

1997

Third year survival guide: 1997-1998

<https://hdl.handle.net/2144/25888>

Boston University

**Third Year
Survival Guide
1997-1998**



INTRODUCTION

This is the second edition of the Third Year Survival Guide. The first was compiled by the students from BUSM classes of 1996 and 1997 for your use and the use of those to follow. It is intended to give you a head start when you begin your work on the wards.

If we could share all of our wisdom with you it would take more than 60 pages. Instead, we have given you what we have found to be particularly useful and relevant so that you do not have to spend countless hours cluttering your minds and your pockets with it.

This Survival Guide is a work in progress which we hope will continue to benefit BUSM students for years to come. It can only do that with your input. Should you want to make additions to this guide for next year, jot down your notes and get in touch with your nearest SCOMSA rep.

We hope that you find this guide useful and that you will continue to edit and add to the what we have given you.

Special Thanks to Tina Rosenthal Waugh, Melanie Maytin, Christy Odell, Allison Tonkin, Debbie Blazey-Martin, Greg Merchand, Roshann Hooshmand, John Dutton and Toni Ann Clare without whom the first edition would never have left the ground.

BUSM Class of 1996 and 1997

YOU'RE NOT A THIRD YEAR WITHOUT A PAGER

One of the biggest mysteries of beginning the third year was getting a pager. When should I get it? Where do you get it? How much does it cost?

For students doing your Surgery rotation the Surgery Department will provide you with a pager if you don't already have one. This can save you a few months in monthly fees if you have surgery during Block A.

We suggest you make every effort to get your pager as soon as possible. There's nothing worse than finding out that you missed out on a procedure, or on seeing a great patient because your resident wasn't able to get in touch with you. This also gives you more freedom during the day so that you don't have to hang around your resident all day, but they'll always know how to find you.

You can get a pager from Operator Services at BMC - E Newton Campus. It is located in the Atrium, at the top of the escalators. The hours are generally 9-5. You should bring your student ID. You don't need to bring money with you because they can bill you.

Tell them that you are a medical student who would like to rent a pager. Most students usually get the numeric display pager for \$10.50 a month (minimum of 6 months). This price includes tax \$.50 and insurance \$2.00. Insurance covers you in case of loss, theft or damage. You only have to pay a \$25 deductible (as opposed to buying the pager). Believe me, it's worth it!

We suggest you rent your pager from BMC - E Newton Campus because this will allow you to be on the in-house hospital paging system. This system is not only faster, but much more convenient to use because you don't need an outside line. The cost of getting a pager elsewhere is comparable anyway.

Operator services also provides free battery changes. You just need to go there and sign a log, they recycle the batteries.

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BASIC MEDICINE NOTES

History and Physical (H&P)

Used for the first official encounter with a patient. Requires previous records (call for the old chart IMMEDIATELY), and may be duplicated in the chart by your team. Very important for your initial presentation of the patient at rounds.

General information

Name, hospital number, gender, admission date, primary care doc, room number.

Chief Complaint (CC)

May be in patient's own words or briefly summarized.

History of Present Illness (HPI)

How problem began, describe character, onset, location, duration, events surrounding, pertinent positives and negatives, things that make it better and worse.

Past Medical History (PMHx)

List all prior conditions and hospital admissions

Past Surgical History (PSHx)

List all previous surgeries and traumas and dates

Medications

list all current medications and doses

Allergies

to medications, latex, foods (if none are known, make note of that fact)

Family History (FHx)

Parents (if alive or what they died of and at what age), siblings, any trends

Social History (SHx)

Alcohol (ETOH), Tobacco, Drug use (Intravenous versus other methods), work history, religious hx, living situation/supports

Review of Systems (ROS)

List pertinent positives and negatives only, meant to address only current symptoms (old problems belong in PMHx)

Physical Exam (PE)-

Vitals—BP, HR, RR, Temp, Weight.

General—How the patient looks to you (cachectic, obese, anxious, uncomfortable)

Head, Eyes, Ears, Nose, Mouth/Throat (HEENT)

Skin

Neck

Lungs/Resp

Thorax (including breasts)

Heart/Cardiovascular System

Abdomen

Extremities

Neurologic exam

Genitalia

Rectal

Pelvic

Labs/Studies

Assessment/Plan

General Statement

Problem list

list each problem individually with your discussion of each item (an assessment including differential dx, your primary dx and why) and the plan for that problem.

Make sure to discuss it with your team before committing the plan to paper.

Be thorough, your evaluations are based in part on your ability to show in your notes that your clinical thought process is logical and complete.

SOAP Note

Used for daily progress notes on in-patients or for clinic visits; not for first time evaluation.

General Intro Statement—*“86 yo black male with h/o HTN, CHF and PVD currently being seen for LE cellulitis”*

Subjective

How the patient feels today, any complaints; what you notice about patient (but not physical exam). Include pertinent positives and negatives. *“Pt. states LE is less painful today, denies throbbing, tingling or numbness in toes. Trouble sleeping last night, but required no pain meds.”*

Objective

Data of any kind (without patient or personal interpretation); include:

vitals—BP, HR, RR, Temp, Wt.

PE—Gen, HEENT, CVS, Resp, Abd, Ext, Neuro

Labs—CBC, Lytes, Micro (etc.)

Studies—CXR, CT, MRI, (etc.)

Assessment & Plan

Evaluate data and observations in problem list format; formulate plans for the day, including new labs, meds, studies, procedures. Format varies from service to service. Some prefer a general assessment before the plan (*“This is an 86 year old gentleman with h/o HTN, CHF, and PVD with cellulitis of LE now resolving after 3 days of IV abx.”*), others will prefer an assessment with each problem. Check with your resident or intern. A more detailed assessment and plan section indicates to your team that you know what’s going on with your patient. This is the most important part of the note.

#1 Cellulitis—Wound swab grew out staph sensitive to oxacillin; improving after 3 days broad spectrum abx. Plan—change to Oxacillin, reculture if pt spikes to 101.

#2 HTN—Well-controlled on current regimen, however patient complains of dizziness. Plan—Check orthostatics.

Admission Orders—(ADC VAANDIIMSL)

- Admit**—note service, attending and/or resident “*Admit to Medicine, Dr. Jones*”
- Diagnosis**—“*Pneumonia*”
- Condition**—*Stable* (most people have never written “critical” except in ICU setting)
- Vitals**—how often (q shift, q8 hours, etc.)
- Allergies**—NKDA, PCN, Sulfa. Include reaction: hives, anaphylaxis
- Activity**—as tolerated, strict bedrest, OOB to chair, ambulate q4hours, etc.
- Nursing**—these are orders to the nursing staff, do not write “nursing” on your order. Covers things like foley to gravity, dressing changes, drains, aspiration precautions, notify HO if temp>101, fingersticks q4 hours, etc.
- Diet**—NPO, 1200 cal ADA, clears, regular, lactose free, soft solids, etc.
- Ins and Outs**—strict measurement of intake vs output
- IV Fluids**—1/2NS 100cc/hr x 1 Liter then 75cc/hour (etc.)
- Medications**—Medicine orders specific to patient
- Standing meds**, aka “PRN” medications (check with your resident if they have certain things they like to prevent them from being paged at 4am)
- Labs**—for the next morning or later that day (check am CBC, SMA-7, etc.) or standing labs

Discharge Summaries

All patients upon discharge need a “Discharge Summary” which provides information concerning their hospital course, admitting diagnosis, any additional diagnoses, discharge medications, important labs, surgeries, follow up appointments, and any patient instructions. These forms are located either in the patient’s chart (since discharge planning begins upon admission) or in one of various locations around the nurses’ station. It is very helpful for medical students to fill out these forms for their interns. The forms are very self-explanatory, except for the large space left for “Hospital Course”. Things that are important to include in this section include initial presentation, diagnosis, any important tests or labs, any complications during the admission, patients condition at discharge, and placement or follow-up of patient.

