

Internal Medicine Service

Welcome to Small Animal Internal Medicine! The Internal Medicine Service is often quite busy, but it is fun and you're guaranteed to learn. The Internal Medicine Service runs in a similar manner to most other services. This handout will highlight some of the unique characteristics of Internal Medicine. Please check the 4th year planning website and the intranet for very helpful information with all rotations, UVIS, and VetStar.

Rounds

On the first Monday we meet briefly as a group at 8 AM in the medicine ward for orientation with the technicians. Next, we meet in room 1381 (large Tomo conference room), where we divide into Med I and Med II services. Every weekday morning, each service will have case discussion rounds. Rounds are 8:00-10:00 AM on Monday, Wednesday, & Friday, and at 9:00-10:00 AM on Tuesday and Thursday. Thursday at 8 AM ACVIM rounds are held; you are encouraged to attend. For 2011-12, ACVIM rounds are held upstairs in room 2255. Each Friday you will present a paper or topic of interest (10 mins) for the group to discuss, ideally related to an interesting case you saw that week. This can be a "controversial" topic, or a topic where you have found differing treatment opinions, etc.

Clinic rounds consist of case presentations by you, the senior student. Case presentations should be organized, complete, and concise.

For new cases, give: 1. Signalment, 2. Chief complaint, 3. History, 4. Referral findings and interventions, 5. Presenting PE findings, 6. Problem list, 7. Major differentials, 8. Diagnostic and therapeutic plan.

For ongoing inpatients, give a brief overview of signalment and complaint/diagnoses, with an update on diagnostic results and clinical status and plan.

You should have with you in rounds the results of the diagnostic tests that have been performed. Organize your cases using individual case cards or data entered in a Palm Pilot. **Bring lab work results and notes to rounds as needed; the blue-back record should not be taken to rounds if your patient is in CCU or going to Anesthesia that day.** CCU treatment sheets must stay in CCU. Discussion in rounds is centered on the cases that are currently hospitalized. When the caseload is low, we will discuss interesting outpatient cases and have topics rounds (e.g. diabetes, renal failure). We will review digital radiographs and other images from the computer work stations in the rounds rooms.

On weekends, rounds are one-on-one only, consisting of discussions between the student and the clinician on the case. You are only required to come in on the weekends if you have a patient in the hospital or if you are on duty in CCU or on Emergency. With the nature of medicine cases, however, you should expect to have hospitalized patients over the weekends (please clear your schedule accordingly – this is a 14 day rotation).

Receiving

Receiving starts immediately after rounds at 10 AM. New cases are seen on Monday and Wednesday for Medicine service I, and Tuesday and Thursday for Medicine service II. Rechecks and internal medicine emergencies are seen every day. You will be assigned to Med I or Med II on the first day of the rotation, and will stay on that service for the two week rotation.

The **appointment schedule** is posted on the wall in the receiving hallway. **You will sign up for cases the night before with the SAIM Coordinator.** Once you have signed-up for a case it is your responsibility to check for its arrival at the front desk and to see it. *If* you are unable to see a case that you signed up for, it is

your responsibility to find another student on the rotation to see it; who ever is seeing the case MUST enter themselves in VetStar to be paged when the case arrives. You are to enter your name in the student field in VetStar (see directions), so they will page you when the client arrives; however, it is your responsibility to check up front for the case even if you are not paged. If time allows, review patient charts prior to their arrival.

We also have a student assigned for **transfer duty** each morning; you are required to sign up the night before at the same time you are signing up for cases. The transfer student is required to phone in to CCU (608-263-9920) or check the transfer website, <http://uwveterinarycare.wisc.edu/transfers> in the morning to check to see if the SAIM service has any cases to take on transfer from the previous night. If there are cases, you are required to be in CCU by 7:30 to round with the student that took the case in. The overnight student is responsible for the morning SOAP-you are responsible for having the case facts by rounds so that you can present it to your group at that time. The SAIM resident will round and transfer the case with the over night intern/resident.

Emergencies may be added on at any time during the day. Check the schedule frequently and sign-up for cases as they appear. The ER board is in the hall just outside of the SAIM ward. If you see an ER with your services resident on it please sign up accordingly and put your name on the case in VetStar ASAP so that the front desk knows who to page.

