

Utilizing eConsults and Cases



DANIEL LEE, MD

What are eConsults?

- eConsults are electronic consultations between a PCP and a subspecialist.
- Research has shown that more than 40% of primary care referrals to subspecialists are unnecessary.
- eConsults are designed to replace a referral for an in-person evaluation by the subspecialist.

History of eConsults

- Was pioneered at San Francisco General Hospital in 2007
- UCSF was the first academic center to implement eConsults in 2012.

Implemented in many other academic centers:

- UCSF
- UCSD
- UCI
- UCDavis
- UCLA
- Univ. of Wisconsin
- Univ. of Virginia
- Univ. of Iowa
- Dartmouth-Hitchcock

Advantages of eConsults

- Patient avoids costs with an office visit (travel, parking, insurance co-pay, missed work, child care).
- Patient receives timely access and advice from the subspecialist expertise
- Maintains continuity relationship with the PCP
- PCP has dynamic access to subspecialist expertise and maintains management responsibility
- Patients don't get lost to follow up when they miss their referral appointments
- Subspecialist makes optimal use of office visit appts for patients requiring in-person evaluation

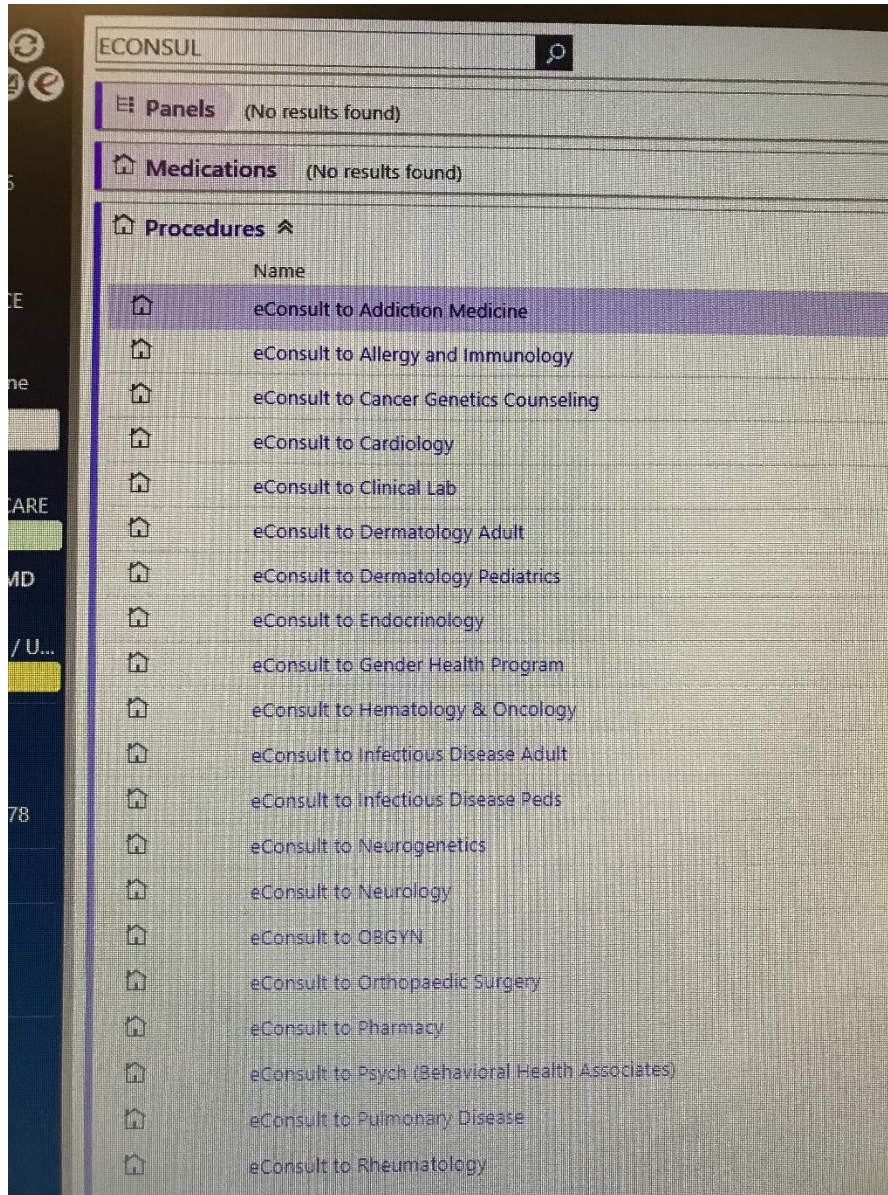
Advantages of eConsults

- The care coordination burden faced by PCPs is formidable
- To care for 100 Medicare patients, the average PCP coordinates care with 99 other physicians in 53 practices.
- The goal is the entire enterprise benefits by addressing all aspects of the “Triple Aim”: Better health, better patient experience, and lower costs.
- The enterprise incentivizes the use of eConsults by providing a modest RVU reimbursement to both the subspecialist and the PCP for each consult.