An example is:

“Mr. Smith was admitted on 3/6/96 with SOB, 3+ pitting edema of the lower extremities in apparent CHF. The patient had self discontinued his cardiac medications 2 months ago. The pt’s CXR showed an enlarged heart with evidence of pulmonary edema. EKG on admission showed evidence of enlarged right and left ventricles. The patient was given Furosemide and restarted on Digoxin. The patient’s hospital course was complicated by a LLL pneumonia diagnosed clinically and by sputum cultures done on day 5 of admission. Pt was treated with a 10 day course of Unasyn. The patient had a repeat CXR on 3/16/96 which showed resolution of his pulmonary edema and pneumonia. Patient was discharged on 3/20/96 on Digoxin and Augmentin. Mr. Smith will follow up with Dr. Crane in the DOB on 4/20/96 at 3pm.”

Another piece of important paperwork is a “page 1” which is needed for anyone who will be needing VNA (Visiting Nurses Association) upon discharge. The “page 1” is located in various drawers around the nurses station or in the patients chart, it is a good idea to ask one of the nurses where these are located. Again this form is very self-explanatory. You should make sure you fill out the more “medical” information, including diagnosis, medications, and any treatments that the patient will need the VNA to do. The demographic information at the top of the sheet will be filled out by the nurse. If you have any questions as to what you should write, particularly on the discharge summary, it is best to ask your intern.

SURGERY

Pre-Op Note

Necessary to be confirm patient is prepared and medically stable for surgery the next day (or soon after)

Pre-Op Diagnosis—"Acute appendicitis"

Procedure—"Exploratory Laparotomy"

Labs—Usually CBC, Lytes, PT/PTT, UA

Chest Xray—results (no CHF, pneumonia, etc.)

ECG—results

Blood products—Check computer to be sure type and cross has been completed if necessary

H&P—"On Chart" (check to be sure)

Orders—any necessary prep for surgery—bowel prep, NPO after midnight, etc.

Consent—confirm that it is "signed and on chart."

Operative Note (Brief Op Note)

Pre-Op Diagnosis

Post-Op Diagnosis

Procedure—What was done *lysis of adhesions, lap choly*

Surgeons—List attendings, residents (in hierarchical order of seniority), and students who scrubbed in to surgery

Findings—brief description of what was found *gall bladder with stones, perforated appendix, etc*

Anesthesia—General, spinal, local

Fluids—Amount and type pt received during case (get from anesthesia)

Estimated Blood Loss (EBL)—ask anesthesia or nursing

Drains—type and location

Specimens—anything sent to pathology

Complications—none (*check with resident before writing anything else!*)

Condition—Where patient is sent and in what condition "*transferred to RR, extubated and in stable condition*"

Post-Op Note

To be written within several hours of surgery to assure patient remains in stable condition.

Procedure—operation performed

Level of Consciousness—awake, drowsy, etc.

Vitals—HR, BP, RR

Intake and Output (I's and O's)—Calculate fluid balance

Labs—review any results obtained since surgery

Physical exam—check HEENT, CVS, Resp, Abd, Ext, and especially look at dressing for bleeding (do not disturb the dressing!)

Assessment/Plan—Evaluate post-op course to date, document any changes from original plan. Include pain, diet and I/O's.

Post-Op Orders

Transfer—PACU (Recovery Room) to floor/SICU, note resident

Diagnosis— status post (s/p) whatever procedure

Condition—*Stable* (most people have never written "critical" except in ICU setting)

Vitals—how often (q shift, q8 hours, etc.)

Allergies—NKDA, PCN, Sulfa, latex, with reaction (hives, anaphylaxis)

Activity—as tolerated, strict bedrest, OOB to chair, ambulate q4hours, etc.

Nursing—these are orders to the nursing staff, do not write "nursing" on your order. Covers things like foley to gravity, dressing changes, drains, aspiration precautions, notify HO if temp>101, fingersticks q4 hours, etc.

Diet—NPO, 1200 cal ADA, clears, regular, lactose free, soft solids, etc.

Ins and Outs—strict measurement of intake vs output

IV Fluids—1/2NS @ 100cc/hr x 1 Liter then 75cc/hour (etc.)

Medications—Medicine orders specific to patient

Routine—Pre-op medications

Antibiotics

Pain

PRN

Labs—for the next morning or later that day (check am CBC, SMA-7, etc.) or standing labs

Operating Room Etiquette

As you begin your General Surgery rotation one of the most daunting tasks you will face is successful navigation of the many pitfalls of the operating room. Below you will find a list of rules to assist you in your journey. Good Luck!!

Rule #1: *Always wear a mask when you enter the OR.* This rule may seem easy, but you will be entering and exiting the OR many times a day, and even multiple times per surgery, and you must remember to put your mask back on.

Rule #2: *Put your mask on before you start to scrub.* Chances are you will forget this rule and have to rescrub at least once.

Rule #3: *Be nice to the surgical nurses.* When you enter the OR you will see at least 2 nurses/assistants. One will be in gowned (Scrub Nurse), and the other will be running in and out of the room (Circulating Nurse). Introduce yourself politely to the circulating nurse as "*Fill in your name, medical student*". If you have not scrubbed before don't try to fake it, they will eat you alive. If you need help, just ask, they are usually more than willing to pass on their infinite wisdom. It is also nice if you let them know what size gloves you wear before you barge in all scrubbed and ready to be gowned.

Rule #4: *Scrubbing is easy, keeping yourself scrubbed is hard.* Put on your mask!! Turn on the water, then tear open a brush. Apply soap to the sponge side of the brush if it does not come with soap. Use the sponge side to soap up your hands and arms to the elbow. Then start with the brush on your fingers working toward your elbows. When you are finished, rinse yourself, remembering to keep your hands above your elbows so the water runs down away from your hands. After you have scrubbed enter the OR backward through the door and keep your elbows bent with your hands about chest level away from your body.

Rule #5: *Spin to win.* Wait in a clear area for the scrub nurse to hand you a towel. Put out your right hand and she will lay the towel across it. You will then use one side of the towel to dry your left arm, then transfer the towel wet side to your left hand and dry your right arm with the other side. Hold your arms slightly away from yourself and the nurse will slide the gown over your arms. At this point the circulating nurse will secure the gown from behind. The scrub nurse will hold the right hand glove out open and you plunge your hand into it. Don't worry if you end up with two fingers in one hole, you can fix that later. Now hold the index and middle fingers of your right hand up like you are about to do a rectal. The nurse will hook the opening of the left glove around your fingers and you plunge your left hand into the glove. Now you can do any adjusting of fingers that needs to be done. The last part is the spin, this will close off your gown around your waist. Look down at your waist and grab the tag and hold it out for the nurse, being careful not to touch anyone with your hand. Once you have passed off the tag spin around counterclockwise, grasp the tie and the tag will be pulled away. Now just tie it off on your left side and you are ready.

