Night Float

Read the Checklist on the following

page in your packet and be prepared to observe and provide feedback on a hand-off.

Hand-Off Observation Checklist

During the Hand-Off, did you observe the participants perform the following skills:

Yes	No	
☐	☐	Triage & Prioritize -- Detail and history given more on complex patients, less on simple ones
☐	☐	“Tell the Story” -- gives a succinct, relevent presentaition
☐	☐	“Details on Demand” -- interactive questioning of status/assumptions
☐	☐	Contigency Plans -- For every follow-up item, there is an If...then type statement

Second Reading

1: Curr Treat Options Gastroenterol. 2006 Jun;9(3):265-71.

Update on Clostridium difficile.

Thorpe CM, **Gorbach SL**.

Department of Geographic Medicine and Infectious Diseases, Tufts-New England Medical Center, 750 Washington Street, Box 041, Boston, MA 02111, USA. cthorpe@tufts-nemc.org.

The most dramatic change in the past several years has been the increased incidence and severity of Clostridium difficile colitis reported from multiple countries. A number of factors have likely contributed to this. One major event has been the emergence of a fluoroquinolone-resistant clone of C. difficile with enhanced virulence properties that is associated with epidemic disease. Also noteworthy is the apparently decreasing effectiveness of the first-line agent metronidazole in treating this disease. Aggressive treatment of severe C. difficile colitis requires a multifaceted approach, including: 1) cessation of antibiotics where possible; 2) oral vancomycin; 3) if an ileus exists, intravenous administration of metronidazole and possibly intracolonic administration of vancomycin; 4) intravenous immunoglobulin if response to therapy is not rapid, or if there are signs of sepsis; and 5) early surgical consultation. Although it is likely that intravenous immunoglobulin contains antibodies against C. difficile toxins, its benefit remains unproven in rigorous clinical trials. Efforts to actively or passively immunize patients at risk are being explored to prevent the increasing morbidity and mortality associated with this disease. However, defining exactly who is at risk for severe C. difficile-associated disease is complex, as cases are being reported in populations not previously believed to be vulnerable.

PMID: 16901390 [PubMed - in process]

1: Clin Infect Dis. 2002 Sep 15;35(6):690-6. Epub 2002 Aug 26.

Comment in:

- Curr Surg. 2003 May-Jun;60(3):227-30.
- Rev Gastroenterol Disord. 2003 Fall;3(4):228-9.

Adjunctive intracolonic vancomycin for severe Clostridium difficile colitis: case series and review of the literature.

Apisarnthanarak A, **Razavi B**, **Mundy LM**.

Division of Infectious Diseases, Washington University School of Medicine, St. Louis, MO, 63110, USA.

Successful treatment of severe Clostridium difficile colitis has been reported with the use of adjunctive intracolonic vancomycin (ICV) therapy. We report a descriptive case series and review the literature on patients with C. difficile colitis who received adjunctive ICV therapy. Nine patients received antibiotics within 6 weeks prior to presentation. Complete resolution of the clinical presentation occurred in 8 patients (88.9%), and eradication of C. difficile cytotoxin production was documented in 3 (75%) of 4 patients who were tested after the completion of adjunctive ICV therapy. One patient (11.1%) died as a result of progressive multisystem organ failure. In the 6 weeks after the completion of treatment for C. difficile colitis, no patient had recurrent disease, required surgical intervention, or experienced complications from adjunctive ICV therapy. In this case series, administration of adjunctive ICV therapy appeared to be a safe, practical, and effective adjunctive therapy for severe C. difficile colitis.

Publication Types:

- Case Reports
- Review

PMID: 12203166 [PubMed - indexed for MEDLINE]

Third Reading

Third Reading -- Overnight:

Dr. Heya's abdominal pain continued to progress into the night. You started Vancomycin enemas and consulted general surgery, and they agreed with your plan. He also developed nausea and vomitting, and a repeat X-ray was consistent with illeus, so you placed an NG tube to low intermittent suction, and this improved his symptoms. Over the night you did serial abdominal exams and, by morning, his abdominal exam was not progressing.

Mr. Con Fused had an episode of bloody diarrhea last night. You did an exam and found hemorrhoids, his Hgb has been stable.

Mrs. D. Monas had increased dyspnea last night which responded to Lasix and morphine.

Ms. Payne developed a fever to 102 and chills. You obtained blood cultures, started her on piperacillin/tazobactam, and called the pancreato-biliary service for an emergent ERCP.