23 eConsult Specialties at UCLA

- Addiction Medicine
- Allergy and Immunology
- Behavioral Health (Psych)
- Cancer Genetics Counseling
- Cardiology
- Cardiology: Genetics (found under Cardiology)
- Clinical Laboratory
- Dermatology: Adult
- Dermatology: Peds
- Endocrinology
- Hematology/Oncology
- Gender Health
- Infectious Diseases-Adult
- Infectious Diseases-Peds
- Neurogenetics
- Neurology
- OB/Gyn
- Orthopaedics
- Pharmacy
- Pulmonology
- Rheumatology
- Sleep Apnea
- Urology

Type in econsult under orders section:



When and How to eConsult?

- If a question arises while you see your patient or get results back from a test, etc., that you think a subspecialist can answer without an in-person evaluation, then this would be a good time to eConsult.
- The question(s) should be focused.
- Give enough information to help the subspecialist answer your questions.
- Do not have to add all the details since the subspecialist will have access to the EMR.

When and How to eConsult?

- Avoid logistical questions (e.g., “where should my patient get PFT’s?) or questions easily answered by a looking at UTD or clinical guidelines.
- The eConsultant will provide their recommendations within 72 hours and often by the end of the day.
- Do not use it for urgent advice
- They will tell you if an in-person evaluation is deemed appropriate.

Real eConsult Cases

- Go through a variety of different subspecialties so you can see the various examples of how/when to do the econsults
- All the cases are real eConsults and many are my own or with the residents
- As we go through the cases, test yourself to see how you would handle the case before reading the consultant's recommendations

Allergy

- Question:
- 37 yo man reports shellfish allergy in the past with perioral swelling, however has tried in moderation without any observed side effects.
- Patient is wondering if it's safe to eat shellfish again and whether he had a true allergic reaction in the past.
- Does he need allergy testing?

Allergy

- Answer
- Shellfish allergy can be confusing.
- People sometimes react to chemicals in aging shellfish as opposed to allergic reactions to the muscle proteins.
- Some shellfish cross-react with others (high incidence of allergy to lobster in those who have allergy to shrimp)
- Perioral swelling can be a sign of anaphylaxis.
- Therefore it would be worthwhile to test sensitivity to a variety of seafoods, and potentially perform an oral challenge in our office if testing is negative.

Allergy

- Answer
- Obtain a serum specific IgE blood test by putting “IgE” in the order space and then order specific IgE (I suggest crab, lobster, shrimp, mussels, oysters, codfish, and others of concern).
- If the blood tests are negative, we could then arrange skin testing (more sensitive).

Allergy

- Question
- 72yo female has Sulfa allergy. She reports that symptom was emesis. I want to start a diuretic for venous stasis. Most diuretics have a warning about potential cross reaction with sulfa allergy. In my opinion, she has no evidence of anaphylaxis, so I'd like to start her on HCTZ. Is this reasonable?

Allergy

- Answer
- Even if she does have a true allergy to sulfa antibiotics, this should not preclude her from receiving other non-antibiotic sulfa medications.
- Antimicrobial sulfonamides contain an arylamine group and an aromatic ring attached to the sulfonamide core. The presence of both of these moieties is believed central to the pathogenesis of hypersensitivity reactions, and only the antimicrobial sulfonamides contain it.

Allergy

- Answer
- Nonantimicrobial sulfonamides include diuretics, hypoglycemics, antiinflammatories, and antihypertensives, such as furosemide, hydrochlorothiazide, acetazolamide, sumatriptan, glyburide, ***celecoxib, and ***sulfasalazine.
- The nonantimicrobial sulfonamides do not contain an arylamine group or a substituted aromatic ring, therefore patients who have a hypersensitivity to sulfa antibiotics generally tolerate nonantimicrobial sulfonamides.
- I think it's safe to start HCTZ without allergy testing

Cardiology

- Question

- 77 yo pt is going to have cataract surgery and they are going to do it under G/A. ECG shows T wave inversion in anterior leads new from 2007. Pt has dementia so getting good hx is difficult. Family reports pt is easily exhausted and is not active.
- Is this T wave inversion a significant finding that would necessitate postponing cataract surgery for further evaluation.
- No cardiac risk factors, has elevated cholesterol but good TC/HDL.