Rule #6: You are the human retractor. Enjoy the show, observe the anatomy, don't break scrub and stay out of the surgeon's way. Words to live by!! HAVE FUN!!

PEDIATRICS

Pedi History and Physical

Identifying Information

Source

Chief Complaint

History of Present Illness

Birth History

Antenatal = *health of mother during her pregnancy, prenatal care, diet, infections, bleeding, pregnancy induced hypertension, gestational diabetes, Rh typing, serology, gonorrhea, chlamydia, ultrasounds, amniocentesis*

Natal = *gestational age of child at birth, kind and duration of labor, type of delivery, sedation and anesthesia, birth weight, resuscitation required,*

Neonatal = *Apgars, jaundice, fever, hemorrhage, congenital abnormalities, birth injury, feeding difficulties, jaundice, length of hospital stay*

Developmental History

Milestones = *age when first raised head, rolled over, sat alone, pulled self up, walked alone, talked (first word and sentences), use Denver Developmental Screening Test*

Urinary continence (during day and night)

Fecal continence

Any failure to grow or unusual growth

Grade in school, academic performance

Nutrition History

Breast or formula feeding

Vitamin supplements

Food likes and dislikes

Allergies

Solid Food = *when introduced, balance of food groups*

Past Medical History

Illnesses

Hospitalizations

Infections (*type, age, number, severity*)

Contagious diseases (*chicken pox, measles, rubella, etc.*)

Other serious illnesses

Immunizations

Is child up to date?

Any reactions?

Last TB test

Operations

Accidents and injuries

Medications and allergies

Family History

Personal History

Relationships with other children

School progress

Social History

Family structure and support systems

School situation

Habits

Sleep

Elimination

Safety

Behavioral concerns = *excessive bed-wetting, thumb sucking, nail biting, temper tantrums*

Adolescent habits = *smoking, ETOH, substance abuse, sexual activity, contraception, gangs, guns*

Dental hygiene

Family health habits

Review of Systems

Physical Exam

Similar to that for adults, but it can be a lot trickier with a 3 year old

Don't forget Tanner Stages of genital development in pre-teens and adolescents

Laboratory Data and Radiology Exams

Assessment and Plan

OB Admission Note

Written for patients being admitted to Labor & Delivery floor...

___ yo GxPyAz; EDC ___/___/___ by LMP, ___/___/___ by ___ week Ultrasound.
Onset regular, painful contractions on ___/___/___ at ____, +/- SROM at ____,
+/- Bloody show.

Hx current pregnancy: Received prenatal care at ____, with Dr. _____.

Total # prenatal visits= ____. Total weight gain= _____.

Problem list

#1

#2

OB Hx—Year, type of birth, gestation, birth weight, completion of pregnancy,
complications, hospital/location of delivery

GYN Hx—Age at menarche, #days apart, #days long, regularity, STD Hx

PMHx/PSHx—

FHx—Include genetic defects, multiple gestations

SHx—esp include substance abuse, domestic abuse, social supports

Prenatal Labs—MBT/ABS, rubella, HepB, PPD/CXR, sickle, G6PD, GTT,
HCT, UA, GC/Chlamydia, RPR

PE—Vitals, HEENT, Thyroid, CVS, Resp, Breasts/Nipples, Abd—fundal Ht,
EFW, Leopolds, Pelvic—SVE (SROM) or SSE (Ferns result), Ext, FHR
pattern, Uterine Ctx pattern

Assessment/Plan—IUP @ ___ wks, size consistent with dates, +/-SROM for
___ hours, phase of labor, FHR, Risks, pain management

OB/Labor Progress note (SOAP format)

S Complaints, situation (“*I have to push*”)

O Cervix and station (10cm / 90% / 0 station), FHR and pattern, vitals

A Entering or continuing in ___ stage, FHR pattern assessment

P Management (expectant)

Delivery Note

NSVD _____ gm male/female @ _____, Apgars _____ and _____. Cord clamped and cut, cord vessels x _____. Cord gasses (if indicated). Pediatrician(s) present (if indicated, if urgent, note time of arrival). Suctioned on perineum for small/mod/large amt meconium +/- stained fluid (if nec). If shoulder dystocia, describe maneuvers, time of delivery of head and body. Include peds assessment of baby (if present). Spontaneous delivery of placenta at _____, Schultz, intact. Describe methods used to facilitate involution (fundal massage, Pit, etc.). MLE or Lacerations —describe, repaired with _____ suture using _____ anesthesia. Rectal exam, condition of Mom and baby.

G P Classification

Gravidity - total number of pregnancies (not fetuses or infants delivered)

Parity - number of pregnancies (not fetuses or infants delivered) carried to viability (20 weeks or more)

Note - A multiple gestation is counted as one pregnancy. A woman who is currently pregnant and has had one previous singleton pregnancy and one previous twin gestation would be G3P2. A woman who is currently pregnant and has had one abortion and one ectopic pregnancy would be G3P0.

A system used to express more information involves including under parity the number of term pregnancies, premature deliveries, abortions and living children. A woman who is G5P2112 would be currently pregnant for the fifth time, and have had two term pregnancies, one premature delivery, and one abortion. She would currently have two living children.

NOTES

Psych History and Mental Status Exam

In general, the Psychiatry Notes follows the Basic medicine H & P. Your "physical exam" is substituted by the Mental Status Exam. You should not forget to record any physical findings.

General information

Name, hospital number, gender, admission date, primary care doc, room number.

Chief Complaint (CC)

May be in patient's own words or briefly summarized.

History of Present Illness (HPI)

How problem began, describe character, onset, duration, events surrounding, pertinent positives and negatives.

Past Psychiatric History (PΨHx)

Outpatient treatments (counseling)

Inpatient hospitalizations or residential treatments

Past psych meds

Ongoing issues

Attitude toward psych history/issues

Past Medical and Surgical History (PMHx)

List all prior conditions and hospital admissions

List all previous surgeries and traumas and dates

Medications and Allergies

list all current medications and doses, including psych meds

allergies to medications, latex, foods (if none are known, make note of that fact)

Physical Exam (PE)-

Vitals—Usually important when monitoring a patient's response to medications or when monitoring a patient for signs and symptoms of withdrawal

Lab Data

Social / Personal / Family History

Developmental and Family History (FHx)

Parents (if alive or what they died of and at what age), siblings, any trends
Psych history, history of suicide

Social / Personal / Family History (cont'd)

Educational and Occupational History

Highest grade in school
Current and previous employment
If unemployed, why?

Legal History

Has the patient been in trouble with the law? Before age 15?

Support and Relationships

Who does the patient confide in?
Ask about friendships/support and intimate relationships abuse history?

Habits

Alcohol (ETOH), Tobacco, Drug use (Intravenous versus other methods)
Have these caused problems in the past?