Stages of receiving a case:

1) Obtain a history from the owner(s).

These cases are referrals and often have complicated histories. It is important to be complete but it is also important to keep owners on track. Essential questions to ask include: *What is the presenting complaint? (i.e. I see that Gizmo has had increases in liver enzymes and Dr. Google has sent you here for an abdominal ultrasound. Is that correct??)* Then discuss the history and direct questions with regard to the presenting complaint. Characterize the severity and duration of each problem as specifically as possible. If the following questions do not come up in the discussion, ask them as well: Is there any coughing, sneezing, vomiting, diarrhea, change in appetite, polyuria or polydipsia? Be careful not to ask leading questions (e.g. ask “how is his water consumption?” instead of, “is he drinking more?”).

In order to be concise, **verbally summarize back to the owner what he/she has told you, then record it.** (For example, instead of writing a detailed list of each time the dog vomited, write “vomiting bile or foam 2-3 times per day for one month”).

It is also very important to **record exactly which medications the patient is receiving (include dose and frequency). Ask the owner to confirm this information** rather than merely referring to previous written instructions. If the dose has been changed since last visit, record the date of the change. If more space is needed, use the back of the sheet (write “SEE REVERSE” on the front).

2) Perform a complete physical exam.

This may prompt further questions. Complete the physical exam page.

3) Make a prioritized problem list, with duration and severity listed for each problem.

4) Develop your diagnostic plan.

On the bottom or back of the physical exam sheet, list each problem.

For each problem, list the differential diagnoses. Focus on **three or four likely, specific differentials**. Then list the tests that you would like to perform, and initial treatments.

For example: Vomiting bile 2-3 times daily for one week	Gastrointestinal Foreign body Pancreatitis GI LSA or carcinoma IBD Metabolic	CBC Panel Abd. Rads Abd. US cPLI -----
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	Renal failure DKA Hepatic failure Intoxication	IV LRS NPO
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Try to complete your history, PE, and plan in about 30 minutes. You'll have time to further develop your lists in your SOAP. At this point, find the clinician that has signed up for the case. **DO NOT HESITATE TO USE THE PAGERS, and leave the number from which you are calling.**

5) Briefly present case to the clinician (5-10 minutes max).

6) Go back into the exam room with the clinician and finalize the initial diagnostic and treatment plan (take a slip lead with you as needed). Be sure to give the owner all of the animals' belongings so that we do not lose any leashes, collars, etc while they are in our care.

7) Write all diagnostics, etc on the white board in the Med Ward. Be sure to appropriately label your patient with a stamped neck collar. All patients who occupy a cage in the wards should be properly identified with the following: Paper I.D. Collars, Cage Card (3x5 for outpatients, larger for inpatients), proper color for your service, and treatment sheet. All patients, unless indicated otherwise, should be given a blanket and water. Cats should be given litter pans unless you need to collect a urine sample.

Please double check all latches!

8) Draw blood and urine, submit lab request forms on-line, submit imaging requests, shave for ultrasound, etc. The technicians will assist with these tasks.

9) Submit test requests in UVIS. **Make sure to enter the name of the clinician with whom you saw the case in field as it defaults to the faculty on service. THIS IS IMPORTANT.**

Kenneling Patients

Inpatients are fed once in the afternoon by the kennel people as long as the cage card is a large one and is properly filled out with the diet the pet is to be fed. The large cage card allows the kennel worker to list each day the appetite and waste of the patient. If you require your patient to be fed in the morning as well, you will need to do that yourself and include it on the orders for the day in your treatment plan. If an animal needs to be fasted, put a **DO NOT FEED** sticker on the cage card and date it. There are other stickers (WILL BITE, CAUTION, BIOHAZARD, etc) that should be put on the cage card and/or record if indicated. There are also "to" tags (to radiology, CCU, anesthesia, sedated, etc.) located just in side the door to the cages. Walking dogs – watch your patient. The "walk area" is by the large animal unloading area. **The door locks behind you. The code to get back in is 4474.**

Tests, Procedures and Diagnostics

- Any patient that stays in the medicine ward for any length of time needs to have its diagnostic tests and procedures listed on the whiteboard. Any patient staying overnight must have orders written on the Daily Treatment Sheet and it's own treatment sheet which is kept on the cage.

