



UFHealth
UNIVERSITY OF FLORIDA HEALTH

Consult Handbook



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Anesthesia

General consult – Scheduling for procedure

- Who is the consulting service?
 - o What type of surgery?
 - o Where is the patient located?
 - o MRN
- Significant PMH (neurologic/neuromuscular disorders, cardiac disease, airway disease, reflux)
- Cardiac history (MI, Echo, EF, Pacer/AICD, pulmonary HTN)
- Vital signs (is the patient stable?)
- Pertinent labs (H&H/Plt/INR/BUN/Cr)
- Is the patient on any vasopressor support? If so, please include medications
- Airway status (trach/laryngectomy/mouth wired/intubated)
- Vascular Access
- Antibiotics
- Anticoagulants
- Any known complications with anesthesia in the past?

Pain consult – APS

- Who is the consulting service?
- Who is the attending ordering the consult?
- Call back number for resident/fellow/attending
- Primary reason:
 - o Management
 - o Discharge planning
- If requesting intervention:
 - o Does the patient want/consent to intervention? (verify before consult)
 - o NPO status
 - o Are they on anticoagulation therapy?
 - o Coagulation labs
- If requesting intervention for rib fractures:
 - o Baseline respiratory status
 - o FiO₂ support?
 - o SpO₂ currently
 - o Respiratory rate, and volumes achieved with incentive spirometry
- Pump issues:
 - o Call charge nurse on floor
 - o Call charge nurse on 6W for further assistance
- Intrathecal pain pumps are managed by the chronic pain service

Cardiology

The Cardiology consult service at Shands can be contacted by Spok. A Spok message is preferred instead of calling the phone for a consult request due to the busy nature of the consult service.

At the VA, the cardiology service can be reached by calling the consult phone (352-538-7514) Monday through Friday from 7 am to 6 pm. After hours and weekends, please contact the operator to obtain the pager number for the on-call cardiology fellow. Although the cardiology consult service is available 24/7, please wait until the morning to contact cardiology for consults in which the recommendations will not impact management overnight.

Please keep the following things in mind when contacting the cardiology service for a consult:

- Always have a current ECG if calling about an arrhythmia, if not done within the last couple days
- If concerned for acute coronary syndrome, order stat ECG and troponins
- If a patient is being treated for an NSTEMI, please obtain an ECG with each troponin draw to monitor for dynamic ECG changes
- Elevated troponin is not diagnostic of a myocardial infarct and must be interpreted in clinical context (ie sepsis vs chest pain). Please do not order a troponin unless you are concerned for myocardial ischemia!
- If the patient has not had a recent echo within the past 6-12 months, please order a repeat
- Know when the last ECG, echo and/or heart catheterization was done, and have the results available
- If you are concerned a patient is in decompensated heart failure, make sure they have had a BNP, otherwise order one
- Patients with known heart failure and a reduced ejection fraction do not need a repeat echocardiogram every time they are admitted for decompensated heart failure
- If a patient has an abnormal MPS with SDS >3, keep patient NPO in case of possible left heart catheterization the next day. These patients can be seen by the consult service the following morning if stable.

Patients followed by the heart failure/transplant service may be admitted to the heart failure (MCH) service if they are here for decompensated heart failure. Patients with complex disease (including but not limited to LVAD, heart transplant, end-stage disease on home inotropic support) are usually admitted to the MCH service.

Patients with routine NSTEMIs or simple chest pain rule outs may be admitted to the interventional cardiology (MCI) service. The MCI extender is usually the point of contact for these admissions Monday through Friday 7 am - 5 pm, otherwise contact the on-call fellow.

Dermatology

Please upload photos of the area(s) of concern that prompted consultation to the “Media” tab in Epic prior to contacting the Dermatology Service.

Emergency Medicine

As a consultant calling back recommendation, please call back or discuss recommendations in person rather than leaving notes or sending Spok messages. Because of the frequent sign-outs in the ED, residents there do not use Spok mobile to receive return messages. Instead, they carry phones with direct lines.

As a department, the ED residents will answer those phones at all times unless actively involved in a sterile procedure or trauma alert. Receiving return calls and recommendations in a timely manner is especially important to expedite patient care in the ED because the majority of consults are placed to determine disposition and they are not able to move patients out of the ER (home or inpatient) without those recommendations.

GI, Hepatology, Nutrition

There is a separate GI and Liver consult fellow in Spok since they are different services

GI:

- always make sure pt is NPO >4-6hrs if calling for concern in doing any upper or lower endoscopy
- know when last EGD/Colonoscopy were performed
- know if patient is on blood thinners and when they were last taken
- Make sure Plts (CBC) and INR have been ordered
- check iron panel prior to giving blood transfusions
- patient cannot get colonoscopy next day if they are eating solid foods (need to be on clear liquids allday prior to colonoscopy)
- can utilize colonoscopy prep order set for bowel prep
- Make sure to page the right service. There is a separate GI and Liver consult fellow in Spok since they are different services

Liver:

- check LFTs not CMP for transaminases
- For a transaminitis, check RUQ US, acute hepatitis panel
- if mass/lesion or portal thrombus seen on liver with RUQ US obtain triple phase CT liver
- check if patient is known to Hepatology office (who is the patient's Hepatologist and when were they last seen)
- Make sure to page the right service. There is a separate GI and Liver consult fellow in Spok since they are different services

Internal Medicine

1. The internal medicine consult service is managed by an upper level resident working in conjunction with a hospitalist
2. The consult service functions both to answer clinical questions and participate in co-management of surgical patients
3. The service also functions as a procedure team. The IM consult team is happy to perform paracentesis, lumbar tap and in special circumstances, obtain central access
4. For procedural consult requests:
 - a. please have an up to date CBC and INR on the day you request the procedure
 - b. please keep in mind that the IM consult service does NOT see patients in east or south tower who are being followed by CCM, you would want to request their help instead in this circumstance
5. For general consult questions, we do not necessarily require any pre-emptive lab testing, but for informative purposes, here are examples of how our service might be of use:
6. Surgical team requests evaluation of AKI that does not seem to be severe enough to require HD
7. new onset leukocytosis or fevers that are poorly explained
8. Altered mental status in a patient with co-morbidities with concern for polypharmacy or a case of classic delirium (would not replace a neuro consult in cases of seizure, severe AMS or patients with focal deficits)
9. For surgical patients when co-management is requested
 - a. Please order daily labs and attempt to perform a correct med-rec at the time of admission
10. In certain circumstances, patients may develop a new problem while in the hospital that is unrelated to the specialty in the role as the primary team. When this occurs, assuming there is not ongoing operative planning or active management ongoing by the primary team, the IM consult service may act as a consult to determine if the patient is a candidate to transfer to the hospitalist service
11. This service should be used primarily for NEW problems or medical issues that arise. Patients who have placement issues or lack active non-surgical problems have a lower chance at being transferred.
12. Please be aware that medicine consults is active from 8 am to 5 pm during the week and 8 to 1 on the weekends. At other times the pager will be with the hospitalist in the ED and our services are limited.