Review of Systems (ROS)

List pertinent positives and negatives only, usually to depression and mania.
(Psychosis is usually elucidated by the Mental Status Exam)

Mental Status Exam

Appearance

posture, clothes, groomed, developed, healthy, angry, scared, confused,
anxious

General Behavior

mannerisms, gestures, combative, psychomotor retardation, twitches

Attitude toward the examiner

cooperative, hostile, evasive, seductive

State of Consciousness

alert, somnolent, hyperalert, wandering

Mood/Affect

Mood: Subjective - how the patient says they feel
Affect: Objective - how the patient appears to you
Are their mood and affect congruent?

If they say they're depressed do they look sad or are they giggling?

Attention: distractibility

Mental Status Exam

Speech and Thought

Process

cohesive, coherent v. circumstantial, tangential, flight of ideas, loose
associations, perseverations, blocking, clang,

Content

delusional, paranoid, bizarre
perceptual abnormalities: auditory, visual
suicidality, homicidality

Perceptions

Tactile or olfactory perceptions may be listed here

Cognition (Mini-Mental Status Exam)

(There are several styles to the MMSE. Here are some suggestions)

Orientation (x 4): to person, place, time, situation

Memory

Immediate: Digit repetition
Recent: Events within the last 24 hours (be sure you can verify)
Remote: Long term. Name four Presidents

Registration/Attention: Repeat 3 words now and in 5 minutes

Concentration: Digit Span (7 forwards, 5 backwards)

Calculation: Serial 7's or 3's

Insight and Judgment

Do they understand their circumstances and their role in it?

One can usually assess judgment based on the interview

If they've tried to commit suicide or were out on a drug binge they have
poor judgment

Multi-Axial Classification (similar to differential diagnosis)

Axis I: Major Psychiatric Diagnoses

Schizophrenia, Depression, BPD, Anxiety disorders, Substance Abuse

Axis II: Personality Disorders, Mental Retardation

Axis III: Physical disorders relevant to the psychiatric problem

Axis IV: Psychosocial and Environmental Problems

unemployment, poor social support, financial problems, divorce

Axis V: Global Assessment of Functioning Scale

rating from 0 to 100, measures their current state of functioning

Assessment/Plan

IMPORTANT LOCATIONS

Boston Medical Center - E Newton Campus

Radiology: Located on the 1st floor of the Atrium building, behind the elevators. The file room and reading room are in the rear—ask at the front desk and they can direct you back. The radiologists in the reading room are usually very approachable and would be glad to help you look at films.

Chemistry and Hematology labs: Located on the 3rd floor of the Atrium building. Turn right off the elevators, pass the PACU, the labs are located at the end of the hall.

Operating Room: The operating room is located on the 3rd floor of the Atrium building, and the changing area is on the 2nd floor. To enter the locker rooms, go down the hallway past the Atrium cafeteria. You will see two doors with combinations on the about half way down the hallway on the right. The entrance to the women's locker room is on the right, and the men's on the left. Ask your intern or resident for the combination.

To get a pair of scrubs, go all the way through the locker room and out the exit at the other end into the lounge area. Scrubs are found on the rack directly in front of you. Enter the OR at the top of the stairs in the lounge area. Shoe covers, hats and masks are located at the top of the stairs. If you are scheduled to go to day surgery, get changed in the locker room and put on a white coat over your scrubs before going to day surgery on the second floor of the atrium (go past the elevators and down the hallway to the end and enter the door that says authorized personnel only).

To get a locker, go to the 3rd floor and enter the OR through the door next to the service elevator (press the large button on the wall). Do NOT go past the line on the floor but stand right next to the desk and ask for Tom. He can assign you a locker to share with someone for your rotation.

Boston Medical Center - Harrison Ave Campus

Radiology: Located on the 1st floor of the new hospital. Take the service elevators (they are the less shiny elevators) to the first floor. Use your card key to enter radiology. The reading room is all the way in the back on the left.

Hematology/Chemistry labs: Located on the 2nd floor down the hallway from the OR. The easiest way to get there is to take the service elevators to the second floor and follow the hallway around past the OR entrance.

Operating room: Enter the OR through the holding area next to the service area on the 2nd floor. Use your card key to get in. You need to be in proper OR attire once you pass the desk at the end of the room.

VA Hospital

Radiology: Second floor, best bet is to follow the signs.

Hematology/Chemistry labs: Located on the 2nd floor.

Operating room: Located on the 5th floor. Women's locker room is on the right behind the lunch room. Men's locker room is located on the right just before the double doors. Scrubs can be signed out in the lounge of the men's locker room (men and women get their scrubs here). Proper OR attire must be worn once you go through the double doors at the end of the hallway.

Library and cafeteria are on the third floor.

HOW TO ORDER X-RAYS AND LABS

Boston Medical Center - E Newton Campus

X-rays: Fill out a radiology request form and put it in the front of the chart. Write an order in the chart for the x-ray, get it cosigned. Flag the chart and the ward secretary will arrange the film with radiology.

Labs: There are 3 lab draws during the day. Write an order in the chart, get it cosigned and the ward secretary will order it. If you need AM labs, write the order the night before.

Boston Medical Center - Harrison Ave Campus

X-rays: Call radiology and arrange to get films directly with them. Fill out a radiology request form and put it in the front of the chart.

Labs: Fill out the lab request. Tube it to station 28 or walk it down to the labs on the 2nd floor personally. Be sure to save the white copy and put it in the patients chart.

VA Hospital

X-rays: X-rays are ordered through the order entry menu in the computer. These also must be electronically signed by the intern or resident

Labs: There is only one blood draw a day at the VA and there is no guarantee that even if you order a blood draw your patient will get drawn. But...its worth a try, so...write an order the night before for AM labs and get it cosigned.

GETTING RADIOLOGY RESULTS

Boston Medical Center - E Newton Campus

- Call 8-6590
- enter ID (ask your resident for the ID code you should use) then the # sign
- patients medical record number followed by the # sign
- You will get the most recent report. Hit 8 to get a prior report.

Boston Medical Center - Harrison Ave Campus

Students have suggested that the best (and fastest) way to get results is to go to radiology reading room and ask the radiologist to read the films with you.

VA Hospital

- Dial 4820
- Enter the full SS# of the patient
- type: 0 for early report
 - # to enter a new patient
 - 9 to end
 - 7 to restart the menu

CONSULTS...You Want What??

OK...there you are on rounds. You do a great job of presenting your complex patient to the team, and then it happens; your resident tells you to “get I.D. to look into that culture”. What???? Who is “I.D.??? And just how does one “get” this entity. Welcome to the wonderful and mysterious world of consults. Honestly, it is not that mysterious of a world. As with all aspects of medical training, it is simply a matter of knowing what the question is, and where to look for the answers.

The first place to go is your intern. If you are not sure of what the question is, ask! Then ask where to call. The latter is the easiest part. (See next pg)

Example: “Hi...do you have the pager number of the ID fellow on this month?”
With this information in hand, you are ready to call for a consult. Now it gets harder.

•The first thing the consultant will want to know is why are you calling? Make sure you know!! The answer, “My resident told me to” may be truthful, but will rarely be well received.

