

THE PERSPECTIVE

WINTER 2019 | NEWSLETTER



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Welcome from the NMPRA Board

A Note From the NMPRA Executive Board

To all Perspective readers,
Congratulations on making it through another Winter! Residency is never easy, but the cold and dark days can take an extra toll. Make sure to reach out to those around you and check-in on one another! And don't forget to give your loved ones a call and check in! (Continue to P.2)

(Continued from P.1)

Shoutout to all the newest members of our family- the recently matched M4s! You are at the beginning of an incredible journey. The next few months will be a whirlwind of transition and firsts, and we just want to remind you that you have so many incredible resources to reach out to for help: NMPRA, your new program directors, your new

co-residents, your family, etc! Never hesitate to ask for help- it is a long journey and there's no point in going it alone!

We invite you all to enjoy this edition of the perspective, and as always reach out with any comments, questions, or concerns!

- NMPRA executive board

Letter From The Chair

Section on Med-Peds of the American Academy of Pediatrics

We just finished up a very busy 2018 for the Section on Med-Peds. I would like begin by welcoming Kristin Wong and Amrit Misra to the SOMP Executive Committee. Dr. Wong is beginning her term as the new Educational Program Chair, and Dr. Misra will be joining us as the new incoming Representative of Residents and Fellows.

I would be remiss if I didn't personally thank the amazing Sam Borden and Dick Wardrop, who have dedicated themselves to this Committee and to the field of Med-Peds for many years.

We are thankful for their dedication, drive, and efforts to improve Med-Peds as a field.

There were several issues that have commanded our attention for the past year, none more so than the newly approved Pediatric Hospital Medicine Fellowship. I would like to thank those of you who spoke up (and there were many of you) about the approval by the ABMS and ABP of this fellowship. It is clear that our membership feels as if it is possible to provide hospitalist care to either adults or children after their residency, without having to complete further training. We will carefully monitor how this affects the ability of our membership to work as Med-Peds hospitalists.

I look forward to seeing some of you at the upcoming ACP meeting in Philadelphia in April, it is always great to be at our reception with Med-Peds physicians from all over the country.

Thank you for your support of the Section, and if you have any topics that you would like the SOMP to address, please feel free to reach out.

Thanks,
Mike

- Michael Donnelly, MD, FACP, FAAP
Chair, Section on Med-Peds, American
Academy of Pediatrics



“From Nine to Ninety”

AAP Section on Internal Medicine- Pediatrics Physician Health and Wellness Exhibit

Himani Divatia, DO, FAAP, FACP
Chair, AAP Section on Med-Peds, Physician
Health & Wellness Committee

It was a historic year in Orlando this past November as Mickey Mouse celebrated his 90th birthday. It is incredible to think, that such a small idea that was born out of Walt Disney's imagination has created such a lasting impact for generations to come. I strongly reflected on this number 90 this year, as our AAP Section on Med-Peds (SOMP)

Physician Health and Wellness (PHW) Exhibit celebrated its 9th year in existence. While an entire order of ten-fold difference between the two numbers, the thought of a small idea born out of the desire to make people feel better about themselves and the world they live in is exactly what brought the Physician Health and Wellness endeavor to the AAP nine years ago. Through the ongoing efforts and support of the AAP Section on Med-Peds, AAP Section on Integrative Medicine, National Med-Peds Resident's Association, and a handful of residents, students and Med-Peds physicians, the J. H. Milligan-Barr Physician Health

and Wellness exhibit continued to provide novel conversations and recurrent reminders to pediatricians about their own health and wellness while attending the NCE this year. As I was en route to Orlando, I was reminded by the airline personnel to “always place your oxygen mask before assisting a child or another individual”. How apropos is this concept? As Med-Peds physicians, we feel a strong conviction to take care of our own amidst being busy taking care of others. While this is a sensible thought, much of the data still points towards neglect for self-care, missed annual physicals, increased rates of depression and suicide among physicians, and decreased levels of joy in the work place.



Bryan Haimes, MD, MPH, Tina Hu, MD, Nicole Baum, DO, Fernanda Delgada, MD, Himani Divatia, DO, FAAP, FACP



Nicole Baum, DO, Fernanda Delgada, MD, Timothy Powell, MD, Cora Breuner, MD

As physicians continue to work harder to make a difference in the lives of their patients, we often forget the importance of taking care of ourselves, focusing on our own wellness, and rebuilding our own resilience to the field and our work. The PHW exhibit gathered physicians to provide preventive health care guidelines, tips on stress reduction, sleep, mindfulness, and vast conversations about existing wellness initiatives at institutions throughout the nation. (Continued on P.4)

(Continued from P.3)

Through a common "Wellness Wall", we shared different ideas for rejuvenating wellness and attendees stopped to take pictures to serve as reminders later. It also, however, brought to light that despite having these conversations with many pediatricians over the past nine years; many individuals are still feeling burned out, overwhelmed, and unwell. And many places are not beginning to think creatively about ways to enhance provider wellness.