Neurocritical Care

Typically, all consults go through the neurology service. The residents that get paged triage the consult and if they think a neurocritical care consult is needed they alert the neurocrit team. In general any neurology consult in any ICU comes to neurocritical care team but if you have a patient who is having myasthenic crises in MICU is a neurocrit consult. Also, the consult service is fairly new (July 2019). Another example is traumatic brain injury (TBI); these patients need neurocrit consult if they are in SICU or trauma ICU. Cold alerts need neurocrit consult as well.

To summarize, the primary teams should page general neurology on-call for new consults if they are unsure about which service to consult and they can direct the consult to neurocrit after triage, or if the primary team is sure about neurocrit consult then page the neurocrit on-call service. This service after-hours is covered by general neurology service and on weekends by general neurology and neurocrit attending.

The majority of the times, general neurology gets paged for below consults and they in turn notify the on-call neurocrit fellow. Also the list is not all inclusive. This is not location specific either, as neurologic emergencies may be evaluated at any level of care.

TBI

GBS

Myasthenic crises

Strokes (not all but hemorrhagic/hemispheric where malignant cerebral edema is expected)

Hyperammonemia

Cold alerts

Status epilepticus

Meningitis

Encephalitis

Altered Mental Status/Metabolic encephalopathy

Cardiac arrest

Neuroprognostication and family meetings at will of primary teams

Hypernatremia

Hyponatremia

Lumbar drain management along with neurosurgery

EVD management along with neurosurgery

Any neuro emergency

Brain Death

General neurology pager: 352-413-1234

Neurocritical Care consult pager: 352-413-9268

Neurosurgery

Step 1: imaging showing CNS pathology uploaded into visage prior to paging neurosurgery service

Step 2: page brief message with MRN # and call back number to our on call pager.

Step 3: when neurosurgery calls back state only the following: patient's name, MRN #, room #, 2 sentence reason for consult, any positive exam findings, and whether the patient is on blood thinners (please know if the patient is on antiplatelet agents or anticoagulation.) If we want any additional information, we will ask for it.

We will do our best to call back with any recommendations. We try to get our consults staffed as quickly as possible with the understanding that sometimes our attendings are in emergent cases.

Obstetrics & Gynecology

Prior to consultation, please obtain when relevant:

1. Urine or blood HCG (unless postmenopausal)
2. Transvaginal US
3. Type and screen & CBC & CMP
4. HIV, HepC Ab, HepB Ag, Syphilis screen, Gonorrhea/Chlamydia urine screen
5. Postmenopausal patients with adnexal masses - Ca125, CEA, Ca19-9
6. At least a cursory attempt at a pelvic exam (even if just looking externally)

Orthopaedic Surgery

The orthopaedic surgery service can be contacted by paging 352-413-3728 for CONSULTS ONLY. All consults, regardless of patient age or pathology should proceed through the Trauma team unless otherwise directed. If you are trying to contact the service for follow up, dressing issues, or other floor questions, please reach out to the team through the floor pager at 352-252-0689. Both of these options are available through Spok as well, listed as "Orthopaedics New Consults 1st Call" and "Ortho Floor Oncall Pager" respectively. These guidelines apply 24 hours a day, seven days a week.

Fractures/Dislocations

Imaging

- Always have an X ray in Visage prior to calling the consult. The most appropriate set of imaging is X Ray to begin, which should be obtained even if advanced imaging like CT or MRI is available.
- All X rays should include at least two views, AP and lateral. X Ray of a joint as ordered in Epic is appropriate
- For a fracture of a midshaft bone, please obtain a dedicated X Ray of the joint above and below the fracture. (e.g. Tibia fracture, also include ankle and knee X rays or Forearm fracture, Obtain wrist and elbow X rays). If there is a fracture at a joint (e.g. Tibial plateau), obtain imaging of the bone above and below the fracture (e.g. Femur and tibia/fibula for Tibial plateau).
- This is especially important for hip fractures (intertrochanteric femur or femoral neck fractures). For these fractures, and AP Pelvis and full length femur films are necessary.

Clinical History

- Is the fracture open or closed (is the skin torn/lacerated over the fracture?). If there is concern for open fracture, antibiotics should be administered IMMEDIATELY
- If there is skin compromise, a clinical photo in the media tab is helpful. Please try to orient the limb in the photo

Specific Fractures

- Proximal Humerus fractures: XR of the shoulder MUST include either an axillary lateral or a Velpeau view. Scapular Y is NOT a substitute
- AC joint separation: Axillary lateral is helpful to classify the fracture
- Acetabular fractures should include Judet Views. Pelvic rami or sacral fractures should have Inlet/outlet views
- Patella fractures: Sunrise view of the knee is helpful
- Ankle fractures: DO NOT ORDER A STRESS VIEW. If indicated, this will be ordered by the orthopaedic resident.

Abscess

Imaging

Obtain a plain film of the part of the extremity that is involved. CT should not be obtained unless the mass is deep. IF a CT is ordered, it MUST BE WITH CONTRAST, unless contraindicated due to patient factors.

Labs

CBC, ESR, CRP. If concern for necrotizing fasciitis, call General Surgery

Clinical History

It is important to know what prior antibiotics they had been given and how long they took them.

Clinical Picture

Helpful, but not necessary

Septic arthritis

Imaging

Plain film of the joint is mandatory

Clinical history

Prior surgery at that joint, length of onset, history of gout, ability to bear weight, ability to tolerate range of motion of the joint, current bacteremia or systemic infection.

Labs

CBC, ESR, CRP

ALWAYS MAKE A PATIENT NPO IF CONSULTING FOR SEPTIC ARTHRITIS

Foot Ulcer

-If the patient is diabetic, has an elevated A1c, or elevated glucose, call Vascular Surgery first. They have the first right of refusal for the consult. If they are called and defer to orthopaedic surgery, please lead with this in the consult call.

Toenail Trimming

This is not an orthopaedic consult and can be referred to outpatient Podiatry. There is no inpatient podiatry service

Pediatric Consults

Imaging

The rules for plain films as above apply to pediatric patients, but often times an XR of the extremity will cover the joint/bones above and below the area of concern. Please do not call unless imaging is in visage.

Clinical history

Patient NPO time is extremely relevant. If they are not NPO, make them NPO prior to consulting. If the fracture is open, this is clinically relevant and antibiotics should be administered IMMEDIATELY.

If the patient will likely need a reduction (Both bone forearm fracture, tibia, ankle that is displaced) please determine time able to sedate the patient (whether ED Staff or Anesthesia staff)

Specific fractures

Supracondylar Humerus fracture: Obtain XR of the wrist for secondary fracture of the distal radius/ulna

Clinical pictures are helpful, but not necessary

Ophthalmology

Ophthalmology is the field of medicine specializing in the medical and surgical management of disease within the eye as well as its surrounding structures. Our service is happy to help you with patients from the newborn nursery to geriatrics and all ages in between. Here's a few pointers we can offer that will help you help us when you place a consult:

Why am I calling?