•Next, have appropriate data handy to relay to the person on the other end of the phone. Generally, all consults will wish to know the following at a minimum:

- Name and medical record number of the patient
- Location of the patient
- Brief** history of present illness
- Medicines that the patient had been taking before admission, and those now ordered
- Significant** past medical history
- Relevant lab studies
- What question you would like the consult team to address
- Where you or your intern may be reached

This list is a basic one, but one that is common to all consults. It should be tailored to the service being called. For example, while the ID people will be immensely interested in the WBC count for you patient, the urology group may hardly care. Just think about it, and it does become rather simple. Always have the patient’s chart on hand so that any question you may not anticipate will not be a big deal. Don’t be afraid to call for a consult. It’s a great opportunity to learn, and that is why you’re here, right?

How to Request a Consult

Boston Medical Center - E Newton Campus

Call the page operator (8-page) and ask for the page number for the fellow who is doing the consults for that service. Then dial 31 to page the fellow to your extension. Fill out a consult request form and place it in the front of the chart. Fill in the top part of the form.

Boston Medical Center - Harrison Ave Campus

Call the page operator (85) and ask them to page the fellow doing consults for the service to your extension. Fill out a consult request form and put it in the front of the chart.

VA Hospital

Request consults through the order entry menu of the computer. You will need to have the intern, fellow or attending electronically sign it when you are finished. Then call the page operator to get the page number of the fellow or resident doing consults for the day. Page them to your extension (the VA pagers are voice pagers—ask someone how to page the first time).

PROCEDURES

“The most important part of any procedure is the preparation.”

MICROBIOLOGY

Gram Stain

Gram stains can be prepared in the microbiology labs at selected hospitals - all materials needed should be in the lab. Specimens should be smeared on a glass slide (Don't forget to glove up and smear under a hood!) and barely heat-fixed on a hot plate. Next, simply rinse your slide with each solution in the following order:

- Flood slide with crystal violet - 1 minute
- Wash off slide with water then flood with Gram's iodine - 1 minute
- Wash off slide and add 95% ETOH to decolorize - 15 seconds
- Wash off slide and counterstain with Safranin - 1 minute
- Wash off Safranin and blot dry

Examine your smear under oil immersion:

- Gram (+) organism = purple
- Gram (-) organism = red

Acid Fast Stain

- Briefly heat-fix air-dried smear on a hot plate
- Flood slide with carbol-fuscin - 2.5 minutes
- Wash off slide with water and decolorize with acid alcohol (completely)
- Wash off slide and flood with methylene blue - 30 seconds
- Wash off methylene blue and blot dry

Examine slide under oil immersion:

- Acid fast organisms = red
- Non-Acid fast organisms = blue

PHLEBOTOMY

Peripheral Blood Sampling (Venous Blood Draws):

For venous blood sampling, you'll need to bring:

- | | |
|-------------------------------|--|
| Gloves, ETOH pads, Tourniquet | Needle/butterfly, adapter, vacuutainer |
| Sterile gauze, Band-aid | Lab requisition form(s) |
| | Label(s) with patient ID |

Collecting tubes

- RED top = anything measured in the serum: chemistries, type and cross/screen, antibodies
- PURPLE top = CBC (measures blood cells)
- BLUE top = PT/PTT (it has a preservative to prevent clotting)

The blood draw is easier for you and less painful for the patient when drawn from the antecubital fossa. Apply the tourniquet tightly and palpate the vein. Once you have palpated the vein, swab the area with ETOH, and enter the skin with the needle at a slight angle. Make sure each tube is at least one-third full. After collecting your last tube, remove the tube from the vacuutainer before swiftly removing the needle from the vein. Then apply firm pressure for approximately 30 seconds.

Arterial Blood Gas

For drawing arterial bloods, you'll need an arterial blood gas kit. Each kit contains a syringe with a drop of heparin, two different size needles (one for radial ABGs and one for femoral ABGs), a cap for the syringe after you've collected the blood, and a specimen bag. Fill the specimen bag with ice prior to drawing the blood.

Select your needle, depending on the site you plan to stick and push the heparin out of the syringe. Then, locate the radial pulse. Once you've found the pulse, you can either mark the area with a pen or hold your index finger proximal and your middle finger distal to the area in which you plan to enter the radial artery. The needle should be inserted at a 90 degree angle to the skin. If you are in the artery, there is no need to pull back on the syringe - the arterial pressure will fill the syringe. Now that you have collected your sample, remove the needle, and apply firm pressure for approximately 2 minutes. Cap the syringe, make sure it's labeled, pack it in ice, and hand deliver the sample to the chemistry lab.

Type and Cross/Screen

When asked to draw a type and cross or type and screen, you'll need to draw almost a full red top tube. The label(s) on the tube(s) must be signed, dated, and timed by the person who drew the blood. The tube(s) should be sent to the blood bank with the appropriate requisition forms (also signed). If you are responsible for type and crossing a patient for the OR, it is a good idea to call the blood bank prior to the surgery to make sure the blood will be there. Also, it is important to remember that type and cross/screens are only good for 72 hours; if you need blood after that time period, a new type and cross must be drawn. (NB: This time period may vary from lab to lab, so it's a good idea to call and check with the blood bank at your hospital.)

BASIC INFO, FACTS AND FORMULAS**ACID-BASE CALCULATIONS**

ACID-BASE CALCULATIONS

CALCIUM CORRECTED FOR ALBUMIN

Hypoalbuminemia is the most common cause of hypocalcemia.

Corrected Ca = (4 - measured alb) 0.8 + measured total serum Ca

COAGULATION CASCADE

PT/INR : coumadin : extrinsic pathway : factors 2, 7, 8, 10

PTT : heparin : intrinsic pathway : factors 2, 9, 10, 11, 12

CONVERSIONS

1 kg = 2.2 lb

1 in = 2.54 cm

1 fluid ounce = 30 ml

1 lb = 0.45 kg

1 cm = 0.39 in

1 teaspoon = 5 ml

1 cc = 1 ml

1 tablespoon = 15 ml

EXUDATES VS. TRANSUDATES

<u>LAB TEST</u>	<u>EXUDATE</u>	<u>TRANSUDATE</u>
Fluid LDH	>200	<200
Fluid protein	>3g	<3g
Fluid/serum LDH ratio	>0.6	<0.6
Fluid/serum protein ratio	>0.5	<0.5
Specific gravity	>1.016	<1.016
Appearance	Cloudy Viscous	Clear, thin Non-clotting
DDx	Infection TB neoplasm	CHF, nephrosis, cirrhosis

HYPERGLYCEMIA

In hyperglycemia, pts have a pseudohyponatremia. For each 100 mg/dl increase in glucose (above 100), there is a 1.6 mEq/l decrease in sodium.

So, true sodium = $\frac{(\text{measured glucose} - 100) \times 1.6}{100} + \text{measured Na}$

INSULIN

Type	Onset	Peak	Duration
<i>Rapid-acting</i>			
Regular	15-60 min	2.5-5 h	6-8 h
Semilente	30-60 min	5-10 h	8-18 h
<i>Intermediate-acting</i>			
NPH	1-1.5 h	4-12 h	24 h
Lente	1-2.5 h	7-15 h	24 h
<i>Long-acting</i>			
Ultralente	4-8 h	10-30 h	>36 h
PZI	4-8 h	14-24 h	36 h

Dosing

Dose = 0.7 units/kg



I/T RATIO

Neonatal index of infection because it is difficult to differentiate sepsis from respiratory distress in neonates.