Wellness Wall that was presented at the National AP Conference.

"As physicians continue to work harder to make a difference in the lives of their patients, we often forget the importance of taking care of ourselves"

-Himani Divatia



Himani Divatia, DO, FAAP, FACP, Allen Friedland, MD, FACP, FAAP, Jayne Barr, MD, MPH, FAAP, FACP, FHM, J. Tommy Cross, MD, FAAP, FACP

So while we have been able to impact individuals with conversations over the last nine years, this endeavor is just in its infancy. We now need to develop data, analyze existing initiatives, partner across sections, and bring wellness to the forefront. We just have to think to ourselves, if Mickey didn't squeal with laughter, jump high and low, play with his friends, throw a bone with Pluto or be thinking about how to change for the better, would he have made it to 90?

I look forward to these discussions and more as we celebrate ten years of the physician health and wellness exhibit next year in New Orleans.

See you at the bayou!

New Web Page!

A New Web page has been created especially for the AAP Med-Peds Community. Visit the collaboration page at <https://collaborate.aap.org/medpeds/Pages/default.aspx>



PLEASE JOIN US! Each year the Section on Med-Peds (SOMP) offers an educational program with CME and MOC credit for Med-Peds physicians:

Sunday, October 27, 2019 1:00 pm – 6:00 pm
Hilton New Orleans Riverside, New Orleans, LA
Moderator: Kristin Wong, MD, FAAP

- 1:10PM -2:30PM Understanding clinical reasoning and the common pitfalls, Harry Hoar, III, MD FAAP and Robert L. Trowbridge, MD
- 2:45PM -4:15 PM Strategies to teach clinical reasoning to a varied workforce. Harry Hoar, III, MD FAAP and Robert L. Trowbridge, MD
- 4:15PM - 4:45PM Abstract Posters
- 4:45 PM -5:15 PM Abstract Oral Presentations, Moderator: Jennifer F. Gerardin MD, FAAP
- 5:15 PM Adjourn
- 5:15-6 PM Reception

Abstracts accepted for the 2019 Section on Med-Peds Abstract Program:

Decision	Submission Title
Accept Oral	HIV Screening in an Urban Adolescent Population
Accept Oral	The Sweet Smell of Encephalopathy
Accept Poster	A 23-year-old with Acute Lymphoblastic Leukemia: Treat Me Like a Child
Accept Poster	A 6-year old with Recurrent Pancreatitis and Moderate Hyperchylomicronemia
Accept Poster	A Closer Look at the Genes: An Atypical Explanation for Diarrhea and Diabetes
Accept Poster	Adult Onset Still's Disease in an Elderly Patient
Accept Poster	Bone Teaser: A rare case of primary sternal osteomyelitis in a pediatric patient
Accept Poster	Choking on air: First presentation of restrictive cardiomyopathy in an adolescent male
Accept Poster	Cryptosporidium Enteritis in an Immunosuppressed Child: Applying the Adult HIV Treatment Regimen
Accept Poster	Cytomegalovirus Pneumonia and Enteritis in an Immunocompetent 18-year-old Male
Accept Poster	Diagnostic Ageism: When Not to Miss Toxic Megacolon
Accept Poster	Headache and Vaso-occlusive Crisis: A Young Adult with a More Common Neonatal Diagnosis
Accept Poster	Improving Human Papillomavirus Vaccination Rates in an Urban Internal Medicine-Pediatrics Clinic
Accept Poster	Kawasaki disease in a 20-year old male
Accept Poster	Minimizing blood wastage during blood draws from implanted subcutaneous ports (PORT) in patients with End Stage Renal Disease (ESRD).
Accept Poster	Not Only in Kids: An Adult Case of Kawasaki Disease
Accept Poster	Presentation of Rare Unstable Hemoglobinopathy in Mother and Son
Accept Poster	Stress Cardiomyopathy and Acute Respiratory Distress Syndrome from Influenza A in a Young Medically Complex Adult: the Importance of Transitioning Care
Accept Poster	The Curious Case of a Rash: Staphylococcal Scalded Skin Syndrome, a Pediatric Disease in an Adult Patient
Accept Poster	Un-DRESSing Lithium: A Pediatric Case of Lithium Induced Drug Hypersensitivity Syndrome

Med-Peds Section Events at American College of Physicians Annual Meeting

Med Peds Executive Committee Meeting (by invitation only)

Friday, April 12, 2019
8:30 am - 12:30 pm

Med Peds Reception

Friday, April 12, 2019
6:00 - 7:00 pm
Franklin 13

Med Peds Educational Program: Beyond Surviving in Medicine: Strategies to Thrive, Be Well and Find Joy in Practice

Saturday, April 13th, 2019
11:15 AM - 12:45 PM
Room 114

Speaker: Richard Wardrop III, MD, PhD, FACP, Professor

Description: Understand the current scope, causes, and burden of burnout within the health care system. Relate evidence-based measures and expert recommendations shown to reduce the burden of burnout at the institutional and individual level. Explore strategies that can increase engagement of providers to achieve better work-life integration.

