty claims?



This is an image of the earliest incarnation of *The Hospitalist*. The NAIP, or National Association of Inpatient Physicians, was the precursor to SHM.

HOSPITALIST EMPLOYMENT MODELS: WHICH FITS YOU BEST?

HOSPITALISTS ARE ENJOYING A FAVORABLE EMPLOYMENT MARKET.

As a job seeker, you might be tempted to snag the best-paying opportunity. But there's another factor you should consider: culture. Each employment model has cultural benefits and limitations that will significantly impact your day-to-day practice. Below are the four major types to consider.



BY SURINDER YADAV, MD
Vice President

Hospital Employee

Many hospitals directly employ hospitalists in hopes of fostering physician alignment with their administrative goals.

For most of us, this is the most familiar model and the one we experienced during residency. Its attractions include defined benefits with predictable schedules and workloads. The hospital also assumes responsibility for billing, risk

management, and staffing. As a result, its physicians have relatively little administrative burden.

This model has potential downsides. For one, clinical autonomy is limited. Directives affecting the practice often come from the top down. This can squelch engagement and limit opportunities for career development. In this model, highly motivated physicians may find themselves working alongside those who only do the minimum for productivity requirements.

Company Employee

When it comes to designing hospital medicine programs, management companies often have a greater depth and breadth of experience than hospital leaders. They can bring expertise, fresh ideas, and best practices to the table.

Being employed by a management company has some of the same perks as working directly for a hospital, including predictable schedules and benefits. Most also offer practice management services, though the level of support varies.

Individual physicians employed in this model have very little voice in practice matters. In some large companies, the top clinical leaders oversee an enormous number of physicians and practice locations. Even if they are in touch with the needs of the front-line hospitalists, they may be spread too thin to offer meaningful support. In addition, some physicians find corporate culture at odds with clinical practice.

Independent Contractor

Self-employment is another option. Physicians following this model work as independent contractors for hospitals and practice management companies.

Independent contractors can choose long- or short-term jobs, take breaks between assignments, and increase their workload to boost earnings. On the downside, these physicians have fewer opportunities to innovate or create change.

Physician Partner

Another model to consider is a physician partnership or independent group. These can be local, regional, or national. Vitivity is one example of a national physician partnership.

Partnerships are practices in which all physicians have the opportunity to become owners. Finances are transparent, and physician owners share profits as well as responsibility for success.

This model fosters cooperation among physicians, because everyone is motivated toward the same goal. This collaborative spirit can also cross service lines. For example, when a partnership staffs both the hospital and emergency medicine services, colleagues work together to facilitate admissions. Patients see everyone working together as one team, which is a great satisfier.

The partnership model is a good fit for physicians who want to be engaged in developing best practices and innovative protocols that fit the needs of their hospital and patient community.

Making the Right Decision

Salary is definitely an important consideration, but in the end, cultural fit will be the best predictor of your long-term career satisfaction.