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**FROM THE JOURNALS**

Deepika Jain MD

*Tiotropium versus Salmeterol for the prevention of exacerbations of COPD*

NEJM 2011; 364: 1093-1103

This study investigated the use of tiotropium vs salmeterol in reducing the exacerbations in patients with moderate to severe COPD. The current treatment guidelines recommend the use of long acting bronchodilators but do not specify beta agonist vs anticholinergic therapy. In this one year, randomized, double-blind study, a total of 7376 patients were randomly assigned to receive treatment with either salmeterol (50 mcg) or tiotropium (18 mcg). The authors concluded that tiotropium, as compared to salmeterol, significantly increased the time to the first moderate or severe exacerbation of COPD (187 days for tiotropium vs 145 days for salmeterol) and significantly decreased the annual rate of exacerbations among patients with moderate to severe COPD (reductions of 14% and 28% in moderate and severe COPD patients, respectively). This benefit was consistent and independent of the concomitant use of inhaled glucocorticoids.

*Characteristics and short-term prognosis of perioperative myocardial infarction in patients undergoing non-cardiac surgery.*Devereaux, PJ et al., *Annals Int Med* 2011, April 19; 154(8): 523-528

The authors examined the characteristics and short-term outcome of perioperative MI; 8351 patients enrolled in the POISE trial were studied. The perioperative MI was defined as either autopsy findings of acute MI or an elevated biomarker of infarction and at least one of the following features: ischemic symptoms, new pathologic Q waves, ischemic changes on the EKG, coronary intervention or cardiac imaging evidence for an MI. The results showed that, within 30 days of random assignment, 5% of the patients had a perioperative MI, of which (cont)

(continued) 74.1% occurred within 48 hours of surgery; 65.3% of the patients did not experience ischemic symptoms. The 30 day mortality rate was 11.6% for those who had a perioperative MI vs 2.2% for those who did not have an MI; the mortality rate in the MI group was similar for those with and without ischemic symptoms. Since cardiac markers were not monitored beyond 3 days of the surgery, additional asymptomatic MIs may have been missed. The authors conclude that routine monitoring of cardiac markers in high-risk patients is warranted to detect perioperative MIs since the majority of these patients will not have ischemic symptoms.

#### *Four Nephrology myths debunked*

Rachoin, JS and EA Cerceo, J Hospital Med, 6: n/a. doi: 10.1002/jhm.703

This article reviews some important and often debated issues related to renal disease in hospitalized patients: 1. Hypothyroidism, unlike myxedema, is not a cause of hyponatremia; the simultaneous presence of both disorders is often noted since both are widely prevalent but additional investigations are needed to determine if there is a true correlation. 2. Sodium bicarbonate is effective for the treatment of hyperkalemia primarily by enhancing renal potassium elimination rather than by translocating potassium into cells. 3. Acetaminophen can be a cause of metabolic acidosis by causing 5-oxoprolinuria. 4. Furosemide (and sulfa containing diuretics) can be safely used in patients with an allergy to sulfa-containing antibiotics.

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## **ID CORNER**

WILLIAM SALZER MD

### PREVENTION OF IV CATHETER INFECTIONS

The IDSA has just released its updated, evidence-based practice guidelines for the prevention of IV catheter infections. This will be useful for your infection control program.

O'Grady, NP et al., Guidelines for the prevention of intravascular catheter-related infections

Clin Infect Dis 2011; 52: e1-e32

<http://cid.oxfordjournals.org/content/early/2011/04/01/cid.cir257.full.pdf+html>