Define a personal approach to building resiliency and bringing joy back into practice.

Maintenance of Certification (MOC) for Med-Peds Physicians Made Simpler

By Jayne Barr, Tommy Cross, Hilary Haftel and Michael Donnelly

MOC can never be simple, but it can be simplified and the work reduced.

The most important point: In order for Med-Peds physicians boarded in both general internal medicine and general pediatrics to obtain reciprocity (ie. Go through one MOC program and obtain credit for the other), they must be enrolled in BOTH MOC programs. They can then complete an attestation form for the other Board's MOC program. (Continued on P.7)

(Continued from P.6)

GENERAL RULES: (See Table One)

1. Pay fees to both ABIM and ABP
 - a. ABP- yearly or every 5 years.
 - b. ABIM- yearly or every 10 years.
2. Have an unrestricted license to practice medicine in the U.S. (MOC Part 1)
3. If seeking reciprocity with both boards, chose your primary board (ABP or ABIM)
4. Complete web-based self-assessment activities (MOC Part 2)
5. Take a knowledge assessment activity (MOC Part 3)
6. Complete QI activities (Peds requirement).

GENERAL RULES: (See Table One)

MOC Component	ABIM	ABP
Cycle	10 years	5 years
Cost	Either yearly or lump sum (get discount) plus additional test fee	Lump sum (discount if pay at least 1 year in advance of due date). Fee includes MOCA-Peds
MOC Part 1 (Evidence of Professional Standing)	Proof of unrestricted license	Proof of unrestricted license
MOC Part 2 (Self Assessment)	100 points every 5 years (total 200 per cycle) Must earn points at least every two years during cycle <ul style="list-style-type: none"> • Self-assessment activities • QI activities • CME activities 	40-60 points*, any combination of: <ul style="list-style-type: none"> • Self-assessment activities • Question of the week • CME activities
MOC Part 3 (Cognitive Expertise)	<ul style="list-style-type: none"> • Must take exam within 10 years of last exam OR • Must pass knowledge check-in (KCI) every two years (restrictions apply)** 	Every 5 years, one of the following: <ul style="list-style-type: none"> • MOCA-Peds (included in fee) • Closed book exam† (additional fee)
MOC Part 4 (Quality Improvement)	Currently waived, but need to do in order to get reciprocity with Pediatrics	40-60 points*, any combination of: <ul style="list-style-type: none"> • Local or national projects • Personal projects • QI leadership activities • EQIPP (AAP), PIMS (ABP)
Reciprocity	ABIM as primary: <ul style="list-style-type: none"> • Complete all ABIM requirements • Attestation for ABP • Complete Part 3 for both ABIM and ABP 	ABP as primary: <ul style="list-style-type: none"> • Complete all ABP requirements • Attestation for ABIM • Complete Part 3 for both ABIM and ABP

*Must total 100 points, with at least 40 points of Part 2 and 40 points of Part 4

**Must still have active certification, or if lapsed, successfully pass two successive KCI's to qualify as participating in MOC. Can only enter cycle on even-numbered years (2020, 2022. etc). Hospitalists have additional requirements to received certificate of Focused Practice in Hospital Medicine through the ABIM.

†Currently being phased out. (Continued on P.8)

(Continued from P.7)

Additional Notes:

Regarding Fees:

If you do the bulk one-time payment (the ABP-5yr or 10-year ABIM fee), you are likely get a discount. (for ABP only if you pay it a year or more ahead of time.) Bulk payment-

1. Advantage: the authors believe fees will continue to increase over time, so lock in a 5 or 10 year annualized rate at a discount.
2. Disadvantage: More money up front. It is much easier to afford annual fees if:
 - i. Household finances are tight
 - ii. Fees come out of limited CME/licensing monies on a yearly basis from the employer
3. Note that in addition to the MOC annual (or lump) fee, you have to pay an additional assessment fee the year(s) you take the exam or Knowledge Check-in

Regarding the ABIM Cognitive Assessment:

Can be fulfilled with a 10-year exam at a testing center or through an every-2-year "Knowledge Check-in", which is on a two-year cycle. You must take it either in the year your certificate expires, or the YEAR BEFORE; you cannot do the test after your certificate has expired and be said to be Maintaining Certification. You either have to take the 10-year exam or pass TWO sequential Check-Ins to be Maintaining Certification.

Examples on Passing the ABIM Assessment Part 3:

Dr. Jones is due in 2021. If she did not take the "Knowledge Check-In" in 2020 her only option is to take the "10 Year exam" in 2021 if she wants to be listed as "Maintaining certification".

Dr. Smith is due in 2021. She took the "Knowledge Check-in" in 2020 and passed. She does not need to do anything until 2022, where she will take her next "Knowledge Check-in".

