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## The Weights Felt Heavier Today...

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## The Weights Felt Heavier Today...

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**Mentor:** Rebecca L Peebles

**Program:** Family Medicine

**Type:** Case Report

**Background:** Cervical radiculopathy can occur across all activity levels. It is most common in ages 50-54 and in the C6-C7 nerve roots. It is a clinical diagnosis that commonly resolves with non-operative management, but imaging and surgical intervention are sometimes indicated.

**Methods:** Physical exam, EMG, X-Ray, MRI.

**Results:** A 52 year-old male weightlifter presents with 1.5 years of left elbow pain. Symptoms were insidious, but acutely

worsened after feeling a sharp pain while bench pressing. He rested for several months but, when he resumed bench pressing, noticed decreased strength and range of motion with elbow extension. He subsequently completed a full course of physical therapy, relieving his pain entirely, but presents to Sports Medicine for persistent weakness. Patient notes triceps atrophy compared to his right but denies bruising, swelling, numbness, or tingling. Pertinent exam findings include triceps insertion tenderness and 4/5 elbow extension strength. Workup revealed a moderate olecranon enthesophyte on elbow x-ray and changes consistent with triceps tendinopathy and possible proximal radial nerve entrapment on limited ultrasound. EMG was suggestive of left C7 radiculopathy and MRI C-spine

confirmed multilevel degenerative changes with foraminal narrowing greatest at C6-C7. After discovery of the C7 radiculopathy, the patient was referred to neurosurgery, but no intervention was ultimately performed.

**Conclusion:** The initial exam was consistent with triceps tendinopathy. Treatment was tailored accordingly but the problem persisted. Subsequently, C7 radiculopathy was found to be the true etiology of triceps pathology. Expanding the differential is paramount when a patient is not improving and consideration of proximal etiologies is crucial to explain distal injuries. ■

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## Improving Clinical Performance and Quality Measures Following Acute Myocardial Infarction

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**Mentor:** Edward O'Leary

**Program:** Cardiology

**Type:** Original Research

**Background:** ACC/AHA has set clinical performance measures (CPM) and quality measures (QM) for the care of acute myocardial infarction (AMI) patients during their index hospitalization. Despite these criteria, standards are not consistently met in real-world practice. The aim of this project is to improve our institution's compliance with the national performance and quality metrics.

**Methods:** Retrospective data analysis of AMI patients was completed at our institute for a data more than three months specifically measuring baseline standards met for CPM and QM. Following this, a checklist was implemented to be utilized in the process of discharging every AMI patient. This checklist was distributed in the form of laminated cards to physicians (Figure 1A) involved in direct patient care, coupled with monthly provider meetings to encourage checklist use. Post-intervention, the standards met for CPM and QM will be measured again to assess for interval change.

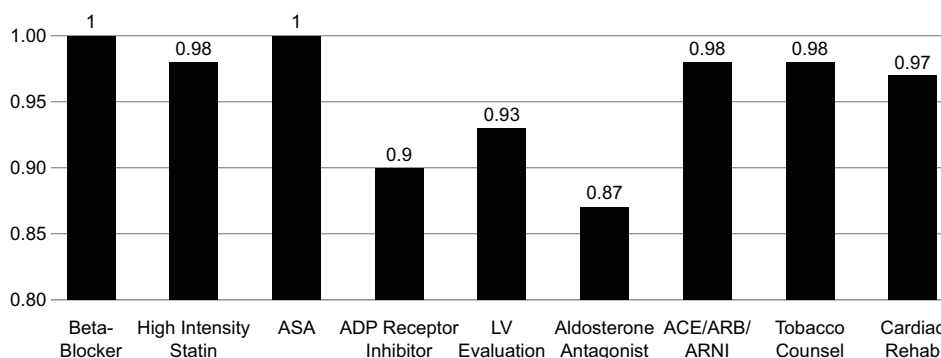
**Results:** Pre-intervention CPM regarding aspirin and beta-blocker use at discharge were met in 100% of cases. CPM for high-intensity statin and P2Y12 receptor inhibitors were 98% and 90%, respectively. Evaluation of left

ventricular function was completed in 93% and cardiac rehabilitation facility referral was done in 97%. QM of aldosterone antagonist

prescription at discharge was met in 87% cases (Figure 1B).

AMI Checklist (STEMI/NSTEMI) Discharge Measures (if not ordered-document why contraindicated)	Recommended Medication Choices
<input type="checkbox"/> ASA	High Dose Statin:
<input type="checkbox"/> High Intensity Statin	Atorvastatin 40-80mg once daily
<input type="checkbox"/> Beta Blocker	Rosuvastatin 20-40mg once daily
<input type="checkbox"/> Aldosterone Antagonist (EF <35%)	Beta Blockers:
<input type="checkbox"/> ACE/ARB (EF <40%)	Extended Release Metoprolol
<input type="checkbox"/> LV Function Evaluation (ECHO)	Carvedilol
<input type="checkbox"/> Tobacco Cessation	Bisoprolol
<input type="checkbox"/> Outpt Cardiac Rehab Referral	
<input type="checkbox"/> DAPT	

**Figure 1A.** Checklist distributed to physicians.



**Figure 1B.** Standard met for checklist items.