This is the first question you should ask. For patients with *acute* vision loss or eye related symptoms or issues, our service should be involved with their care. If the problem has been ongoing (months to years), we are still happy to help but based on the information you provide us we may suggest seeing the patient in a less acute setting, such as one of our clinics.

Who do I call?

Adult inpatient consults or emergency department patients:

Monday – Friday 8am – 5pm: 352-413-4380

Weekends, holidays or any day from 5:01pm to 7:59AM is the call phone: 352-494-6150

Pediatric inpatient consults or emergency department patients:

SPOK

Outpatient consults (you are calling from a clinic)

Monday – Friday 8am – 5pm: 352-494-6150

What information should I have at hand when I call?

Please include patient's **MRN, last name, location & your reliable callback number**. A brief vignette is helpful (65 yr female with suspected open globe), but not critical.

Our vital signs are the patient's **best corrected vision, pupil responses** and **intraocular pressure**. Aside from the emergency department, checking intraocular pressure is not necessary by the service requesting our help. However, *checking a patient's vision and pupil responses are well within the capabilities of all of us who graduated from medical school* and it is expected when you contact our service as this information helps us triage our patients. If you do not have a vision card (which are found on most lab coat pocket guides) you can use a chart printed from the web which will give us a rough estimate of the patient's visual acuity . The vision should be checked with the patient's glasses on if they have them.

Past ocular history:

- Have we seen them in our clinic? (Chart review – notes – filter for ophthalmology)
- Have they had any eye surgeries?
- Are they being treated by an outside ophthalmologist or optometrist for an eye condition?
- Do they take eye drops?

When should I call back?

If you haven't received a call from within a few minutes of your request. If this is about an update about a patient who is admitted and our service is following, the pager or call phone is your best bet. When possible, we prefer to treatment outline or recommendations in our consult notes and these will be helpful for you.

Any other tips?

Please remember that eye drops are sight preserving in many of our patients and should be carried over from outpatient medication regimens, even in patient's who are not being cared for by our service while in the hospital. We look forward to working with your service and if you have suggestions on how we can improve our service to you and our patients, please let us know.

Otolaryngology

- Epistaxis:
 - Prior to ENT consultation, please try holding firm, constant pressure on the nasal dorsum for at least 15 minutes. Have the patient lean forward to avoid swallowing blood. If this does not resolve bleeding, spray two large sprays of afrin in each nare and repeat. Control any hypertension. If bleeding continues despite these measures, then may proceed with ENT consult.
- Tracheostomy consults:
 - please confirm with the patient's family/medical decision makers that they would like to proceed with tracheostomy prior to ENT consultation.
- ED procedure consults (peritonsillar abscess, incision and drainage, otitis externa with debridement, etc) - Please ensure the patient is in an ED bed space with suction available in order to expedite care. We are unable to perform these procedures in hallway beds.
- Please note there is a separate pediatric ENT pager for peds consults.

Pediatric Psychiatry

Pediatric Psychiatry Consult Coverage Schedule

ROUTINE Pediatric Consult Requests (Preferred times for all non-urgent consult requests)

	Monday	Tuesday	Wednesday	Thursday	Friday	Weekend/ Holiday
AM						
PM	Pediatric Psychiatry Consult Team Rounds Dr. Pumariega		Pediatric Psychiatry Consult Team Rounds Dr. D'Alli		Pediatric Psychiatry Consult Team Rounds Dr. Pumariega	
After 4pm						

URGENT Pediatric Consult Requests (which cannot wait for Pediatric Psychiatry rounding times)

	Monday	Tuesday	Wednesday	Thursday	Friday	Weekend/Holiday
AM	General Psychiatry Consult Service	General Psychiatry Consult Service	General Psychiatry Consult Service	General Psychiatry Consult Service	General Psychiatry Consult Service	General Psychiatry on call SPOK
PM	Pediatric Psychiatry Consult Team Rounds Dr. Pumariega	General Psychiatry Consult Service	Pediatric Psychiatry Consult Team Rounds Dr. D'Alli	General Psychiatry Consult Service	Pediatric Psychiatry Consult Team Rounds Dr. Pumariega	
After 4pm	General Psychiatry on call SPOK	General Psychiatry on call SPOK	General Psychiatry on call SPOK	General Psychiatry on call SPOK	General Psychiatry on call SPOK	

- Pediatric Psychiatry Consult Team will round on patients at the times listed above
- General Psychiatry Consult Service and General Psychiatry on call will respond to consult requests that cannot wait until Pediatric Psychiatry Consult Team rounding, with access to pediatric psychiatry fellow or attending consultation.
- Please contact Pediatric Psychiatry Consult SPOK as well as placing order through Epic under PEDS PSYCHIATRY.

- We will follow up on all patients unless we sign off on them; in that case we will let the primary team know that we are signing off on the patient
- Please contact Dr. Andres Pumariega at 610-223-9980 at any time for backup or any questions. Dr D'Alli (at 919-812-5138 cell) will serve as backup.

Information needed from primary team prior to consult:

- Consent from parent/guardian is required for psychiatry to see any pediatric patient unless it is a safety evaluation. Please make sure parents have consented and document it in EPIC prior to placing the consult.
- Send SPOK with Team/Service and callback name/number for us to give our recommendations to the appropriate providers
- Reason for consult- should also be documented in Epic note and psychiatric history should be taken. Please be as specific as possible about the question you would like us to answer. For example, “how to manage this child’s delirium” or “evaluate for safety/Baker Act criteria.”
- If possible, a good time to see the patient and patient’s possible discharge date
- If patient’s needs are therapy only, please consider consulting PSYCHOLOGY

Radiation Oncology

- Relevant history to know:
 - Has the patient received radiation before? If so, to what region? Where did they receive radiation treatments?
 - Duration of symptoms, especially neurologic (acute or chronic?)
 - Prior tissue biopsy confirming malignancy? Where/when performed? What was biopsied? We must have a copy of report.
- Example consults:
 - Symptomatic malignant spinal cord compression:
 - Ensure tumor is what is causing the cord compression – radiation can’t help with bone fragments in cord
 - Order steroids and MR of the entire spine STAT
 - Consult neurosurgery first for operative evaluation
 - Brain lesion with neuro changes:
 - Order steroids, MR Brain STAT
 - If asymptomatic brain lesions, outpatient Rad Onc referral
 - Bone Pain:
 - Will take 2 weeks for radiation to alleviate pain
 - Focus should be on immediate pain control
 - Optimize opioid regimen