MOC through the ABIM route for reciprocity:

1. You cannot fill out the form for the ABP until your last year (Year 5).

2. Don't forget you have to do hours in Part 4 for Peds (this can be done in IM or Peds—note that the ABP Part 4 activities and credit are all 40 points, if you are doing reciprocity using IM credit you only need to do 20 points and this counts for the ABP).
3. You still have to do Part 3 in Peds—either the MOCA-Peds or the test at the testing center every 5 years (new from every 10).
4. For those who elect to do the Focused Practice in Hospital Medicine exam:
 - a. The same requirements for Internal medicine in terms of points required. However, there is not a "Knowledge check in".

MOC through ABP Route for reciprocity:

1. Complete 40 points every 5 years in a Part 2 activity (Life long learning/Knowledge). This can be done with ABP modules or Combined CME/MOC activities approved by the ABP.
2. Part 3: Either enroll in MOCA-Peds, which will send you via email 20 questions to answer every quarter or take the 200 test at the testing center every 5 years
3. Part 4: complete 40 points during each 5 year cycle.
4. Notes about going this route for reciprocity:
 - a. fill out the form on the ABIM website
 - b. don't forget to take the Part 3 exam as listed under IM.

Also new this year for Focused Practice in Hospital Medicine:

1. It has been recognized that physicians who earn the Focused Practice in Hospital Medicine (FPHM) designation may see their inpatient care practice change over time, making it difficult to continue meeting their minimum patient encounter threshold. The ABIM previously would only permit you to continue to take the Focused Practice in Hospital Medicine. But if you decided to switch back to general internal medicine if you did not have requirements to stay in FPHM, you had to take the Internal medicine examination in the year that you notified them that you were going to switch to remain board certified. (Continued on P.9)

(Continued from P.8)

2. ABIM has revisited the FPHM program requirements and introduced an option for physicians to transition back to maintaining an Internal Medicine certification. The FPHM certification status and assessment due date will now be assigned to your Internal Medicine certification. This means you will not need to pass an internal medicine assessment any earlier than is currently required for your FPHM designation.

Med-Peds Fellowship Pursuit Guide

Burton Shen, MD PGY3; Janaki Vakharia, MD PGY4; Suzanne McLaughlin, MD

Fellowship for Medicine-Pediatrics (MP) residents: Congratulations to the many MP PGY4s and recent graduates who opened emails on November 28 or December 12 and learned of their successful match for fellowship!

More than 25% of MP residents opt to pursue fellowship , but how do they get there? We wanted to share some recent experiences and insights.

What types of fellowships do MP residents pursue?

After successfully completing residency, Combined Internal Medicine-Pediatrics residents are eligible for all of the categorical fellowships open to their categorical IM and categorical Pediatric peers. You can find a full list on the American Board of Medical Subspecialties website: <https://www.abms.org/member-boards/specialty-subspecialtycertificates/>.

Some categorical fellowships may have opportunities to further a combined focus, such as an extended experience in adult congenital heart disease within a pediatric or adult cardiology fellowship.

There are also fellowship opportunities open to graduates of multiple types of residency training, such as Hospice and Palliative Care, Sleep Medicine, Sports Medicine, Geriatrics, and Adolescent Medicine. Fellowship opportunities in non-boarded specialties, such as Patient Safety and Quality Improvement, Medical Informatics, or cross-specialty programs such as the National Clinician Scholars Program (the former Robert Wood Johnson Clinical Scholars Program) are also great opportunities for graduates. Lastly, there are fellowships that combine adult and pediatric fellowships. (Continued on P.10)

Upcoming NMPRA Conferences



NMPRA National Conference

New Orleans, Louisiana
Saturday, October 26, 2019



2019 NMPRA Midwest Regional Conference

"Med-Peds in Public Service"
Rush University in Chicago, Illinois
Saturday, May 18, 2019

Stay tuned for details on registration, agenda, poster session and more. See updates on the conference website here:

<https://medpeds.org/about-nmptra/regional-meetings/>

(Continued from P.9)

How do you find these fellowships?

The NMPRA fellowship guide is a good place to start. It lists programs that have current or prior MP-trained fellows and experience with combined fellowship:

<https://medpeds.org/residents/fellowship-guide/>.

It is important to realize that since there are only about 380 MP residency graduates each year, and only a subset of them pursue fellowships, there aren't going to be programs that consistently have and fill combined positions every year.

Knowing programs that have trained combined residents in the past or have current MP-trained fellows can smooth your path.

Why pursue combined fellowship?

Similar to the reasons you sought out combined residency training...an applicant in the current match cited a career goal "to specialize in a particular disease process, rather than an age group, and be able to take care of people and understand a specific disease all the way from birth through old age", or to practice where there are limited resources and a need for subspecialty care across the lifespan, to retain your patients across their lifespan or focus on their transitional years.

But don't assume you must be dual subspecialty trained to have elements of both medicine and pediatrics in your eventual practice. Many MP graduates who opt to pursue categorical fellowship find strong components of dual practice in their ultimate practice spanning the lifespan (e.g. transitional care for conditions within their specialty).