Cardiology

- Answer:
- I reviewed the EKG and there are abnormal TW inversion in the anterior leads which were not present on the prior EKG. She also has early R wave progression which could be due to lead placement or less likely, possible old posterior infarct.
- TW inversion are non specific but may represent significant underlying structural heart disease and if there isn't an obvious reason (LVH with repolarization abnormality, related to BBB or otherwise, post perimyocarditis), we'd consider evaluating further.

Cardiology

- Answer:
- Given they want to do GA for her eye surgery I would start with an assessment for structural heart disease by getting an echo, to make sure reduced systolic function/heart failure is not the etiology for her symptoms of fatigue and so forth.
- If her echo is abnormal (shows significant wall motion abnormalities or reduced EF) I would pursue a stress test as appropriate.
- If her echo is completely normal, then it is unlikely she has a significant prior infarct and could be medically managed through cataract surgery

Cardiology

- Question:
- Patient is a 17 yo female with Down syndrome, Autism, intellectual disability. As per screening guidelines for patients with Down's syndrome, we ordered a screening TTE. However, per caregiver and per my exam, patient will likely not cooperate with the TTE and would need sedation for the exam per radiology. Our question is how necessary is this screening TTE as her heart/lung exam is normal and she has not observable cardiac symptoms? Would other tests be indicated such as an EKG. If we should still perform the TTE, how would we arrange to get that done under sedation? Thanks!

Cardiology

Answer:

- I reviewed patients chart including labs. Down syndrome is associated with cardiac anomalies including ASD and VSD. As such it is good idea to do screening echo if possible. If test can not be completely EKG and chest xray can give some clues but are not definitive to rule out these findings. Lack of murmur may indicate absence of VSD but it does not tell about ASD. Regarding anesthesia in TTE request please mention need for anesthesia, and choose TTE option to rule out Congenital anomalies.
- Asim Rafique, MD
- 10/14/2019 12:19 PM

Clinical Laboratory

- Question:
- I am checking a PSA on this 61 yo. patient as a screening test for prostate cancer.
- What is the difference between the PSA, Total vs. the PSA, Screening lab tests.

Clinical Laboratory

- Answer:

The test methods are the same for PSA total and PSA screening. My understanding is that total PSA can be used to follow patient.

PSA screening is for Medicare patients who can get one PSA test per year.

As far as the test is concerned, they are the same test.

Thanks,

Lu Song, PhD.

Director for clinical chemistry

Endocrinology

- Question:
- 43yo female with multinodular goiter. Her thyroid function tests are normal and the ultrasound did not reveal suspicious nodules. There was a dominant cystic mass of her L lobe measuring 4.5cm. Given the size alone of the dominant nodule would FNA be recommended (despite benign features)?

Endocrinology

- Answer:
- In general, purely cystic masses, and this one is >95% cystic, are low suspicion for harboring malignancy.
- Partially cystic lesions are a different story and certainly if this nodule were to increase in size or develop a solid component that was expanding size, you could make a reasonable argument for biopsy.
- It is reassuring that the ultrasonographer regarded all of the nodules, including the cyst, as not suspicious. TFT's appear normal so it does not appear that any of the nodules are functional at this point.

Endocrinology

- Answer:
- I would not necessarily biopsy this cyst because of size alone. If she were to bleed into the cyst (with pain) or the cyst continued to accumulate fluid and became a cosmetic concern, you could needle and drain it (fluid for cytology though often not terribly helpful) but the fluid might well reaccumulate.