- In general, outpatient Rad Onc referral
- SVC syndrome: first consult IR or pulmonary to evaluate for stent
 - Performing urgent, crude RT is slow and ruins the patient's chances of curative RT later
- Heterotopic ossification prophylaxis: please call us before the patient has surgery, or as soon as possible
- Other basic Rad Onc information:
 - We must have a tissue diagnosis before treatment
 - Not just by history, at least the pathology report (even if it is an outside record)
 - With some exceptions, radiation takes time (up to weeks) to start taking effect. If immediate intervention is needed, please take appropriate action
 - Tumor causing mass effect → evaluate for surgical intervention first
 - Severe pain → find pain regimen that will bridge those weeks
 - For non-palliative or non-urgent radiation, we strongly prefer outpatient evaluation because we have much more modern equipment in our clinic for treatment planning
 - If you would like to place an outpatient referral, please enter an appointment request into Epic
 - Many patients starting radiation as an inpatient will be discharged from the hospital before its completion. Knowing the disposition plan is helpful for us.
 - Radiation treatment cannot be transferred mid-treatment to another center
 - Some rehab facilities will not transport the patient to outpatient radiation
 - If the patient lives far away, we can sometimes help arrange lodging while they finish radiation (Hope Lodge)
 - We need time to prepare a plan for our outpatient machines
 - For patients who are admitted to the hospital during their radiation treatment, you do not need to place a new consult to continue their treatments
 - Usually, our radiation therapists are aware that they are in the hospital and will help make arrangements to continue treatment on the inpatient machine, if it is appropriate to continue
 - If a patient is not stable enough to be on a floor, they most likely are not stable enough to travel to the machine to receive radiation (ex – IMC, ICU)

Radiology

Interventional Radiology Consultation Guide:

- 1) Place order in EPIC. – “Consult interventional”
 - a. There are multiple choices to choose from. The list of procedures available can be seen when you click the consultation.

Service		Type of Procedures	Daytime	On Call
Body	All consults require phone call / SPOK	<ul style="list-style-type: none"> Biopsy (Abdominal Mass, Breast, Chest Wall, Liver-Percutaneous, Lung, Lymph Node, Mediastinum, Pancreas, RENAL, RP Mass, Spleen, Thyroid) Chest Tube Drainage (Abscess, Lymphocele, Pericardial, Seroma) Paracentesis Thoracentesis 	278-2078 Ph: 278-2078	Resident 413-5512 SPOK: "int rad" - or - In House Nurse 50116 SPOK: "int rad nurse"
Head & Neck		<ul style="list-style-type: none"> Biopsy (Head & Neck) 	413-6759 - or - 46570	
Musculoskeletal (Ortho Institute)	All consults / orders require phone call	<ul style="list-style-type: none"> Consult Required <ul style="list-style-type: none"> Biopsy (Bone, Soft Tissue, Spine) NO Consult Required, Place Order in EPIC <ul style="list-style-type: none"> Arthrocentesis Arthrogram Bursa Injection Drainage (Abscess, Aspiration) Spine (Lumbar Epidural Steroid Injection, Lumbar Nerve Root Injection, Myelogram) Tenogram 	273-7159	
Spine (Ken Hospital)		<ul style="list-style-type: none"> Blood Patch Discogram Lumbar Puncture (Diagnostic, Therapeutic, Chemo Injection) Myelogram 	413-6759 - or - 46570	
Visceral	EMERGENT consults require phone call / SPOK	<ul style="list-style-type: none"> Ablations (Cryo, RFA, IRE) Arterial/Venous - Non-Neuro (Angioplasty, IVC Filter Placement/Removal, Thrombolysis, etc.) Biliary (PTHD, etc.) Central Venous Access Embolizations (Bronchial, GI bleed, Oncologic, Pre-Op, Trauma, etc.) Epidural (Steroid Injection) Facet Joint Injection, Median Branch Block Feeding Tubes (G, GJ) Fistulograms / Decolts Liver Biopsy - Transjugular Nerve Root Injection Portal Procedure (TIPS, BRTO, Thrombolysis, etc) Renal (PCN/NU Placement, Exchange, Removal) SI Joint Injection Suprapubic Catheter Placement Vertebral/Sacral Augmentation (Vertebroplasty, Kyphoplasty) 	x50116 x50116 Pg: 413-5512	50116 - or - 413-5512 - or - SPOK: "int rad"
Neurovascular		<ul style="list-style-type: none"> Cerebral Angiogram +/- Intervention Spinal Angiogram +/- Intervention Note: If angiogram +/- ambo needs to be ordered, NEUROSURGERY should call 494-4982 to place Verbal Order for procedure 	Outpatients (Clinic) 265-0621	413-4736

- 2) Page/SPOK the appropriate IR service if the request is urgent, emergent, or needs to be discussed. Request for same day procedures should also be placed ASAP in the morning, and it must be understood that this is not always possible to accommodate them into the schedule.

Consult to Visceral Interventional Radiology

Process Inst.: Ablations (Cryo,RFA,IRE), Arterial/Venous Procedures -Non -Neuro (Angioplasty, IVC Filter Plc/Rem, Thrombolysis, TIPS ,etc), Biliary (PTHD, etc), Biopsy (Renal, TJLBx) Central Venous Access/ Fistulograms/ Declosets, Embolizations (Bronchial, GI bleed, Oncologic, Trauma, etc), Feeding Tubes (G, GJ), Renal (Nephrostomy Placement, Exchange, Removal)

The Interventional service will place the proper radiographic order AND requested labs/micro/path. ASAP or STAT consults require a call to the respective service. See reference link below

Priority: Routine Routine STAT

Frequency: ONCE Once

Starting: 11/15/2019 Today Tomorrow At: 1415

First Occurrence: Today 1415

Scheduled Times ↗
11/15/19 1415

Reason for Consult?

Procedure Requested:

Laterality: Left Right Bilateral N/A

Contact person for this request:

Service for Contact person:

Phone number for contact person:

Requires General/MAC Anesthesia? Yes No

Are they consentable? Yes No

Requested Lab/Micro/Path: None

Reference: [1. Click here for the IR service numbers and On Call contact information](#)

Links: [Comments: + Add Comments \(F6\)](#)

Next Required **Link Order** **Accept** **Cancel**

ALL required boxes must be filled out appropriately. Contact numbers must be working phone numbers. "SPOK only" is not acceptable.

- 3) In general for IR procedures, platelets need to be above 50 and INR less than 2.5. This varies depending on the procedure and the patient's clinical picture. Additionally, anticoagulation must be held for most nonemergent cases, and reversed in most emergent cases. Be aware of patient's allergies, specifically to IV contrast, as this may limit our ability to treat a patient appropriately.

For the following commonly performed procedures, the following are required:

Abscesses – Imaging, Coags, CBC – Trending WBC

Biopsies – Imaging, Coags, CBC

Bleeds – Trending CBCs, Coags +/- TEG, Imaging (GI Bleeds – 3 phase CT unless bleeding source is apparent on EGD)

Tunneled lines – Negative blood cultures x48 hours, CBC, Coags, BMP.

Cirrhotic / Liver failure patients – TEG, MELD score labs – LFT/BMP, CBC

Nephrostomies – Imaging, CBC, Coags, BMP

Lumbar Punctures – Coags

Please contact the appropriate interventional service should there be any concerns or question regarding specifics regarding required labs/imaging.