The ABIM and ABP have affirmed the value of cross-over content in the dual training in a joint statement allowing for MP graduates to complete combined fellowship training with one year less than the duration required of categorical fellows:

<https://www.abp.org/print/75>.

Here are some pearls from residents who've recently undergone the process:

- You may find your "perfect program," but you may also need to develop it, so start early!
- Start by talking to former MP graduates who have pursued a combined fellowship in your field of interest. You can find a list of them on the NMPRA fellowship guide: <https://medpeds.org/residents/fellowship-guide/>.
- Identify programs with accredited fellowships for both adult and pediatrics in your field of interest, and reach out to the program directors early to learn more about their interest in creating a combined fellowship and the logistics involved.
- Most programs will ask you to apply via ERAS, while a handful may have an alternative application process. If applying through ERAS, it is usually best to apply to both the adult and pediatric program at each institution separately.
- Questions to be prepared for on the interview trial will definitely involve "why do you want to do a combined fellowship in blank." They will ask you why you don't think you can meet your career goals by just doing adult or pediatric fellowship. Anticipating these questions, and even addressing them in your personal statement, is a great start to interview prep.
- Choosing which match to enter is tricky. Some programs may want you to enter the adult match, while others may ask you to go through the pediatric match. The adult and pediatric fellowship matches are not integrated, and you cannot enter both matches. That is, if you are active in the adult match, you cannot be active in the pediatric match. The key is to communicate this with your programs and keep them in the loop when you decide. We are reaching out to the National Residency Matching Program (NRMP) to understand why dual or integrated match lists are not an option.

(Continued on P.11)

(Continued from P.10)

Be aware of some efforts underway to address some of the issues noted, and contribute if you can:

NMPRA is working to update the fellowship guide. Please reach out to me as Director of Professional Advancement if you have information to update on your institution's combined fellowship options, or experiences to share with your peers! Burton.Shen@lifespan.org

The MedPeds Program Directors' Association is drawing on NMPRA's expertise to generate a "Fellowship Directors' Guide to having a Combined Fellowship Program" that will highlight features of successful programs and include FAQs that a resident could use as well when outreaching to fellowship directors. I'm hoping you can share your successes and lessons learned.

Suzanne_mclaughlin@brown.edu

**Frohna JG, Melgar T, Mueller C, Borden S. Internal medicine-pediatrics residency training: Current program trends and outcomes. Academic Medicine (2004);79(6):591-6.*

However, there is significant heterogeneity in the curricula among residency programs, with a lack of consensus as to the most effective methods to train residents in this arena. A longitudinal transitional care curriculum was therefore developed and implemented within our medicine-pediatrics and categorical pediatrics programs at the University of Maryland Medical Center.

With institutional IRB approval, a half-day practice-based learning (PBL) session was incorporated into the existing required adolescent medicine rotation, completed during the intern year at the University of Maryland. A baseline assessment of intern's transition-related knowledge is first completed, and a faculty-led online lecture is then viewed. Using the Got Transition initiative's transition readiness assessment¹ as a guide, interns meet with adolescent patients in clinic to discuss their patient's readiness to transition to the adult setting. At the completion of the clinic, a post-PBL survey assessing transitional care knowledge is completed, as is a reflection on their experiences through a formal reflection tool.

Eighteen first year residents have participated in the transition curriculum since implementation; the majority of resident participants have identified it as a valuable experience. Commonly identified themes in the formal reflection tool include a greater recognition of the importance of introducing transition in mid-adolescence, improved understanding of patient-, physician- and systems-level barriers to transition, and greater skill in assessing pediatric patient's readiness to transition. Efforts are ongoing to implement the second and third phases of the longitudinal curriculum, which will occur during the resident's PGY2 and 3 years, all in an effort to inform the local and national dialogue regarding effective transitional care curricula.

Implementation of a Longitudinal Transitional Care Curriculum

**Alissa Werzen, MD; Leah Millstein, MD
Resident, PGY4 and Associate Pediatrics
Program Director/Assistant Medicine-
Pediatrics Program Director
University of Maryland Medical Center**

Transitioning pediatric patients to the adult health care setting is a topic of emerging interest in medicine-pediatrics. As children with complex healthcare needs increasingly survive into adulthood, pediatric residents must develop the knowledge base and skill set necessary to facilitate this transition. However, there is significant heterogeneity in the curricula among residency programs,

Eggs - A Short Story

Sharon Cheng Li, MD, Internal medicine-pediatrics resident in the Department of Medicine, University of Minnesota, Minneapolis, Minnesota.

Mr. G was my very first patient as a student, bright and fresh on internal medicine. He had a prealbumin of 3.

He also had a tiny cirrhotic liver, a history of army service, left lower extremity cellulitis, and a bed on our VA service. Dutifully, I rounded on him in the morning-- as my sole patient, Charles spent cumulative hours telling me about his family and his drinking; I had the time and the naïve patience to listen.