Endocrinology

- Question:
- 50 yo. Male has incidental right thyroid nodule noticed on MRI as workup for his cardiac LV non-compaction. The thyroid nodule was biopsied and the results are:
- THYROID NODULE, RIGHT LOWER LOBE (ULTRASOUND-GUIDED FINE NEEDLE ASPIRATION):
- - Benign nodule with prominent Hurthle cell metaplasia and features consistent with chronic lymphocytic thyroiditis
- My question is what do you recommend for future follow up and management for this patient?
- Thanks,
- Daniel T. Lee, MD

Endocrinology

- Answer:
- Dear Dr. Lee,
- This patient has a 2 cm right thyroid nodule that was benign on biopsy, and appropriate follow up would be to repeat the ultrasound in 1 year. If there is not a significant change in size then you can continue ultrasound every 1-2 years. If it has been stable for a couple ultrasounds, then you can spread out the ultrasounds to every 3-5 years. Each nodule must be viewed independently, so if one of his smaller nodules grows to >1.5 cm, then it would deserve a separate FNA.

Gastroenterology

- Question:
- 45 yo F recently hospitalized for severe C. Diff colitis and was dc'd home to complete a 14 day course of oral Flagyl and vancomycin. Her last day of antibiotics is tomorrow. She is doing better and no longer having diarrhea, but is still having small soft BM's multiple times a day and some abdominal cramping. She is very anxious about infecting her colleagues.
- My questions are 1) When would it be appropriate/indicated to repeat stool testing for C. Diff if the loose stools continue? And 2) How long is a patient considered to be at risk of infecting others?

Gastroenterology

- Answer:

- It seems this developed after antibiotics for dental issues. I suspect her altered bowel movements are more related to antibiotics and post-infectious IBS rather than persistent C. Diff, as she no longer reports diarrhea.
- I would not recheck her still C. Diff toxin unless she is having diarrhea. Note that C. Diff can still be positive in 50% of people up to 6 weeks after infection (and sometimes longer).
- I would consider either probiotics (i.e., Align or VSL#3) or fiber (i.e., Fiber One cereal) if her bowel movements do not improve after a week of stopping antibiotics. This is more for changes in microbiome and/or motility changes

Gastroenterology

- Answer:
- Risk for infecting others is low. Typically people get C.Diff in response to taking antibiotics and altering their microbiome; the C. Diff which is present becomes more prevalent.
- Theoretically, she could still have C. Diff for up to 6 weeks, but I doubt she would be infectious, especially if hand washing. I would think she could resume normal activities.

Genetics

- 34 y.o. patient is an Ashkenazi Jewish woman with an aunt recently diagnosed with breast cancer that is BRCA positive. She has no other relatives that she knows with breast, ovarian or colon cancer. She was told by aunts doctor to get tested. Should she be tested? If so can I order that or send her to you?
- 5/21/2019 1:00 PM

Genetics

- If your patient's aunt has a germline BRCA1 or BRCA2 mutation, then your patient has a 25% chance of carrying the mutation herself. Her parent (whichever is the sibling of the affected aunt) has a 50% of carrying the mutation, so if they're available, I would recommend genetic testing for them first. If that's not an option, your patient would be next in line. If her parent's testing was negative, your patient would not need it.

Genetics

- As there are thousands of possible mutations in these genes, it is crucial that the correct one is tested, so your patient should obtain a copy of her aunt's genetic test results prior to her own testing. I strongly recommend she have formal genetic counseling to discuss the risks and benefits of genetic testing. We will review her family history to determine whether additional testing is also recommended. We'll go over cancer risks, medical management recommendations, and insurance implications of a positive test result.

Genetics

- Question:
- 30 F notes a paternal grandmother with hx of diagnosis of breast cancer at age 35, however no other family members with breast cancer diagnosis. She is otherwise currently asymptomatic. Is there any particular genetic screening that must be done for this patient and if not, would you just recommend starting breast cancer screening with mammogram at 40 years. Thanks!
- Jennifer K. Casabar, MD
- 2/3/2020 11:02 AM

Genetics

- Answer:
- I recommend formal genetic counseling for risk assessment and consideration of genetic testing to determine your patient's medical management. Given her grandmother's very early age at diagnosis, there is some concern for a hereditary cancer syndrome in the family. We would be happy to see her (and/or her father) in Westwood, or she may wish to go to the High Risk Breast Clinic in Santa Monica.
- If an inherited mutation is identified in the family, your patient's management would depend on her genetic test results.

Genetics

- Even if an inherited mutation is not identified in the family, high-risk breast screening may still be indicated. If her lifetime breast cancer is greater than 20% on a validated model such as Tyrer-Cuzic (available online at <https://ibis.ikonopedia.com/>) we would recommend she begin annual mammogram and annual breast MRI now.
- Since your patient has an HMO, she will need prior authorization for genetic counseling. Please request CPT 96040 x3 units for department HEM ONC MP2 120.

