POCUS ANECDOTES

Minnesota ACP - 2016

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integrate and
• **CASE: 57 yo female**

• Presents to outpatient clinic

• “I have a sinus infection again and need antibiotics, please”
**VITALS**
- T: 98.5
- HR 75
- BP 128/72
- RR 12

**HEENT:**
- Minimal posterior erythema but _well demarcated_ area of erythema unilaterally over left upper palate.
- No tenderness to palpation over maxillary/frontal sinuses

**NECK:** Supple, no LAD

**RESP:** Clear

**CV:** RRR, no murmurs
Patient Transverse Sinus US

Right Maxillary Sinus

Left Maxillary Sinus
IMBUS-BREATHE STUDY

- Historically:
  - Our clinic Abx: 55% of patients with “Sinusitis, drainage, URI” (low to high pretest probability)
  - Observational reports in literature up to 80% of patients (13%
  - Suspected, 13% were probably inappropriate

- With maxillary sinus US:
  - 28% (28/101) have + maxillary sinus
  - 28% got abx, 72% did not
    - 1/73 returned and had isolated frontal on CT scan and received abx
    - 3/73 returned with persistent sx and then had positive US and received abx (11, 12, 9 days)
32 year old female, CC: Postop f/u, establish care

- Had gallbladder removed 7d ago for “cholecystitis”. Pathology showed grossly edematous gb without stones.
- Presents to clinic for postop followup and has some sob increasing since surgery, but present prior to surgery as well
- Exam: sinus tach (120), BP 110/70. Afebrile, sat 98%
  - “I found her lungs to be clear with diminished breath sounds on the R. Her heart sounds were distant, but I appreciated no rub or murmur. There was no JVD visible, but mild LE edema bilaterally to mid tibia. Abdomen was unremarkable.”
• Pulsus of 30mmHg
• 900cc blood removed
• Cytology, ANA, cultures, AFB/Silver, Mycobacterial Cxs = Negative
HPI:
Patient reports gradually increasing pain over the last two days. It is epigastric and does not radiate elsewhere except to her back with coughing. Denies n/v but unable to eat since yesterday given pain. Regular BMs. +chills, no fevers. Has had heartburn before but did not feel like this. Some shortness of breath when pain is present.

PHYSICAL EXAM:
General Appearance: NAD
BP 140/84 | Pulse 105 | Temp 98.4 °F (36.9 °C) | Resp 18 | Ht 1.626 m (5' 4'') | SpO2 98%
There is no weight on file to calculate BMI.
regular rate and rhythm
Clear to auscultation bilaterally
Abdomen soft, mildly tender in right upper quadrant, nondistended
Extremities warm/wp
47 YO WOMAN

- PMHx: Rheumatic heart dz with severe TR/MR and pulm htn

- CC: **RUQ Pain off/on** for months, worse today.
  - epigastrium with radiation through to back
  - LFTs normal
  - Outpt plan was for elective cholecystectomy 10 days from now due to gallstones and intermittent pain

- IVC 2.8cm no collapse, dilated hepatics, bilateral diffuse interstitial and small bilateral effusions

- Plan: Formal RUQ US in the AM, antibiotics if fever, aggressive IV diuresis
• HD#2 RUQ pain improved, minimal SOB, diuresed net -2.2L. IVC 30-40% collapse, significant decrease in interstitial pattern bilat

• Formal RUQ US: small stones, o/w normal gb

• Diuretics held as BP somewhat low and concern for early sepsis
HD#3 increased RUQ pain c/w biliary source, Wt up 1.2kg, SOB worse
IMBUS exam: “Put the probe where your stomach hurts the most when you push”

The sensitivity of the sonographic Murphy’s sign is reported from 75-86% with a positive predictive value of 92% when combined with the finding of gallstones.
47 YO WOMAN

- Increase diuresis, ?transient gb edema/obstruction as volume status increases
- ? wrong formal ultrasound on this patient’s chart
- Please repeat the formal US... can’t get to it till this evening (+4hrs)
- Discussed with radiology and reviewed images
Pt diuresed 3.8kg, and RUQ pain resolved. IMBUS shows...
TRANSIENT GB NECK OBSTRUCTION WITH VOLUME OVERLOAD
HAD TVR/MVR 6WK LATER

- no recurrent RUQ pain for 27 months, hasn’t had GB removed
TO THE OUTPATIENT WORLD FOR A COUPLE....
62 YO with “My COPD is going crazy and I’m out of meds”
ID: 54 yo woman with bipolar d/o, seizure d/o and cerebral palsy.

HPI:

- Seen 8/30/13 for a physical. Noted 3 weeks of R rib, worse with deep breaths. No SOB or cough. No known trauma. Exam unremarkable other than pain w/ palpation over lower right rib. Rib x-rays at that time were normal. Felt to be muscle strain.

- Followed up 10/1/13 for worsening ongoing R rib pain. Sharp, constant, worse with movement, not improved by ibuprofen. Quite tender to palpation over the R ribs. Also with RUQ fullness - ? palpable liver edge.
• CASE: 19 yo s/p hockey injury from behind over bench at the NIP Clinic
• Chest wall and respirophasic chest pain
TO THE HOSPITAL FOR A FEW...
CASE: 82 MALE W/ HEART FAILURE

CTPE 6wks prior

Impression:
1. No pulmonary embolism.
2. Small pleural effusions, left greater than right, increased from the prior examination.
3. Mild dependent atelectasis but no frank lung consolidation.
4. Upper lumbar compression deformities as before.
5. Thyroid goiter as before.
ED VISIT/CDART
INCREASED SOB, ORTHOSTATIC, AKI, BP 92/52
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INCREASED SOB, ORTHOSTATIC, AKI, BP 92/52
• CASE: 60 yo male

• HD# 16: Sepsis, ARDS, On/Off Ventilator

• 2:15AM in ICU:
  • Acute Hypotension, hypoxia

• PEA Arrest
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Hypovolemia
Hypoxia
Hydrogen ion
Hypoglycemia
Hypo/HyperK+
Hypothermia
Tension Ptx
Tamponade
Toxins
Thrombosis
LAST ONE...ALMOST PEA

- 38 yo male with sob presents to ED with bp 224/128, pulse 105, sat 89% ra, diffuse rales. cxr with pulmonary edema. 2/6 systolic murmur apex/left lower sternum

- IV lasix 40mg and enaliprilat given
  - 1150cc UO and bp down to 84/68
- SOB worsened and syncopal episode in bed
- Stat CTPA ordered and transferred to the ICU
SAM WITH HIS OWL, “HOCM”