Every morning, I folded my rounding sheet into thirds and carefully copied down the day's labs: vitals in black, CBC in red, BMP in green-- overly meticulous as only a newcomer can be.

One morning, on repeat liver labs (orange), I met my first, real life prealbumin. I had heard about this, read about this, done practice questions about this. This was my shining moment and, informed by my preclinic curriculum and the little red exclamation points next to the lab value, I panicked to my senior resident: "Did you see his prealbumin?! It's crazy low!"

Completely unimpressed, my senior told me to bring it up on rounds and said flippantly, "That's not unusual for someone who's on the transplant list."

But I thought it was unusual.

In fact, after checking both UpToDate and Wikipedia, I knew it was unusual.

"Recheck in a week," my senior said on rounds.

"Nutrition consult," added my attending.

But I was dissatisfied.

How do you fix a prealbumin when you're a medical student with an incomplete understanding of biochemistry and only one patient to care for? The answer: eggs.

In my mind, albumin and prealbumin were more or less the same thing—they half-share the same name, after all. And what has albumin? Eggs.

What's available in the Veterans Canteen, 2 for \$2.99? Hard-boiled eggs.

From the day this stroke of brilliance hit me to the day Mr. G was discharged on oral antibiotics for his cellulitis, I would stop by the Veteran Canteen on the way in to work for two eggs. Before I went to the team room—lest my team find out about my vigilante patient care—I would put a yellow gown on over my backpack (he had a history of *C. diff*), sneak into his room, and put his daily dose of eggs on the faux wood side table.

I added a new checkbox to my morning rounding sheet: ate protein. Check.

We never rechecked his prealbumin, and I have been able to figure out if eggs have been linked to anything but excess bowel gas. I do know that in all my time at the Houston VA, long after he was discharged, Mr. G did not go for liver transplant. As far as I know, he is still waiting.

Days and years go by, and I see T. bilis in the 20s, single-digit prealbumins, bone densities several standard deviations from the mean. I tell learners my junior that we'll talk about it on rounds.

"We can just recheck it in a week," I will tell them.

My attending will nod. "Consult rheumatology."

And maybe the medical student, dissatisfied and on her own, will set out on a lone vigilante medical mission of her own.



NMPRA's Annual Community Service Week!

Greetings NMPRA Members!

Spring is here (pretty much, right?) and the time has come for NMPRA's Annual Community Service Week! We hope that with a full week dedicated to the event, there will be more flexibility to allow for increased participation across all programs and more FUN!

**The date for this year's event is April 20th through April 28th
(The week of Earth Day!)**

As the week will fall over Earth Day, there will likely be several community projects that involve being outside in the sunshine, interacting with community members, and maybe throwing in a little elbow grease to better the community and environment. We hope you take this opportunity to GET OUT AND GET DIRTY. Our main goal is to bring NMPRA members from across the country together in service, therefore however you and your program choose to volunteer is fine by us!

If you are interested in participating but are having difficulty finding a community service opportunity in your area, please do not hesitate to email us at outreach@medpeds.org for assistance! We will do our best to use our resources to help you find a project that fits your program's and community's needs. Other resources include: volunteermatch.org, idealist.org, volunteer.gov, Habitat for Humanity (<https://www.habitat.org/volunteer>), and the National Park Service (<https://www.nps.gov/getinvolved/volunteer.htm>).

We will be featuring all participating programs on our website and social media pages throughout the week, so send pictures to outreach@medpeds.org! The programs with the most participants (based on percentage), and most creative project as voted on by the NMPRA board will get special shout outs online and in our newsletter!

Thank you all for your participation and we at NMPRA are excited to get out together in the community!

Ashley Cobb
University of Michigan, HO-3

Case Report: Takotsubo Cardiomyopathy

Mayra A. Oseguera, PGY-1
University of Puerto Rico, Med-Peds

Introduction

Takotsubo cardiomyopathy (TC) also known as stress induced cardiomyopathy, is described as a reversible regional dysfunction of the left ventricle, with symptomatology and clinical findings indistinguishable from an acute myocardial infarction (MI). Chest pain and dyspnea are the most common presenting symptoms (1). Apical ballooning, secondary to transient hypokinesis or hyperkinesis of the left ventricle mid segments, with or without involvement of the apex, is the classical finding on echocardiogram (EKG) (2,3). Coronary angiography reveals no obstructive coronary artery disease. TC is common in postmenopausal women after an acute emotional or physical trigger; but cases in which no trigger is identified have been reported.

Case Presentation

A 60-year-old female with a past medical history of epilepsy well managed with Phenytoin, arrived to the emergency department (ER) with retrosternal chest pain that began about 10 hours earlier. The pain was pressure-like in quality and initiated with an intensity of 4/10. The pain slowly progressed throughout the night to an intensity of 10/10; accompanied by nausea, shortness of breath, and radiation to the left arm. Pain worsened on deep inspiration. The EKG displayed a normal sinus rhythm without ST or T wave changes. The echocardiogram was consistent with hypokinesis of the basal–midanteroseptal, inferolateral, and inferior myocardium. The initial Troponin I level was 0.25 ng/ml. Vital signs and physical exam were unremarkable. Initial treatment consisted of aspirin, nitroglycerin, morphine, heparin, and prasugrel.