Hematology/Oncology

- Question:
- 43 yo M pt with asymptomatic borderline leukocytosis, stable 1 year. Current WBC 11.68, and was 10.0 one year ago. Do I need to do any additional workup?

Hematology/Oncology

- Answer:

- Assuming there is no active sign of infection or any indication for underlying autoimmune disorder, this can be followed up for the time being. Rarely, leukocytosis can be the sole manifestation of myeloproliferative disorders but typically, in those situations there is a persistent rise in leukocyte count.
- Finally stress, cigarette smoking, and being obese are associated with leukocytosis/neutrophilia.
- I would recommend monitoring the CBC every 6 months to a year. If there is a rise in the WBC and/or additional abnormalities in CBC, patient should then be seen by hematology formally.

Hematology/Oncology

- Question:
- 44 yo female taking B12 supplement with level >4,000. I will have her stop the supplement, but my question is for her and other patients that are routinely taking B12 supplements, we are often getting these high levels.
- Do high levels cause harm?
- Is it fine to allow levels to remain high and if so, what is the highest acceptable level.. Or should we always try to get the patient below 1,000?
- Thanks for your advice on these questions.

Hematology/Oncology

- Answer:
- Some literature show an association of high b12 with conditions such as cancer, liver disease, poor renal function(causation not shown). Not clear what upper limit considered acceptable.
- Very appropriate to see if stopping supplementation leads to normalization.
- Can send to office if level does not drop significantly after stopping for a couple of weeks
- Andrae L. Vandross, MD

Hepatology

- Question:
- Asymptomatic patient with incidental hyperbilirubinemia on labs done last year. Work up with further labs last year revealed normal direct bili, LFT's, CBC, peripheral smear, LDH. Haptoglobin was mildly low. Repeat bilirubin today is still high but has not trended upwards.
- Labs are consistent with Gilbert's Syndrome, right?
- If you agree, please give recommendations for any further testing or monitoring if even indicated

Hepatology

- Answer:

- This seems consistent with Gilbert's syndrome with no evidence of hemolysis.
- She should also have an increase in bili when she is stressed, febrile or fasting. Did you get such a history from her? Did she ever report her eyes were yellow? If so, this is consistent.
- She should know that her liver tests are normal and she has no evidence of liver disease, that Gilbert's is a common phenotype not associated with disease and no treatment is required. A small percentage of these patients may develop splenomegaly and bilirubin is usually <6.

Infectious Diseases

- Question:
 - I am referring a 25 yo F for evaluation of recurrent UTI. Pt has had recurrent UTI's—5 episodes in the past 5 months; several of them with resistant organisms. What would be best strategy for prevention?

Infectious Diseases

- Answer:
- In a patient of this age, I would first confirm that she is not using spermicide. If yes, stop. If not, then I would consider giving one dose of antibiotic immediately after sex. Based on her most recent E coli susceptibility pattern, you could have her take 1 macrobid post-coitus.

Infectious Diseases

- Question:
- 25 yo female patient with recent positive PPD. This was her first PPD. Her chest xray was normal. Her Quantiferon is negative.
- She has never lived in another country, did not have BCG vaccine and has not been exposed to active TB as far as she knows.
- Does she need any further work up and if she is in a situation in the future that requires TB screening, what is your recommendation?

Infectious Diseases

- Answer:

- When screening for latent tuberculosis infection, the sensitivity of PPD and Quant-GOLD are equivalent but the latter is more specific in that it is not made positive by BCG and other non-TB mycobacterial exposures, and the results are less subjective.
- Thus while follow up Quant GOLD is not routinely recommended in people whose PPD is positive, it can be used to exclude one of those sources of false positive PPD's such as the reading is in question, prior receipt of BCG or exposure to (for instance) *Mycobacterium marinum*.

Infectious Diseases

- Answer:
- In this case the subsequent negative QFT-G makes true LTBI unlikely and suggests the initial reading can be overturned. This is particularly true for people with low prior probability of having LTBI.

Infectious Diseases

- Question:
- 74 yo male patient. Should Zostavax be deferred for a patient diagnosed with cancer but not yet treated with chemotherapy?
- In general, is all chemotherapy a reason to defer Zostavax?