After hours and weekends consults – Urgent and emergent procedures need to have their request placed into EPIC and the IR resident on call paged (413-5512 for all services after 5pm and on weekends) or contacted via SPOK (Interventional radiology resident). Appropriate consultations include internal bleeds, abscesses in clinically declining patients, infected obstructed biliary trees, infected obstructed kidneys, lumbar punctures for meningitis if the primary service fails, infected lines in a declining patient, and septic joints.

Emergent central lines should be placed by the primary service, ER, or the ICU. If unable to be placed, these can be done on an emergent basis. PICC placement should be attempted by the PICC team prior to consulting IR.

Routine consultations do not need phone calls after hours. These will be reviewed on the next working day.

Outpatient consult - An outpatient consult order can be placed in EPIC via the “Appt req interventional radiology”. Please fill out all the required boxes appropriately.

Cancelling a procedure - To cancel a scheduled interventional procedure, place an additional consult order with the request to cancel the procedure in the reason for consult box. Please call interventional radiology at x50116 as well to ensure the patient is not called for.

While on EDUROAM or UFHEALTH Wi-Fi (or while on Pulse Secure VPN)

<https://ir.xray.ufl.edu/helpme/hm.asp>



Surgery

- NPO status
- Anticoagulation status (indication and last dose of anticoagulant or anti-platelet medication)

SURGICAL FEEDING TUBE ACCESS CONSULTS

The Division of **Minimally Invasive and Bariatric Surgery** is the appropriate service to contact for inpatient - feeding access under the following conditions:

- The patient has previously been operated on by a UF MIS surgeon
- The patient has a history of bariatric surgery
- The patient has a history of advanced foregut surgery (gastrectomy, esophagectomy, other roux-en-y gastric reconstruction, etc)

If the patient in question does not meet one of the above criteria, a surgical feeding tube access consult should be first directed to the **Acute Care Surgery** service.

Thoracic Surgery

Common Thoracic Surgery Consults

Hydrothorax/Hemothorax/Chylothorax (or Pleural Effusion)

What is it?

Excessive fluid (blood, chyle) that has accumulated outside of the lung parenchyma. Complicated versions have loculations or septations interspersed throughout the effusion.

Initial Workup

Chest X-Ray, CT chest (if suspected complicated)

Initial Intervention

Chest tube (large bore if hemothorax), fluid analysis (e.g, Light's criteria), fluid culture, fluid cytology if suspected malignant effusion, chylomicrons and extreme low fat diet for chylothorax.

If continued high chest tube output or loculated, three days of tPA via chest tube. If malignant effusion, consult pulmonology for long-term chest tube (e.g., PleurX™ catheter). If chylothorax, recommend consulting IR for lymphangiogram if not controlled by diet and trial of octreotide (Sandostatin®)

When to Consult Thoracic Surgery

Failure of tPA therapy, workup is not consistent with kidney failure (nephrotic syndrome), malignancy, congestive heart failure or other cases where a surgery would not lead to successful treatment.

If the lung remains uninflated after sufficient drainage of fluid, the lung is said to be trapped, and requires surgical intervention. A VATS vs open decortication may be useful in a setting where the pathology is isolated to the lung.

If chylothorax not amenable to IR intervention or IR intervention failed to treat problem, surgical ligation of lymphatics can be attempted if IR was able to localize the leak.

Questions We Will Ask You

How long has the effusion been occurring, have you tried tPA, comorbidities, workup to suggest pulmonary problem, recent imaging

Empyema (aka pyothorax, empyema thoracis)

What is it?

Collection of purulent fluid in the pleural cavity. Usually present as pneumonia, systemic infection (SIRS/sepsis), a complication from recent surgery, or as simply shortness of breath and chest pain. Rarely as a delayed complication of penetrating trauma.

Initial Workup

Chest X-ray, CT chest with contrast, antibiotics. Bedside ultrasound, if available, of chest can see loculations if fluid collection is large enough

Initial Intervention

Chest tube or thoracentesis, fluid Gram stain and culture. Chest tube that slows in drainage but imaging continues to demonstrate empyema can benefit from 3 days of tPA via chest tube.

When to Consult Thoracic Surgery

Continued signs of sepsis/respiratory problems despite adequate antibiotic coverage and chest tube drainage. Re-accumulation of fluid after removal of chest tube.

Questions We Will Ask You

Microbe if known, comorbidities, recent imaging.

Pneumothorax (PTX)

What is it?

Air outside of the lung parenchyma

Initial Workup

If significant acute respiratory distress and hemodynamic compromise → needle decompression and chest tube placement

If stable, chest X-ray, ABG, CT chest to assess underlying pathology. +/- EKG.

Initial Intervention

If stable, no immediate intervention is necessary.

If small PTX with respiratory symptoms, pigtail catheter by IR.

If large PTX with respiratory symptoms, but not unstable, a chest tube should be placed for decompression (thalquick or large bore)

If unstable, chest tube.

Do not use positive pressure ventilation (intubation, CPAP, BiPAP) until underlying etiology known.

When to Consult Thoracic Surgery

For second (or beyond) incidence of spontaneous pneumothorax or if there is a prolonged (> 3 days) air leak after chest tube placement that is not amenable to interventional pulmonology intervention, a pleurodesis procedure can be performed.

Questions We Will Ask You

Known cause, how long have they had chest tube, prior chest tubes, prior chest surgeries

Pneumomediastinum

What is it?

Air in the mediastinum usually after a coughing fit, asthma attack, or protracted emetic episode.

Initial Workup

Chest X-Ray and/or CT chest. If there is concern for or suspected perforated esophagus, the **best test** is a CT Esophogram (or fluoroscopic esophogram if patient cannot tolerate drinking the PO contrast).

Initial Intervention

None. The most common cause of pneumomediastinum is called the Macklin Effect, where increased alveolar pressure causes alveoli to tear or rupture, allowing air to track along the peribronchial tracts and dissecting the connective tissue in the mediastinum.

When to Consult Thoracic Surgery

After a CT Esophogram is ordered. Esophageal perforation patients are usually very ill-appearing, and have significant laboratory abnormalities. Seldom are they hemodynamically stable, on room air, talking comfortably, and have a normal white count.

Questions We Will Ask You

How long have symptoms been going on, associated symptoms, have you ordered a CT esophogram. Hemodynamics and pressor requirements, labs, antibiotics, consentable

VV ECMO

What is it?

Venovenous extracorporeal membrane oxygenation (VV ECMO). VV ECMO assists in respiratory support and gas exchange, it does not bypass the heart. That means if there is significant hemodynamic instability or a failing heart, this is not the correct intervention.

Initial Workup

Securing airway, blood gases, Chest X-ray and/or CT chest. Drain pleural effusions if applicable.

Initial Intervention

Aggressive ventilator management and pulmonary hygiene including pulmonary arterial dilators (epoprostenol [Flolan™] or inhaled nitric oxide [iNO])

When to Consult Thoracic Surgery

If there is consideration of VV ECMO among the rounding team, early consultation is warranted, as rapid decompensation of the patient can lead to catastrophic outcomes. If there is no clear recovery pathway (e.g., a nonreversible condition) then VV ECMO is never indicated. Common pathologies requiring VV ECMO include pneumonia, ARDS, pulmonary embolism, or bridge to lung transplant.