The patient underwent left and right coronary angiography showing no coronary artery occlusion, and an estimated ejection fraction of 50-55%. Hypokinesis of the anterolateral myocardium and of the apical myocardium was perceived. As a result, the diagnosis of TC was made. After the procedure, the patient was initiated on a statin, beta-2-blocker, and an angiotensin converting enzyme (ACE) inhibitor.

The patient denied any physical or emotional stressors prior to the event. The following day, the patient had complete resolution of chest pain and troponin levels had decreased to 7.46 ng/ml.

Discussion

The exact cause of Takotsubo cardiomyopathy (TC) is unknown, but it is hypothesized to be triggered by an emotional or physical stressor, resulting in an abnormal response to a catecholamine surge. The surge in catecholamines is believed to cause a direct myocyte injury, diffuse coronary vasospasm, endothelial and microvascular coronary dysfunction (1,3). The most frequent abnormality seen on EKG is ST-segment elevation of the precordial leads. Diffuse T wave inversion can also occur, but less frequently. Other less common findings include QT prolongation, T wave inversion, and Q wave abnormalities. Such abnormalities tend to be transient and resolved within a few days to months (1). Patients may present with no changes on EKG. (Continued on P.15)

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1. Transient hypokinesis, akinesis, or dyskinesis of the left ventricle mid-segments with or without apical involvement; the regional wall motion abnormalities extend beyond a single epicardial vascular distribution; a stressful trigger if often, but not always present
 2. Absence of obstructive coronary artery disease or angiographic evidence of acute plaque rupture
 3. New electrocardiographic abnormalities (either ST-segment elevation/or T wave inversion) or modest elevation in cardiac troponin
 4. Absence of pheochromocytoma and myocarditis
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Figure 1: Mayo Clinic Criteria for Takotsubo Cardiomyopathy

(Continued from P.14)

There is an increase in cardiac biomarkers at presentation that tend to decrease quickly (1). Angiography is necessary to distinguish TC from an acute MI. The Mayo Clinic Criteria is widely used in the diagnosis, and all four criteria are required.

There are no current specific guidelines for the treatment of TC, and thus treatment consists of supportive management. At presentation, treatment is the same as for an acute MI, since both are initially indistinguishable. Patients are monitored for complications and managed accordingly. (2) Possible complications include cardiogenic shock, severe left ventricular outflow tract obstruction, mitral regurgitation, hypotension, arrhythmias, thrombosis, and heart failure.

Clinically stable patients are often treated with diuretics, angiotensin-converting enzyme (ACE) inhibitors, and beta-blockers. Patients with loss of motion of the Left ventricular apex can be treated with anticoagulation to reduce the risk of thromboembolism until contractility of the apex improves. (2, 3) TC has a relative good prognosis, with a complete recovery in about 96% of the cases and a mortality rate of 2%. (2) The development of preventative and management strategies are still to be developed.

Reference:

1. Sachdev E, Merz Bairey CN, Mehta PK. Takotsubo Cardiomyopathy. *European Cardiology Review*, 2015; 10(1):25-30
2. Prasad A. What is Takotsubo (Stress) Cardiomyopathy? *European Cardiology Review*, 2015; 10(1):6-8.
3. Komamura K, Fukui M, Iwasaku T, Hirotsu S, Masuyama T. Takotsubo cardiomyopathy: Pathophysiology, diagnosis and treatment. *World J Cardiol* 2014 July 26; 6(7): 602-609.

Save the Date: Northeast Regional NMPRA Conference

Saturday, May 11, 2019
Jacobs School Of Medicine And Biomedical Sciences
955 Main St, Buffalo, NY 14203

Students and residents registration fee - Free
Attending physicians/faculty registration fee - \$50

SUNY University at Buffalo Med Peds Program cordially invites you to attend the Northeast Regional NMPRA Conference! Our theme is "Technological Innovations in Medicine," which will focus on daily technological challenges and advances in modern medicine and medical education. Conference will be held in the Buffalo Niagara Medical Campus in Buffalo, NY in the new medical school campus.

We have invited various respected guest speakers from the Northeast Region Med/Peds programs. A hotel discount is available for those interested in spending the night with us. It is located in the heart of downtown Buffalo. Register below and a discount code/link will be emailed to you.

There will also be a poster session which will be accepted from students, residents and faculty. We have a very exciting day planned! Since Niagara Falls is in our backyard, we are excited to share the fun we have to offer! We are truly looking forward to hosting you! Please use the following link to register:

https://docs.google.com/forms/d/e/1FAIpQLSfTICWOxqLuGWS2XpzGXFFUrc7iRVwX9QqI39tPPH0Uqsnyuw/viewform?usp=pp_url

If you have any questions, please feel free to reach out to us at ubmedpedschiefres@gmail.com or (716) 961-9402.