Defined as: immature neutrophils (bands)/total neutrophils

An I/T ratio > 20% suggests infection, and usually requires empiric abx therapy.

LAB GRIDS



ABGs pH / P CO₂ / P O₂ / HCO₃

MAINTENANCE FLUIDS - Calculation

For an afebrile 70 kg adult: 35 ml/kg/24h

Calculate the **daily** water requirement according to the following "kg method":

For the first 10 kg of body weight: 100 ml/kg/day plus...

For the second 10 kg of body weight: 50 ml/kg/day plus...

For the weight above 20 kg: 20 ml/kg/day.

Example: For a 60 kg adult:

for first 10 kg, 100 x 10 = 1000ml

for second 10 kg, 50 x 10 = 500ml

for above 20 kg, 20 x 40 = 800ml

2300ml/24hrs = approx. 96 cc/hour

For a "quicky" **per hour calculation:

first 10 kg = 100cc/24 hours/kg → approx 4 cc/hour/kg

second 10 kg = 50cc/24 hours/kg → approx 2 cc/hour/kg

kgs > 20 kg = 20cc/24 hours/kg → approx 1 cc/hour/kg

Example: For a 60 kg adult:

for first 10 kg, 4 cc/h/kg x 10 kg = 40 cc/h

for second 10 kg, 2 cc/h/kg x 10 kg = 20 cc/h

for above 20 kg, 1 cc/h/kg x 40 kg = 40 cc/h

approx 100cc/h

OSMOLALITY

osmolality = $2\text{Na} + \frac{\text{glucose}}{18} + \frac{\text{BUN}}{2.8}$ (norm = 290 mOsm/L)

Osmol gap = Osm (msrd) - Osm (calc) (normal < 10mOsm/L)

Increased Osmolar Gap

Measured Osm normal/Calculated Osm low

- Decrease in serum water
 - hyperproteinemia
 - hypertriglyceridemia

Measured Osm high/Calculated Osm normal - slightly high

- Presence of unmeasured osmol
 - sorbitol
 - glycerol
 - mannitol
 - ethylene glycol
 - ethanol
 - acetone
 - methanol
- *(ASA and lithium levels can't get high enough to cause osmol gap bc pt is already dead by then)

PRESCRIPTIONS

Must include the following:

Patient's name, address or hospital number, age, date

Recipe (Rx): drug name, strength, and type

Dispense (Disp): amount of drug or time period

Signa (Sig): Latin "signa" meaning "mark" referring to patient instructions.

Refills — Number, if any, allowed

You must then have your resident or attending sign it

Some abbreviations:

How/Where

PO = by mouth
PR = by rectum
OD = right eye
OS = left eye
to affected area

When

bid, tid, qid = 2,3,4 times a day while awake
qd = daily
PRN = as needed
qhs = every night at bedtime
q6h = every 6 hours

Example:

Rx: Griseofulvin 500 mg

Disp: #45 (forty-five)

Sig: 1 po qd x 6 weeks for rash

RENAL FUNCTION

Creatinine Clearance = $\frac{(140 - \text{age}) (\text{weight in kg})}{(\text{serum Cr})(72)}$

FENa = $\frac{(\text{Urine Na})(\text{Serum Cr})(100)}{(\text{Serum Na})(\text{Urine Cr})}$

RENAL FAILURE

	<u>PRERENAL</u>	<u>RENAL</u>
BUN	<input type="checkbox"/>	<input type="checkbox"/>
serum Cr	nl	<input type="checkbox"/>
BUN/Cr (nl = 13-20)	<input type="checkbox"/>	nl
urine Na	< 10	> 20
urine osm	> 500	< 350
FENa	< 1	> 1
response to volume	good	none
need for dialysis	no	if oliguric/anuric

Causes of Prerenal Renal Failure:

ECF volume depletion CHF Hypotension

Causes of Renal Renal Failure:

ATN (75%) ABO incompatibility
Contrast All prerenal causes
Toxins Eclampsia
Sepsis Malignant HTN
Vasculitis Hemolytic uremic syndrome
Post-op Hepatorenal syndrome
Pigment release (crush injury, rhabdomyolysis, transfusion reactions)

Causes of Postrenal Renal Failure:

Bilateral ureteral obstruction Bladder outlet obstruction

STATISTICAL EQUATIONS

sensitivity = # true positives/# all people with disease

specificity = # true negatives/# all people without disease

positive predictive value = # true positives/# who tested positive

negative predictive value = # true negatives/# who tested negative

STONES

15% of gallstones are radio-opaque

85% of renal stones are radio-opaque (ie - they can be seen on plain films)

Renal stones

Calcium stones : 80% of all stones; made of Ca, oxalate, & phosphate; seen in hypercalciuria, hyperoxaluria (in pts with IBD), distal RTA, medullary sponge kidney, sarcoidosis, hyperparathyroidism, hypocitraturia

Uric acid stones: seen in uric acid overproduction, low urinary volume, persistent acid urine pH

Cystine stones: seen in cystinuria, as a result of inborn error of amino acid transport; hexagonal crystals seen on microscopic exam of urine

Struvite stones: also called **Staghorn calculi**; occur with high urinary pH, which suggests infection with urea-splitting organisms (eg Proteus)

TRANSFUSIONS

RBCs

Transfuse @ Hct <= 21-25%

Transfuse over 3-4 hrs (blood should not hang for >4 hrs).

Premedicate with acetaminophen and benadryl to □ minor transfusion reactions.

1 unit of PRBC increases hemoglobin by 1g/dl & hematocrit by 3%

Platelets

Transfusion indicated for:

platelet count < 20K

platelet count < 50K and bleeding or planned surgery

thrombocytopenia and/or dysfunctional platelets and bleeding

1 unit of platelets increases platelet count by 5000-10,000/ul

SURGERY — QUICK FACTS

BURNS

Degree

1st degree: epidermis involved; painful; pink; no blisters

2nd degree: partial dermal involvement; painful; white to pink; blebs and blisters

3rd degree: entire dermis involved (all dermal appendages destroyed); asensate; white, black, or red; dry and leathery

4th degree: exposed adipose tissue, fascia, muscle, and/or bone

Rule of 9's:

Method to estimate total body surface area (TBSA) involved in 2nd and 3rd degree burns.

9% = head and neck

9% = each upper extremity

18% = each lower extremity

18% = each hemithorax

1% = perineum

CHILD'S CLASSIFICATION

Determines operative risk of a shunting procedure in a patient with Portal HTN

Child Group

	A	B	C
Serum Bilirubin (mg/dl)	<2	2-3	>3
Serum Albumin (g/dl)	>3.5	3-3.5	<3
Ascites	Absent	Easily controlled	Refractory
Encephalopathy	Absent	Minimal	Severe
Malnutrition	Absent	Mild	Severe
Operative mortality rate	2%	10%	50%

POST-OP FEVERS: THE 5 W's

Wind - atelectasis, pneumonia

Walking - pulmonary embolus

Water - UTI

Wonder drug - drug fevers

Wound

GLASGOW COMA SCALE

Eye opening (E)		
Spontaneous		4
To Loud Voice		3
To Pain		2
None		1
Motor response (M)		
Obeys Verbal Command		6
Localizes Pain		5
Flexion Withdrawal		4
Decorticate Rigidity		3
Decerebrate Rigidity		2
None		1
Verbal Response (V)		
Oriented/Converses		5
Disoriented/Converses		4
Inappropriate Words		3
Incomprehensible		2
None		1

RANSON'S CRITERIA

Measure of prognosis in pancreatitis.