Include on the whiteboard, in this order:

The cage number, first and last name of the patient, the list of procedures and both yours and the clinicians name. Beside each diagnostic procedure place a box . When the procedure is completed, place an X in the box. If some of your tests require pre and post samples, remember to put the times when the samples are to be drawn, beside the boxes. For example, if you draw a pre sample at 11:00am and there is a 2 hour post to be drawn, write on the board 2 hour post 1:00pm .

- There is a black recipe box in the area of lab forms that details various tests and procedure protocols. Most are lab tests but some are also for Derm. Uvis is also a good resource.
- If an **ENDOSCOPIC PROCEDURE** is being planned, notify the ward techs as soon as possible. There is a request form that will need to be completed; these are kept in the hall just outside of the

Med Ward. Some endoscopy procedures require overnight sterilization of equipment. Some procedures require specific prepping of the patient 24 hours prior to the procedure. Talk to one of the ward techs for help.

- Radiology requests (CT, Ultrasound, MRI, radiographs, fluoroscopy, etc) must be made on the **RISORDER system** which is found in VetStar. You may enter requests ahead of time (**not ultrasound**) however you must be sure to note in the comment section when the patient will be coming in as well as change the time of the procedure to the appropriate time (i.e. if the patient comes in for an 11:00am appt then realistically it won't be ready for radiographs until 1:00pm). **MAKE SURE** to change the doctor to the actual person seeing the case, as it will also default to faculty. Also make sure to attach yourself as the student. **THIS IS IMPORTANT**, as the wrong people will get paged if more information is needed on your patient, and can delay procedures.

Anesthesia

IN-Patient

For procedures that are performed on patients that are either being housed in CCU or are staying in the Med Ward overnight and require anesthesia these need a complete Anesthesia request form filled out and turned in by 3:00pm the night before the procedure. The forms are kept in the Med Ward above the sink. They are reusable and can be stamped and written on with a fine point Sharpie. A stamped blue cage card must be included with these requests. The requests are to be placed in the Anesthesia bin as early as possible. Please do not write on the cage card, only on the request. If you do not turn the request in by 3:00pm the day before DO NOT throw the request in the bin you must take it to the Anesthesia supervisor and see when it can be fit into the schedule. If you need help with this see Shannon or any medicine or anesthesia tech.

OUT-Patient

For procedures that are to be performed same-day that require the Anesthesia service (general anesthesia, "quick" Propofol or monitored sedation) all that is required to request service is a stamped 3x5 card. Simply write on the back the procedure, approx. time needed, patient weight and clinician/student involved. Give this request directly to the Anesthesia supervisor.

Required for all anesthesia cases:

A pre-anesthesia checklist filled out from the day of anesthesia (i.e. you can not use yesterdays SOAP for today's procedure). If your patient is going to be anesthetized in the first slot (8:15-10:00am) you must have the patient SOAP'd by 7:30am and in the Anesthesia Recovery area by 8:00am along with the chart. After anesthesia, once the patient is extubated, you are responsible for monitoring if necessary until the animal is able to return to the ward and have its catheter pulled. You are also responsible to return and clean the recovery cage. All cases are required minimally to have a PCV/TP/Azo the day of Anesthesia. Most cases need more in-depth blood work as well as chest radiographs – consult with your attending to determine what all needs to be performed prior to anesthesia.

SOAPs/Treatments

Daily SOAPS are due, before 7:30am for cases going to anesthesia at 8:15 am (have your patient and record in recovery by 8:00am. You are responsible for all of the 8:00 am treatments. At the end of your SOAP, on the Daily Treatment Sheet, write down your treatment schedule with times for initialing. For example:

Amoxicillin 400mg PO TID 8a □ 4p □ 12mid □

The techs will transfer treatments and procedures to the treatment flow sheet. If you can't get a SOAP completed by the time you go to rounds, write your plans on the Daily treatment sheets. All morning medications and treatments should be completed before you leave for rounds. The techs can help with treatments throughout the day if you get tied up with appointments, etc. During the day the student on the case must verbally communicate any changes made in the treatment schedule of a patient to a ward tech, and the treatment flow sheet corrected as well as the Daily Treatment sheet. Students need to do the flow sheet for their own inpatients on the weekends. You are responsible for making sure the emergency student is clear on how to take care of your patient before you leave for the day. **Pharmacy** is open from 7:00am to 6:00pm Monday through Friday and 8:00am to 12:00noon on Saturday. Saturday's hours are for emergency needs. Be sure you have enough medications before the weekend and overnight as they will get charged extra.

