**Appendix. Examples of Discrepancies and Management Changes**

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| **Example #1** |  |
| **Clinical question** | How should patient with chest pain be evaluated? Should the patient be admitted? |
| **Data given during curbside** | Patient with chest pain and a recent negative ischemic evaluation. EKG’s unchanged from prior.  |
| **Additional information obtained during official consult** | Patient with no chest pain but ear and throat pain and purulent discharge from ear.  |
| **Resulting management changes** | Otorhinolaryngology consult. No need to further evaluate “chest pain”. |
| **Example #2** |  |
| **Clinical question** | What should be done with a platelet count of >1,000,000? |
| **Data given during curbside** | Platelet count of over 1 million. Asymptomatic patient. |
| **Additional information obtained during official consult** | Recent history of stab wound requiring pericardial window and left pleural empyema. Had been on intravenous antibiotics and recently switched to oral antibiotics. |
| **Resulting management changes** | With additional history there was a clear cause for reactive thrombocytosis. Aspirin not recommended. Repeat chest roentgenogram and complete blood count recommended. |
| **Example #3** |  |
| **Clinical question** | When should a chest roentgenogram be rechecked? |
| **Data given during curbside** | Patient hypoxic and with pyelonephritis. Chest roentgenogram shows elevated left hemidiaphragm and atelectasis. Patient on ceftriaxone and still febrile despite 3 to 4 days of antibiotics. |
| **Additional information obtained during official consult** | Patient with blood pressure of 70/50, heart rate in the 190’s. Had multidrug resistant organism in urine culture (extended-spectrum beta lactamase-producing organism) that was not covered with prescribed antibiotics. Murmur appreciated. |
| **Resulting management changes** | Early goal directed therapy instituted, antibiotic coverage changed to cover infecting organism. Infectious disease consultation obtained, incentive spirometry and echocardiogram recommended. |
| **Example #4** |  |
| **Clinical question** | Should this patient’s chest pain be evaluated by a hospitalist?  |
| **Data given during curbside** | Patient with history of diabetes, hypertension, hyperlipidemia who is intoxicated and complaining of chest pain. EKG with no acute changes, troponins negative. |
| **Additional information obtained during official consult** | Patient with 4-day history of alcohol binge (12 beers daily, 1 quart of tequila daily) with nausea and vomiting. Unable to take orals. Chest pain began after vomiting. Patient in moderate to severe alcohol withdrawal. |
| **Resulting management changes** | Recommended that patient be admitted and treated for alcohol withdrawal and evaluated for possible pancreatitis. No further cardiac work up warranted. |
| **Example #5** |  |
| **Clinical question** | How should patient’s blood pressure medications be managed? |
| **Data given during curbside** | History of polysubstance abuse. Patient on hydralazine. Team was concerned about compliance. Patient with chronic renal insufficiency. |
| **Additional information obtained during official consult** | Patient positive for cocaine on admission with systolic blood pressure in the 200’s. Blood pressure now normalized. Creatinine 0.9. |
| **Resulting management changes** | Stop hydralazine as patient’s blood pressure was likely transiently increased secondary to drug use. |