Venoarterial (VA) ECMO is for cardiac failure, massive pulmonary embolism causing heart failure, or bridge to ventricular assist device or transplant, which is the purview of Cardiovascular Surgery.

Questions We Will Ask You

How long has respiratory difficulty been going on, likelihood of recovery, ventilator settings, recent blood gas, what drips is the patient on, has this patient been paralyzed, has the patient been proned. What is this a bridge to, i.e. to recovery or a lung transplant.

Tracheal Stenosis

What is it?

Narrowing of the subglottic trachea, usually due to trauma, traumatic intubation, head and neck irradiation, or un- or undertreated reflux disease, that leads to respiratory problems and stridor

Initial Workup

History assessing respiratory distress. CT neck.

Initial Intervention

Noninvasive ventilation or intubation if severe respiratory distress. Treatment of GERD (if present).

When to Consult Thoracic Surgery

Early in hospital course or after issue is diagnosed. If patient is hospitalized for respiratory issues, will likely need a tracheal dilation versus tracheostomy. If stable on room air, can be seen in clinic.

Questions We Will Ask You

Any identifiable reason for them to have the tracheal stenosis

Tracheostomy (Trach)

What is it?

A hole in the neck below the vocal cords through which a smaller ventilation tube can be placed. Used for ventilator weaning and/or post-hospital disposition planning.

Initial Workup

Enough to inform clinical suspicion that liberation from the ventilator will not occur within 10 days.

Initial Intervention

Wean ventilator settings to FiO₂ < 70%, PEEP < 10; correct coagulopathies/hold anticoagulants; control any local infections if present

When to Consult Thoracic Surgery

AFTER bringing the subject up with the patient and/or their family. Often, after a goals of care discussion where the decision is to proceed with aggressive measures. Thoracic Surgery is happy to be part of these discussions, but the primary team should broach the subject. This also facilitates obtaining consent from family

When Not to Consult Thoracic Surgery

When a service already has open consults with Trauma Surgery and ENT for the same procedure

Questions We Will Ask You

Why do they need a trach, is the patient ready, on any anticoagulation (enteral or gtt), any known cervical injury/surgery/radiation, someone available to consent

Percutaneous Endoscopic Gastrostomy (PEG) Tube

What is it?

A feeding tube with direct access to the stomach that sits, usually, in the left upper quadrant of the abdomen. These are for patients who will likely need > 30 days of supplemental nutrition for their recovery (think: strokes, progressive neurological diseases, trauma, cancers, burns). Can also be part of post-hospital disposition planning (some SNFs, SARs, IPRs, LTACs will not accept patients with Dobhoff tubes).

Initial Workup

CT abdomen, especially in: (1) obese patients, to assess lie of the liver or any interposed organs; (2) liver failure patients, to assess degree of ascites; (3) advanced abdominal/genitourinary cancer patients, if peritoneal carcinomatosis; (4) patients with prior gastric surgeries (e.g., gastrectomy, sleeve, roux-en-Y)

Initial Intervention

Establishment of enteral access (Dobhoff, NG tube) with proof that GI tract can tolerate enteric feeds; correction of sepsis, correction of coagulopathies.

When to Consult Thoracic Surgery

AFTER bringing the subject up with the patient and/or their family. Often, after a goals of care discussion where the decision is to proceed with aggressive measures. Thoracic Surgery is happy to be part of these discussions, but the primary team should broach the subject.

When Not to Consult Thoracic Surgery

When a service already has open consults with Trauma, gastroenterology, and/or interventional radiology for the same/similar procedure.

Questions We Will Ask You

Why they need it, is the patient ready, on any anticoagulation (enteral or gtt), any known cancers, any recent imaging, any prior gastric surgery, someone available to consent

Jejunostomy Tube (J-tube)

What is it?

A feeding tube with direct access to the jejunum. These are for patients who will need long term supplemental nutrition, usually in the setting of an esophageal gastroesophageal junction mass where the stomach is being preserved as a potential gastric conduit.

Initial Workup

If esophageal mass, full cancer workup.

Initial Intervention

Correction of coagulopathies. Possible TPN for nutrition depending on nutritional status of patient.

When to Consult Thoracic Surgery

After completed cancer workup.

When Not to Consult Thoracic Surgery

When a service already has open consults with MIS or Trauma/Acute Care surgery for the same/similar procedure.

Questions We Will Ask You

Why they need it, is the patient ready, on any anticoagulation (enteral or gtt)

Lung Nodule or Chest/Mediastinal Mass

What is it?

A lesion in the thoracic cavity, usually incidentally found on imaging for other reasons. Can be lung nodule or mediastinal mass.

Initial Workup

Lesion-specific imaging, all patient should have a CT Chest. If a lung based-nodule then the patient should have pulmonary function tests (PFTs), which help determine if a patient is an operative candidate, i.e. if they can tolerate a lung resection and tolerated single-lung ventilation.

Initial Intervention

Comparison to prior imaging. Tissue diagnosis via IR-guided biopsy may also aid in diagnosis.

When to Consult Thoracic Surgery

Most of these are on an outpatient basis as they are typically a new finding of a chronic problem.

Questions We Will Ask You

Is there a tissue diagnosis and most recent imaging and PFTs.

Esophageal Mass

What is it?

A mass in the esophagus

Initial Workup

EGD with biopsy, Endoscopic ultrasound, cancer staging scans if applicable (CT chest/abdomen/pelvis; PET)

Initial Intervention

Tissue diagnosis via biopsy – usually endoscopic.

When to Consult Thoracic Surgery

Most of these are on an outpatient basis.

Questions We Will Ask You

Is there a tissue diagnosis

Sternoclavicular Junction Infection

What is it?

Infection of the sternoclavicular joint, often with underlying osteomyelitis

Initial Workup

CT chest with contrast, MRI if suspected osteomyelitis

Initial Intervention

Sepsis workup including blood cultures, antibiotics

When to Consult Thoracic Surgery

Early in course if there is a sternoclavicular junction infection

Questions We Will Ask You

Risk factors, if known – IVDU, diabetes, recent trauma, CLABSI, other infectious source

Common Cardiac Surgery Consults

Coronary Artery Disease (CAD)

What is it?

Acute or chronic blockages in the coronary arteries.

Initial Workup

EKG, transthoracic echocardiogram (TTE) to determine other valvular abnormalities and left ventricular ejection fraction. If a STEMI or NSTEMI is found then cardiology needs to consulted.

Initial Intervention

Cardiology consultation for evaluation of coronary arteries via left heart catheterization (LHC).

When to Consult Cardiac Surgery

If cardiology recommends a cardiac surgery evaluation. Findings of CAD on LHC in the setting of stable angina or asymptomatic may be able to be an outpatient evaluation.