Records:

All hospitalized patients (CCU and Med ward) must have SOAPs written by 8 AM. You must complete at least one thorough SOAP every 24 hours. Entries should be dated, have the time noted, and be signed. If you prefer to write your thorough SOAP in the evening when you have more time, then the morning SOAP can be a brief update on the patient's current condition.

Use your SOAPs to organize your thoughts. Be succinct and use outline form. As you refine your diagnostics, you can SOAP "lumped" problems (e.g. gastric foreign body with resolved vomiting and dehydration) rather than each presenting problem (vomiting, inappetence, alkalosis, hypochloremia, increased HCT, dehydration).

You will find most of the forms you need in the Medicine Ward above and between the sinks. If you do not see or know which ones you need, ask one of the techs to assist you. Some forms are kept in Medical Records only.

REMINDER: All record entries must be signed first on each new side of a page, then initials can be used after that. These records are considered legal documents and can be requested by the owner or a court of law. Keep this in mind when you make your entries. Be thorough and professional.

Discharges, pick-ups, drop-offs

Hospital policy dictates that a student or clinician must be present for discharges, pick-ups, or drop-offs. There is a **discharge notification form** that should be completed and submitted to the reception desk prior the clients' arrival so that the front desk staff knows whom to page. In most cases the senior student on the case is responsible for greeting the client. Encourage clients to come when we are available to spend time with them (ideally between 2 and 6 PM on weekdays and between 9 and 10 AM on weekends). Of course this will not be possible for many clients and will necessitate that other arrangements be made. With the permission of the primary clinician on the case, you may make arrangements for the medicine emergency student to supervise a late visit or late discharge. The emergency student is expected to do this if asked and if available. If you or the primary clinician will not be present for the visit or discharge, the client should be fully updated on all aspects of the case prior to visiting, informed that neither you nor the clinician will be there, and understand that the student will not be able to answer specific questions.

Discharge instructions

All cases are released with computer-generated written discharge instructions in VetStar. It is helpful to start your discharge early in the course of an animal's hospitalization and add to it as the case proceeds, rather than rushing at the end. Use the veterinarian report area to record the history and your PE findings. Diagnostics are summarized in table form and do not need to be repeated in the veterinarian report.

The final discharge version (edited and approved by the clinician) should have 2 copies printed. The clinician will sign both copies. The owner takes one copy, and should sign the second record copy. After discharge, place the record copy in the "TO-BE-FAXED" box outside of medical records. This will be faxed to the referring veterinarian and re-circulated to the medical record by office personnel.

A few tips about discharge instructions:

1. HAVE THE CLIENT CHECK OUT AT THE FRONT DESK PRIOR TO GIVING THEM THEIR ANIMAL.

2. Give your diagnoses in as specific and concise a manner as possible. For example: 1. Gastric foreign body removed by gastrotomy 10/13/04. 2. Resolved vomiting, dehydration, and alkalosis.

3. **Do not provide a lengthy daily record of each day of hospitalization;** instead, provide a brief summary of treatments given, with specific dates only for surgeries, transfusions, or other major interventions.

4. Provide important labwork values for admission and discharge days only.

5. Do not include minor insignificant lab abnormalities. Check with your clinician if in doubt.

6. **Refer to the referring vet by name, NOT as the "RDVM."** The discharge also serves as a referral letter to the referring vet, and should maintain a respectful and collegial tone at all times.

You are required to read about your cases each evening. Make sure you understand everything that is going on with your cases. If you don't understand something, please ask! This is the best opportunity you'll have to learn about internal medicine!

Other useful information to review:

RISORDER

UVIS ordering <http://vmth.vetmed.wisc.edu/Support/uvis/main.htm>

VetStar Student Assignments

Med Ward/ER Duty

CCU ER Duty.

Phones and Policies (can be found online in the student handbook)

http://vmth.vetmed.wisc.edu/Policies/Handbook/Student_manual.htm

We are here to teach you, ask questions!!!