<u>At admission:</u>	<u>Within 48 hrs:</u>
1) Age > 55	1) Δ Hct > 10% decrease
2) WBC > 16	2) Δ BUN > 5 increase
3) Glucose > 200	3) Ca < 8
4) LDH > 350	4) PaO ₂ < 60
5) AST > 250	5) Base deficit > 4
	6) Fluid sequestration > 6L

<u># SIGNS</u>	<u>MORTALITY</u>
< 3	< 5%
3-4	15-20%

VIRCHOW'S TRIAD

Stasis (immobility, obesity, CHF, pregnancy, general anesthesia)
Hypercoagulability (malignancy)
Endothelial Injury (trauma, venous insufficiency)

OB/GYN QUICK FACTS

BIOPHYSICAL PROFILE

An OB/GYN assessment of fetal well-being. Five parameters are given a score of 0 or 2.

BIOPHYSICAL VARIABLE	SCORE	EXPLANATION
Fetal breathing movements	nl = 2sec in 30 min. abnl = 0 in 30 min.	At least 1 FBM of \geq 30 No FBM of at least 30 sec
Gross body movements	nl = 2movements in 30 min. absent = 0 movements in 30 min	\geq 3 discrete body/limb <3 discrete body/limb
Fetal tone	nl = 2 absent = 0	\geq 1 episode of flexion and extension Slow extension with partial flexion <u>or</u> no fetal movement
Reactive fetal heart rate	nl = 2 absent = 0	Reactive NST Nonreactive NST
Amniotic fluid volume (Qualitative)	nl = 2 absent = 0	\geq 1 pocket of AF at least 1 cm No AF or no pockets > 1 cm

A score of 8-10 is considered normal; a score of 6 is equivocal and requires further evaluation; and, a score of 4 or less is abnormal and usually requires immediate intervention.

BISHOP'S SCORE

An OB/GYN assessment of cervical ripeness for induction of labor.

FEATURES	SCORE			
	0	1	2	3
Dilatation (cm)	0	1-2	3-4	5-6
Effacement (%)	0-30	40-50	60-79	80
Station	-3	-2	-1,0	+1,+2
Consistency	Firm	Medium	Soft	—
Position	Posterior	Mild	Anterior	—

A score of 9 or more has a very favorable prognosis for induction of labor.

APGAR SCORE

	<u>0 points</u>	<u>1 point</u>	<u>2 points</u>
Heart rate	absent	< 100	> 100
Respirations	absent	slow/irregular	good/crying
Muscle tone	limp	some flexion	active motion
Reflex irritability	no response	grimace	cough/sneeze
Color	blue	blue extremities	pink

STUDY HINTS

MEDICINE

On this service, you are expected to be a team player, so leave the surgery attitude behind. You should be excited and energetic about this rotation. Rounds tend to be lengthy, but make sure you are always paying attention because you never know when your resident is going to throw a question at you. I've found that attendings and residents would rather you gave the wrong answer to a question (to show that you are thinking) than you saying "I don't know" or keeping quiet. This is your opportunity to speak up and give your opinion, but not to the point that you are overwhelming your fellow third years or your resident or intern. You should take the initiative in your patient management - writing orders, calling consults (once the team has agreed on this), gram staining sputums, spinning urines, etc. You should also read on your patients, and be aware of any controversial or "hot" topics surrounding your patient.

Your grade in medicine is based primarily on your clinical work. Therefore, it is essential that you get to know the attending and the attending get to know you. The rotation is broken down into three sections, 2 four week sections and 1 three week section, and since the attendings' rotation schedule is different than ours, you could spend only two weeks with one attending. So, it is important that you convey your interest to meet with the attending early on. You also want to make a good impression with your residents and interns because they too fill out evaluation forms.

The written exam is a board-style exam. Again, no real consensus on a text. What I did hear was that NMS was too much to get through for the exam. Other students used Fishman or Cecil, which I also heard was a lot to get through before the test. As for pocket references, students seemed to be split between The Washington Manual and Ferri. The Washington Manual provides more information about any given topic; while, Ferri gave clinical applications and advice regarding the topic. A Pocket Pharmacopoeia and Sanford are two pocket references that you don't want to be without. Regardless of text, I highly recommend doing the objectives that are passed out at the beginning of the rotation; I feel they allow for a thorough review.

SURGERY

STUDY early. Use the free time you'll have in anesthesia and your elective to study. Some people recommend doing practice questions from the Schwartz and Sabiston study guides. As for a text, there doesn't seem to be an overwhelming consensus on the best book to use. Some of the texts recommended by students include NMS, Sabiston, and Lawrence (you'll need to get both the general surgery and surgical specialties books). The Mont Reed Surgical Handbook is an essential pocket reference for on the floor and to study for your oral exam. Another little pocket reference that many students utilized is The Surgical Intern's Pocket Survival Guide. It's cheap (\$7-8) and useful and I even saw some house officers pull this book out of their coat to look up information. I highly suggest you buy a Pocket Pharmacopoeia - not only will you be amazed at all the information in this book but you will also use it until you break the binding.

Your grade for surgery primarily consists of the exam - if you don't honor the exam, you won't honor the rotation. The written exam is a board-type exam that is very challenging and heavily weights the surgical specialties, with each version of the exam emphasizing different specialties. Some recurrent themes have been trauma, orthopedics, urology, and cardiothoracic surgery, but don't bet on seeing the exact same topics. The oral exam is supposed to be based on a list of the patients you have seen while on the rotation. Some examiners adhere to this rule, while others will ask you questions regarding everything but the topics on your patient list. Your oral exam will be administered by staff from another hospital. **NB:** Examiners like to ask questions about topics familiar to them. Hence, if your oral exam will be at the VA, brush up on your vascular and GI surgery; if your oral will be at the Harrison Ave. campus, be prepared to answer questions regarding trauma; and, if your oral exam will be at the E Newton campus, I'm not sure what they like to ask, but ask some of the fourth years who had their exam at the E Newton campus - I'm sure they'll remember the questions they were asked.

For the clinical part of your grade, it is important that you are interested and somewhat aggressive/assertive. Be prepared to get pimped in the OR and on rounds and don't take anything personally. Volunteer to help where it's needed. Present your patients when they come up at conference or walk rounds with attendings. Know your patients well and help you interns. All this makes you a valuable contribution to the team and it will be recognized.

PEDIATRICS

I can't speak much for BMC, because the students have a ton of extra requirements in terms of papers and seminars. The majority of your grade is determined by your clinical work. In order to honor the rotation, you must honor the clinical part and honor one of the two exams, ie - written or oral. The written exam comes from old "shelf" board questions, so students primarily did questions from Appleton & Lange's Review of Pediatrics question book and Krugman's Review of Pediatrics to study for the exam. The topics for the oral exam come from your patient list and a list of 7-8 topics clearly outlined in the syllabus. I think the oral exam is easier to honor (simply because there are less topics to cover) and would recommend dedicating more time to one of the two exams. As for a reference text, students primarily used either Nelson or the "half" Nelson, a thinner paperback version.