Questions We Will Ask You

What their symptoms are, why they were admitted to the hospital (i.e. is this a finding unrelated to their presenting issues), do they have a recent TTE, do they have a recent LHC, have they had heart surgery before, can they tolerate being fully heparinized for cardiopulmonary bypass, are they on any anticoagulation, can they tolerate a cardiac surgery, what comorbidities do they have (i.e. patients with poor lung function may require a tracheostomy post-operatively, patients with CKD may require dialysis post-operatively), (see the STS risk score at <http://riskcalc.sts.org/stswebriskcalc/calculate> and the EURO score <http://www.euroscore.org/calc.html> for insight into risk stratification of cardiac surgery)

Aortic Aneurysm

What is it?

An enlargement in the aorta that is at least 1.5x the normal diameter of the aorta. We manage aneurysms that are in the aortic root, the ascending aorta, aortic arch, and thoracic aorta.

Initial Workup

CTA chest, abdomen, pelvis. Transthoracic echocardiogram (TTE) to determine any valvular abnormalities and left ventricular ejection fraction.

Initial Intervention

Comparison to prior CT scans are necessary. Aneurysms may often be able to be managed outpatient unless they are causing symptoms.

When to Consult Cardiac Surgery

Inpatient: symptomatic aneurysms, changes in known aneurysms, any concerning findings like dissection, rupture, end organ dysfunction. Outpatient: found incidentally as part of a work up for something unrelated.

Questions We Will Ask You

What their symptoms are, why they were admitted to the hospital (i.e. is this a finding unrelated to their presenting issues), do they have a recent TTE, do they have a recent LHC, have they had heart surgery before, can they tolerate being fully heparinized for cardiopulmonary bypass, are they on any anticoagulation, can they tolerate a cardiac surgery, what comorbidities do they have (i.e. patients with poor lung function may require a tracheostomy post-operatively, patients with CKD may require dialysis post-operatively, etc.), (see the STS risk score at <http://riskcalc.sts.org/stswebriskcalc/calculate> and the EURO score <http://www.euroscore.org/calc.html> for insight into risk stratification of cardiac surgery).

Aortic Dissection: Stanford Type A or Debakey Type 1 or 2

What is it?

A tearing of the inner lining of the aorta leading to blood dissecting the media layer leaving the aorta split into two channels: the true lumen and the false lumen. Patients may have an associated aneurysm. These are dissections that are in the aortic root, the ascending aorta, aortic arch, and may also include the thoracic/descending/abdominal aorta. Dissections are split into two classifications: Debakey and Stanford classification. A Standford Type A dissection implies the ascending aorta is involved, the Debakey Type 1 dissection implies there is a dissection in the ascending as well as the descending aorta, the Debakey Type 2 dissection implies only a dissection in the ascending aorta.

Initial Workup

CTA chest, abdomen, pelvis. Pulse exam.

Initial Intervention

Comparison to prior CT scans if available (sometimes patients have known chronic dissections). An acute dissection in the above categories are surgical emergencies. Acute dissections need a cardiac surgical consult immediately, arterial pressure monitoring, heart rate and blood pressure control via titratable drips (like esmolol and clevipipine).

When to Consult Cardiac Surgery

Inpatient: any acute dissections, changes in a known dissection. Outpatient: chronic dissections that are confirmed stable from prior imaging that are found incidentally as part of a work up for something unrelated.

Questions We Will Ask You

What their symptoms are, why they were admitted to the hospital (i.e. is this a finding unrelated to their presenting issues), are they neurologically intact, do they have end organ dysfunction, extent of the dissection, do they have a recent TTE, do they have a recent LHC, have they had heart/vascular/aortic surgery before, can they tolerate being fully heparinized for cardiopulmonary bypass, are they on any anticoagulation, can they tolerate a cardiac surgery, what comorbidities do they have (i.e. patients with poor lung function may require a tracheostomy post-operatively, patients with CKD may require dialysis post-operatively, etc.), (see the STS risk score at <http://riskcalc.sts.org/stswebriskcalc/calculate> and the EURO score <http://www.euroscore.org/calc.html> for insight into risk stratification of cardiac surgery).

Aortic Dissection: Stanford Type B or Debakey Type 3

What is it?

A tearing of the inner lining of the aorta leading to blood dissecting the media layer leaving the aorta split into two channels: the true lumen and the false lumen. Patients may have an associated aneurysm. These are dissections that in the thoracic/descending/abdominal aorta. Dissections are split into two classifications: Debakey and Stanford classification. Standford Type B and Debakey Type 3 dissection implies the descending aorta is involved. Any involvement of the ascending aorta changes the dissection type, please see prior section for description of Standford Type A and Debakey Type 1 or 2.

Initial Workup

CTA chest, abdomen, pelvis. Pulse exam.

Initial Intervention

Comparison to prior CT scans if available (sometimes patients have known chronic dissections). An **acute** dissection in the above categories require surgical consultation, arterial pressure monitoring, heart rate and blood pressure control via titratable drips (like esmolol and clevidipine).

When to Consult Cardiac Surgery

Inpatient: any acute dissections, changes in a known dissection. Outpatient: chronic dissections that are confirmed stable from prior imaging that are found incidentally as part of a work up for something unrelated. For these types of dissections there may be endovascular options for treatment, but sometimes these require open operations.

Questions We Will Ask You

What their symptoms are, why they were admitted to the hospital (i.e. is this a finding unrelated to their presenting issues), are they neurologically intact, do they have end organ dysfunction, extent of the dissection, do they have a recent TTE, have they had heart/vascular/aortic surgery before, can they tolerate being fully heparinized for cardiopulmonary bypass, are they on any anticoagulation, can they tolerate a surgery, what comorbidities do they have (i.e. patients with poor lung function may require a tracheostomy post-operatively, patients with CKD may require dialysis post-operatively, etc.), (see the STS risk score at <http://riskcalc.sts.org/stswebriskcalc/calculate> and the EURO score <http://www.euroscore.org/calc.html> for insight into risk stratification of cardiac surgery).

General Valvular Abnormalities

What is it?

An abnormal finding of a heart valve. There are 4 valves: tricuspid, pulmonary, mitral, and aortic.

Valves can be stenotic (letting not enough blood through) or have leakage/insufficiency (blood leaking backwards)

Initial Workup

Transthoracic echocardiogram (TTE) to determine type of valvular abnormalities and left ventricular ejection fraction.

Initial Intervention

Comparison to prior TTEs are necessary. Valvular abnormalities may often be able to be managed outpatient unless they are causing symptoms that cannot be managed as an outpatient. Mitral valve problems may often require a TEE to better delineate the problem. Patients require a LHC prior to cardiac surgery.

When to Consult Cardiac Surgery

Inpatient: symptomatic structural valvular changes with symptoms. Outpatient: found incidentally or with symptoms that are able to be managed outpatient.

Questions We Will Ask You

What their symptoms are, why they were admitted to the hospital (i.e. is this a finding unrelated to their presenting issues), do they have a recent TTE, do they have a recent LHC, have they had heart surgery before, can they tolerate being fully heparinized for cardiopulmonary bypass, are they on any anticoagulation, can they tolerate a cardiac surgery, what comorbidities do they have (i.e. patients with poor lung function may require a tracheostomy post-operatively, patients with CKD may require dialysis post-operatively, etc.), (see the STS risk score at <http://riskcalc.sts.org/stswebriskcalc/calculate> and the EURO score <http://www.euroscore.org/calc.html> for insight into risk stratification of cardiac surgery).