-SUNY UB Med/Peds

Twitter Starter Pack

**Maximilian Cruz, MD,
Cinci Med-Peds, PGY-2**

Whether you are a med student, newly-matched soon-to-be-resident, resident, or attending, one thing that is difficult in this age of social media is finding/developing your voice and brand on social media. Some prefer to keep everything personal, others use strictly for work, and some blend the two. We have some awesome Med-Peds presence on Twitter, but there is always room for growth and improvement. If you're not sure where to start, or still trying to find your own brand, I've listed some great Twitter accounts (in no particular order) that show the varied approach that is out there- and how they all work well in their own ways! Obviously, give us a follow too, at @nmpira.

Of note, all of the following names were pulled directly from what they list as their name/title in their public twitter profiles. Descriptions are simply my perspective/opinion, based on following these accounts!



Chris "The Chiu Man" Chiu, MD

@cjchiu

Med-Peds trained! You may know him from everyone's favorite podcast- The Curbsiders. Lots of great retweets and original content/thoughts, a good follow to find other individuals you may like as well (via retweets).

Med Peds Hospitalist

@medpedshosp

Heavy focus on work. Not a lot of personal injected. Great model if this is what interests you. Lots of great content both via retweets and original tweets. Seems to have a pretty broad base which he culls for his own retweet/timeline, often find some great references or articles I wouldn't otherwise come across.

Joel Topf, MD FACP

@kidney_boy

Just a fantastic resource in a field that often puzzles me immensely - nephrology! You may have heard him on the Curbsiders where he somehow makes everything seem so simple. He is a great generator of #FOAMed both of his own creation and content he helps distribute. A great example of how powerful a platform Twitter can be for #FOAMed.

Eric Warm

@CincyIM

If MedEd is your passion then this is a great account to follow. A recognized global leader in MedEd, his account is a great place to find a lot of good MedEd resources and articles, mostly by the way of retweets. A great follow if you don't know where to start in synthesizing the MedEd twittersphere.

Ben Kinner

@Midwest_MedPeds

Med-Peds back in the house! Another great follow to get into the world of MedEd, injects a little more personal in addition to work. Does a great job of live-tweeting key takeaways from conferences/lectures/etc.

Omnintensivist

@GoodishIntent

Another Med-Peds in the house! Not just Med-Peds, but the rare combined Med-Peds Critical Care doc (brains on brains on brains). If you aren't following Omintensivist on Twitter, are you even on Twitter? If you're trying to figure out how to create a heavy presence of personal (while still maintaining comfortable level of anonymity) in addition to work this is the account to follow. If Twitter was medical TV, this account would be Scrubs. You laugh, you cry, and you learn stuff. Sometimes all in one tweet.

Tony Breu

@tony_breu

The king of tweetorials. In brief, a tweetorial is a thread that someone posts usually addressing a medical question of sorts. Quickest way to understand a tweetorial: head over to this handle and check one out. Ever 1-2 weeks I find myself referencing a Tony Breu tweetorial during discussion of patient care/management.

Dr. Glaucomflecken**@DGlaucomflecken**

Would be remiss to mention Omnitensivist without mentioning Dr. Glaucomflecken, they often trade very entertaining exchanges. If you can't gather from the Twitter handle, he is a doctor of eyeballs. He is also a comedian and writer for Gomerblog. His Twitter is a beautiful combination of these passions. If you want to show off your comedic flair on Twitter this handle is a great example of how to do so while addressing serious medical issues/healthcare complexities. Also creates some great #FOAMed for eyeball stuff which I have found very useful!

Clinical Problem Solvers**@CPSolvers**

A Twitter handle for an awesome new podcast. I like this account because they do a ton of #FOAMed, not just through their podcast but all the diagnostic schema that they produce and provide both on their website and on Twitter. If you are interested in producing/distributing #FOAMed content, a good account to follow to see one way of doing it.

Rick Pescatore, DO**@Rick_Pescatore**

Emergency Medicine doctor. Important to make sure you follow figures in fields outside of your own that you regularly interact with. He is a very different flair from many other physicians on Twitter- personally very active and engaging with the general public, and stands firm in evidence-based medicine. It helps that he really knows his stuff and has the sources ready to go when needed. If you're interested in actively engaging with all-comers, this is a great account to follow to see one way of doing it. Also a great contributor to #FOAMed.

Improving Med-Peds Engagement Through Research

We are interested in developing a resource for medical students to access and become engaged in research and have the opportunity to work with Med-Peds physicians at all levels of training and practice, to be available online through the NMPRA website.

Please complete the survey to let us know if you're interested and what your thoughts are regarding this initiative:

<https://goo.gl/forms/jTDiabGVuVJad2B73>

- Jonathan Li, Sidney Kimmel Medical College, Thomas Jefferson University