OB/GYN

This is a fun rotation. You'll get to assist with deliveries and maybe even deliver a baby or two yourself, but only if you are kind, humble, and helpful to the L&D nurses and your residents. Your grade is the average of your written exam, your oral exam, your presentation, and your clinical work. The written exam is a board-style exam. In this rotation, students primarily used two texts - NMS and Hacker & Moore (the text Dr. Brown recommends). Personally, I felt Beckmann was the easiest to read, especially since I highly recommend doing the ACOG objectives which are handed out in the OB/GYN packet and are in the front of Beckmann. Once you've studied for your written exam, I think you are more or less prepared for the oral. In terms of your presentation, the sophistication will vary with the other students in your rotation. In my rotation, people simply presented a paper they had written critiquing a case. However, I have heard that in later rotations, people expanded their presentation to include overheads and slides.

PSYCHIATRY

Enjoy these seven weeks. You're grade is based mostly on your written exam which is a departmental exam. As a whole, students felt that Tomb's House Officers Guide was sufficient for the exam. If you are ambitious and want to honor the exam, read Tomb two or three times. It is concise and packed with information.

USEFUL PHONE NUMBERS

Medical School

Medical librar	638-4232
Medical school switchboard	638-8000
Occupational Health	638-8400
Office of Student Financial Mgmt	638-5130
Office of the Registrar	638-4160
Office of Student Affairs	638-4166

Tie Lines

To call E Newton Campus from Harrison Ave Campus—Dial 86 + 4 digit ext.
To call Harrison Ave campus from E Newton Campus — Dial 122 + 4 digit ext.
To call BU Undergrad campus from E Newton Campus— Dial 126 + 5 digit ext.

BMC - East Newton Campus paging system

From East Newton Campus 31+ 4 digit page ID
From Harrison Ave. Campus 86-31 + 4 digit page ID
From outside the hospitals 638-5795 + 4 digit page ID

Clerkship Directors

Third Year

Dr. Levin, BMC - Harrison Ave., Medicine	534-5421
Dr. Hershman, BMC - East Newton, Medicine	638-8030
Dr. Caslowitz, VA Medicine	232-4170
Dr. Cantelmo, Surgery (Mary Stafford)	638-8443
Dr. Siegel, Pediatrics	534-5576
Dr. Brown, OB/GYN	534-7481
Dr. Kaufman, Psychiatry	638-8541

Fourth Year

Dr. Barry, Home Medical	638-8383
Dr. Blickman, Radiology	534-4914
Dr. Gan, Neurology	638-5356
Dr. Shaw, Primary Care	638-5110

Boston Medical Center East Newton Campus

638-8000

Wards

Emergency Department	8-6240
SICU	8-6230
Operating Room	8-6200
PACU	8-6215
6E	8-5910
6N	8-6500
6W	8-5930
7E	8-5710
7N	8-5720
7W	8-5730
8E	8-5810
8W	8-5830
MICU	8-6671

Other Useful Numbers

Admitting	8-6090
Blood Bank	8-7844
Chemistry Lab	8-7859
Echo Lab	8-8745
EEG Lab	8-7979
EKG Lab	8-8740
Hematology Lab	8-7889
Medical Records	8-7200
Microbiology	8-7832
MRI	8-6056
Page Operator	8-PAGE (8-7243)
Pathology	8-6990
Pharmacy	8-6784
Physical Therapy	8-7860
Radiology	8-6600
Transport	8-6247
Ultrasound	8-6607

Other Frequently Used Boston Medical Center Numbers

**Boston Medical Center
Harrison Ave Campus
534-5000**

Wards

Operating Room	4-4116
Adult ER	4-4075
Pedi ER	4-4991
3W	4-4363
Labor and Delivery, 3E	4-4364
Newborn Nursery	4-5472
NICU	4-4359
PICU	4-4513
4W	4-5858
4E, Infants / Toddlers	4-4513
4W, School Age / Adolescents ..	4-4511
CCU (5W South)	4-4421
PCU (5W North)	4-4423
MICU (5E North)	4-5825
SICU (5E South)	4-4119
6E	4-4405
6W	4-4182
7E	4-4404
7W	4-4154

Other Useful Numbers

Admitting	4-4128
AIDS Services	4-4559
Bacteriology Lab	4-4729
Blood Bank	4-4141
Blood Gas Lab	4-4068
CAT Scan	4-4678
Clinical Immunology	4-5305
Computer Help Desk	4-7910
Cytology Reports	4-4277
Echo Lab	4-4577
EEG Lab	4-5246
Employee Health	4-4632
Hematology Lab	4-4067
4 PM Blood Draw	4-4171
Interpreter Services	4-5549
Medical Records	4-5749
Microbiology	4-4728
Pathology Reports	4-5310
Pharmacy	4-4882
Physical Therapy	4-4013
PFT's	4-4382
Radiology-Main	4-4854
Transport	4-5835
Ultrasound	4-5870

Other Frequently Used Boston Medical Center Numbers

**Boston Medical Center
Harrison Ave Campus
534-5000**

Wards

Operating Room	4-4116
Adult ER	4-4075
Pedi ER	4-4991
3W	4-4363
Labor and Delivery, 3E	4-4364
Newborn Nursery	4-5472
NICU	4-4359
PICU	4-4513
4W	4-5858
4E, Infants / Toddlers	4-4513
4W, School Age / Adolescents ...	4-4511
CCU (5W South)	4-4421
PCU (5W North)	4-4423
MICU (5E North)	4-5825
SICU (5E South)	4-4119
6E	4-4405
6W	4-4182
7E	4-4404
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Employee Health	4-4632
Hematology Lab	4-4067
4 PM Blood Draw	4-4171
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Medical Records	4-5749
Microbiology	4-4728
Pathology Reports	4-5310
Pharmacy	4-4882
Physical Therapy	4-4013
PFT's	4-4382
Radiology-Main	4-4854
Transport	4-5835
Ultrasound	4-5870

Other Frequently Used Boston Medical Center Numbers

Boston VA Medical Center
232-9500

Wards

4B	6101
4C	6111
5C (SICU)	6131
6B	6145
6C	6151
7C	6171
8C	6191
9B	6211
9C	6221
9D	6231
11B (CCU)	6251
11C	6261
11D (MICU)	6271
12C	6281
13B	6291
13C	6301

Other Useful VA Numbers

Admitting	5262
Biochemistry Lab	5115
Blood Bank	5118
CT	5222
Cytology	5022
Echo Lab	4210
EEG Lab	4798
EKG Lab	4168
Hematology Lab	5095
Immunology	5004
Medical Records	5308
Microbiology Lab	5109
MRI	5656
OR	4890
Physical Therapy/Rehab	4961
Pathology	5094
PFT's	4330
Recovery Room (PACU)	4874
Ultrasound	5151
X-Ray	5153

Other Frequently Used VA Numbers

Your Intern/Resident's Pager Numbers

Medicine

Surgery

Pediatrics

OB/GYN

Psychiatry

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