TAVR (Transcathetic Aortic Valve Replacement) for Aortic Valve Stenosis

What is it?

An abnormal finding of an aortic valve. Valves can be stenotic (letting not enough blood through) or have leakage/insufficiency (blood leaking backwards). Transcatheter aortic valve replacements are typically done for stenosis, are done typically through groin access, and does not require a sternotomy. These are good options for those who are higher risk surgical candidates, who are older, those with multiple comorbidities, have had prior heart surgery, etc. They must have a suitable aortic valve anatomy for a TAVR valve and must have adequate groin access for the deployment device.

Initial Workup

Transthoracic echocardiogram (TTE), EKG.

Initial Intervention

Comparison to prior TTEs are necessary. Valvular abnormalities may often be able to be managed outpatient unless they are causing symptoms that cannot be managed as an outpatient. Patients require a LHC.

When to Consult Cardiac Surgery

Inpatient: symptomatic aortic valve problems not able to be managed as an outpatient. Outpatient: found incidentally or with symptoms that are able to be managed outpatient.

Questions We Will Ask You

What their symptoms are, why they were admitted to the hospital (i.e. is this a finding unrelated to their presenting issues), do they have a recent TTE, do they have a recent LHC, have they had heart surgery before, can they tolerate being fully heparinized for cardiopulmonary bypass or partially heparinized for a TAVR placement, are they on any anticoagulation, can they tolerate a cardiac surgery or can they tolerate a TAVR procedure, what comorbidities do they have (i.e. patients with poor lung function may require a tracheostomy post-operatively, patients with CKD may require dialysis post-operatively, etc.), (see the STS risk score at <http://riskcalc.sts.org/stswebriskcalc/calculate> and the EURO score <http://www.euroscore.org/calc.html> for insight into risk stratification of cardiac surgery), have they had a TAVR protocol CT scan, have they had surgery on their groins, do they have any conduction abnormalities.

Infective Endocarditis

What is it?

An infection of a heart valve. There are 4 valves: tricuspid, pulmonary, mitral, and aortic. Valves can be stenotic (letting not enough blood through) or have leakage/insufficiency (blood leaking backwards). There may be a vegetation visible on the valve. Refer to Duke's criteria for diagnosis of endocarditis. Common causes are IVDU and dental abnormalities.

Initial Workup

Transthoracic echocardiogram (TTE) to determine type of valvular abnormalities and left ventricular ejection fraction. EKG. Blood cultures and antibiotics.

Initial Intervention

Comparison to prior TTEs, if applicable. Small vegetations may often be able to be managed with antibiotics alone. Mitral valve problems may often require a TEE to better delineate the problem. Patients need blood cultures, antibiotics, EKG, TTE, CTA Chest/Abdomen/Pelvis to look for septic emboli, may need CTA head or MRI to look for mycotic aneurysms. Stable patients require a LHC, as well as dental evaluation and teeth extraction (if needed) prior to surgery.

When to Consult Cardiac Surgery

When there are persistent positive blood cultures despite adequate antibiotics, if there is a prosthetic heart valve, if there are septic emboli, if there are conduction abnormalities, if there is an associated abscess, if the vegetation is large, if there is structural damage to the valve.

Questions We Will Ask You

What their symptoms are, why they were admitted to the hospital (i.e. is this a finding unrelated to their presenting issues), do they have a recent TTE, do they have a recent LHC, have they had heart surgery before, are they an active IV drug user and willing to quit, do they have problems with their teeth, can they tolerate being fully heparinized for cardiopulmonary bypass, are they on any anticoagulation, can they tolerate a cardiac surgery, what comorbidities do they have (i.e. patients with poor lung function may require a tracheostomy post-operatively, patients with CKD may require dialysis post-operatively, etc.), (see the STS risk score at <http://riskcalc.sts.org/stswebriskcalc/calculate> and the EURO score <http://www.euroscore.org/calc.html> for insight into risk stratification of cardiac surgery).

Infected Pacemaker

What is it?

An infection of or exposed pacemaker/generator.

Initial Workup

Blood cultures, EKG, antibiotics

Initial Intervention

TTE. Comparison to prior TTEs, if applicable. Evaluation with electrophysiology cardiology to determine dependency on pacemaker.

When to Consult Cardiac Surgery

When there are persistent positive blood cultures despite adequate antibiotics, if there is a pacemaker pocket infection, if the generator is exposed.

Questions We Will Ask You

What their symptoms are, why they were admitted to the hospital, do they have a recent TTE, why did they need the pacemaker, when was the pacemaker placed, are they pacemaker dependent, the risk of removal of the leads can be a perforation in the heart and require emergency heart surgery, can they tolerate being fully heparinized for cardiopulmonary bypass if they needed to, are they on any anticoagulation, what comorbidities do they have.

VA ECMO

What is it?

Venoarterial extracorporeal membrane oxygenation (VA ECMO). VA ECMO is a form of temporary mechanical support that is able to perform gas exchange for patients in acute cardiorespiratory failure. It is not the same as cardiopulmonary bypass, although they have similarities in the ability to maintain cardiorespiratory support.

Initial Workup

Determine reason for cardiorespiratory failure. MI, large PE, heart failure, etc.

Initial Intervention

Aggressive ventilator management and pulmonary hygiene, inotropic support, possible intra-aortic balloon pump

When to Consult Cardiac Surgery

If there is consideration of VA ECMO among primary team, early consultation is warranted, as rapid decompensation of the patient can lead to catastrophic outcomes. If there is no clear recovery pathway (e.g., a nonreversible condition) then VA ECMO is not indicated. VA ECMO is used as a bridge to recovery (large PE, cardiomyopathy, MI, post-operatively), a bridge to a more durable mechanical support (LVAD), or a bridge to a heart transplant.

Questions We Will Ask You

What their symptoms are, why they were admitted to the hospital, do they have a recent TTE, what is their EF, do they have aortic insufficiency, do they have a recent LHC, have they had heart surgery before, what mechanical support do they already have in place, what are the inotropic drips, what are the ventilator settings, can they tolerate being heparinized for VA ECMO, are they on any anticoagulation, what is the VA ECMO a bridge to, can they tolerate a cardiac surgery (if bridge to LVAD or transplant), what comorbidities do they have.

Urology

- Hematuria
 - Bladder scan
 - CBC, BMP
 - Do not start CBI without clearing bladder of clot burden- puts patient at risk for bladder perforation.
- Stones
 - CT – stone location, size, presence/absence of obstruction
 - CBC, BMP
 - UA/Urine culture
- Hydronephrosis
 - Seen on what kind of imaging
 - Unilateral or bilateral
 - CBC, BMP
 - UA/Urine culture

To reach the consult pager: M-F 6am-6pm 413-5777. After hours and weekends, refer to SPOK.