EMERGENCY MEDICINE

- Packing wounds is not evidenced based therefore leave it open with a drain, or open otherwise with adequate FU to ensure healing
- Dexamethasone for severe mono, pharyngitis
- SPARC tool for Afib
- SVT cessation manoeuvre: Blowing into 3cc syringe and elevate legs above their heart level (X30sec).
- Auralgan-OTC – For Otitis Media/Externa
- Dexamethasone (0.3 mg/kg) in Asthma. Fast, long half-life. IV solution or tablets can be given orally. 2 doses in adults. Watch insomnia so give early in day and repeat in 48 hrs.
- Renal Colic-if known past stones probably no need to repeat imaging in ER. Just treat pain. Voltaren 100mg supp Q12hrly. Consider Flomax.
- ***EMGERGENCY PHYSICIANS ARE CURRENTLY PROVIDING RACE COVERAGE***

ENDOCRINOLOGY

- For unusual endocrine tests refer to the website *BC Guidelines-Endocrine Special Tests*
- Type 2 DM: of all the agents available only Jardiance and Victoza have shown good data that reduces cardiovascular mortality. Jardiance: Dose 10mg daily. Renal glucose excretion. Can combine with insulin and metformin but watch hypoglycemia, may need to reduce insulin.

GASTROENTEROLOGY

- FODMAP (Fermented Oligo-saccharides, Di-saccharides, Mono-saccarhides, and Polyols). Reduces the foods which are poorly absorbed and become easily fermented by gut bacteria, therefore reducing gassy emissions and frequency of BMs in IBS (Irritable Bowel Syndrome), but is now being used in IBD (inflammatory bowel disease). It was developed in Australia and has been adopted here for IBS.
- Quadruple therapy would be either: 14 days of bisthmus qid, metronidazole 375 mg qid, tetracycline 500 mg qid and PPI bid (suggest blister pack) or14 days 3 antibiotics plus PPI/bid
- Ways to improve triage discussed included detailed description of symptoms of dysphagia, and referring for Endoscopy if: 10 + years GERD, symptomatic on treatment, 2+ Caucasian, increased BMI, or family history esophageal Ca.
- Low Testosterone - chronic opioids are a major contributor to this issue.
- Probiotics - Align, Tuzan

GERONTOLOGY (additional handouts available)

- Definition of Geriatric Medicine vs Geriatric Psych and items to include in referral (especially what is unstable about patient if deemed urgent)
- Pearls on cognitive screening for primary care, and the importance of frailty in prognosis
- New central referral process for geriatrics & all other senior's health now in place. This includes geriatrics, geri-psych, OT, home & community care. This centralized process may actually make it more difficult to refer due to the added burden on central intake. FP needs to be very explicit about what and to whom they wish to refer. It should be noted that it is not a medical person triaging therefore paramount that FP provides explicit request (e.g. Geriatrics). Age cut off is 75, however it was acknowledged that physiologic age is more important so advantageous to stress this if trying to get < 75yo seen.
- Recommended resources: BC Guidelines for Frailty – instructions on drafting a care plan & 'senior's health link' on the VIHA Intranet also provides guidelines on what to do with the frail and elderly.
- Mini-Cog- Ask patients 3 items to remember. If they fail that, ask them to draw the face of a clock (you draw the circle) – ask them to draw the time 10 past 11. Hour and minute times have to be correct place and length. Pass- remember 3 items. Fail- if forgets an item- then get them to draw the clock face. It has to be perfect.
- ***GERIATRICS IS CURRENTLY PROVIDING RACE COVERAGE.***

NEUROLOGY

Parkinson's Disease

- Anxiety is part of EVERY Parkinson's patient's symptoms and it is ok to treat with SSRI, Remeron suggested. Domperidone can be helpful over the short term for management of nausea associated with starting Sinemet.
- Start treatment early for Parkinson's, before they see a specialist, start with standard treatment, then as the disease progresses shorten the intervals between dosing, perhaps as often as q 1-2 hours. Delaying treatment does not delay development of side effects. Only some patients are susceptible to the side effects. Early and frequent walking program extremely helpful.

Headache Management

- Efficacy of injections for acute headache/migraines (separate handouts available) - 6 separate sites- 3 per side- occipital, supra-auricular, supraorbital.

OB/GYN

- Vestibulodynia: often misdiagnosed as dyspareunia, chronic candida.
- Hyperinnervation and increased candida receptors which initiates inflammatory response with inciting event. Adding estrogen to lidocaine stings less.
- Vulvovaginitis: (great resource) www.mvprogram.org Patient handouts. If swabs negative think lichen sclerosis and atrophic vaginitis. Consider Vagifem, Premarin ring etc. HRT- transdermal replacement probably lowest risk.
- Recurrent vaginal yeast: consider Fluconazole 150mg Q72 hrs x 3 then weekly for 6 months. Best "albicans". Boric acid for "non-albicans".
- BV-recurrent: Metrogel vag x 10 days then 2-3 x/wk for 6 months.
- Vulvodynia: Consider diagnosis when patient has significant vulvar pain. Often preceded by traumatic event. Treatment: Topical 5% lidocaine with low dose topical estrogen (to prevent burning) applied QID.
- Vulvovaginitis: take a swab and give to patient when they are symptomatic - teach them how to swab and Ix for Bv/yeast at that time. R/o BV ect. and do a biopsy of skin if consistently - ve swab for pathology to assess for skin conditions like lichen simplex chronicus/lichen sclerosis etc. (atrophic vaginitis cannot be diagnosed by vulvar biopsy).
- Vestibulodynia: Topical tx (5% lido and 0.5mg/g estradiol in galaxyl base) apply tid - pelvic PT.
- Importance of cycle control for PCOS.

RESPIROLOGY

- Chronic cough is considered a cough >8 weeks. In 90% of cases it is due to GERD or sinus congestion. To rule out GERD as a cause, you must treat with a double dose of PPI for 3 months.
- If that doesn't work- consider Dimetapp plus nasal steroid for post nasal drip
- GERD: endoscopy if 10+ years GERD, symptomatic, 2+: Caucasian, male, increased BMI, or family history esophageal cancer

Do COPD patients need to be on an inhaled steroid?

- If no recent history (several years) of exacerbations (needing oral prednisone/antibiotic) OR asthma ---> then consider stopping any inhaled steroids and put patient on a combination (LAMA, LABA) long acting puffer to reduce risk of pneumonia, simplify puffer strategy, and save money.
- There are many inhaler devices available now, but perhaps the simplest to use is the "Ellipta" device.
- Lung cancer screening is still not prime time in Canada but if done, consider only those between 55-75, smoked >30 pack years (either current or within past decade). Request an annual, non-contrast, low dose CT scan chest.