Infectious Diseases

- Answer:
- Not necessarily. In general, I would avoid live virus vaccination in patients with hematologic malignancies, patients with solid tumors on immunosuppressive chemotherapy (e.g., traditional chemotherapy), or in those receiving radiation.
- In your patient with prostate cancer, he is probably safe to receive the zoster vaccine at this point since he has yet to start radiation.

Infectious Diseases

- Question:

- 9/27/19

Dear Dr. Lee,

Sorry for bothering you and I have a question on rabies vaccine. I had a small open wound and yesterday, I think my wound was accidentally get contaminated by a home-kept dog urine and saliva (it's not bite, just get licked and may contact the urine, too). I received rabies vaccination 7 or 8 years ago but still not sure if I need any additional vaccine. Please advise and thank you so much!

Best,

XXXXX

Infectious Diseases

- Answer:

Hi XXXXX,

First, the chances that this domesticated dog has rabies is very very small. Second, it also depends upon how large and open and fresh your wound was. If it was a healing wound and small and already scabbing over for example, then it is also less likely you would contract rabies from only licking as opposed to a bite. You should monitor this dog for the next 10 days. If this dog does not have any symptoms of rabies now or within the next 10 days, you should be fine. If the dog exhibits any signs of rabies in the next 10 days, then you should go to the Emergency department for consideration for rabies vaccination.

Take care,

Dan Lee, MD

Infectious Diseases

Question:

Hi Dr. Lee,

The wound was very small in the right point finger, with just the superficial epidermis scratched off and blood oozing. I flushed with 70% isopropanol after the contact and now the wound is scabbing and not inflamed. Thanks again for your suggestions and have a great weekend!

Best, XXXXX

I had the following email correspondence with this patient below regarding his questions about getting the rabies vaccine. I just want to know if you would have given any different or additional advice to this patient than I did.

Thanks,

Daniel Lee, MD

Infectious Diseases

- Answer:

- Hi Dr. Lee,
- I agree that if patient had a wound not from a dog bite and a domesticated dog known to the patient licked the wound, that my suspicion for rabies transmission would be very, very low. There would still be the risk for bacterial superinfection of the wound from bacteria in the dog's saliva, however, and the wound should be monitored for signs of infection.
- Regards,
- Marianne Go-Wheeler

Neurology

- Question:
- 63 yo F with 4 days of 1-2 second episodes of disequilibrium with an associated knocking sound. Onset 2 days after discontinuing escitalopram 5mg. No associated symptoms. Not associated with movements, tinnitus, hearing loss, vertigo. Complains of mildly increasing headache as well, consistent with tension-type. Normal neuro exam.
- Are my patient's symptoms due to withdrawal from escitalopram and if not should I order a brain MRI?

Neurology

- Answer:

- Discontinuation of escitalopram can cause withdrawal symptoms in some patients and these include headaches, dizziness, paresthesias among others.
- There are reports of “brain zaps” which patients describe as a sensation of electrical shocks through the brain. This subjective sensation usually subsides within a few weeks.
- Because 1)neurological exam is non focal 2)there is an absence of vascular risk factors 3) the association of symptoms right after discontinuation of escitalopram, I suspect the most likely etiology of her symptoms is related to withdrawal effects from escitalopram.

Neurology

- Question:
- 68 yo female patient for persistent post coital HA's (each sex act or masturbation) with normal MRA brain, non focal exam.
- Is there a simple blocking med or treatment or does she need further neurology evaluation?

Neurology

- Answer:
- I recommend trial of Indocmethacin 50mg po TID prn 30 minutes before each sexual experience. It has good evidence for post-coital and exertional headache treatment. If that doesn't work, please send her to Neurology for further evaluation.

Neurology

- Question:
- 54yo female with a history of developmental delay and seizure disorder, for which she takes Dilantin. Recent levels during hospitalization were found to be subtherapeutic. She reports no seizures for at least a few years. She also reports adherence to medication, which she has tolerated well.
- Does she need an adjustment in dose? How often should this be monitored?

Neurology

- Answer:

- No dose adjustment needed. A general rule of thumb is to “treat the patient, not the drug level”. Major issues are prophylaxis for osteoporosis, gum care, check baseline LFT’s and CBC.
- Good dental care to manage gingival hyperplasia is extremely important in patients on phenytoin (Dilantin)
- The pt should be on prophylaxis for osteoporosis (i.e, calcium supplementation, vit D: note this pt’s low serum calcium 8.4 (L).
- Although a future pregnancy seems unlikely in this case, supplemental folate is non-toxic and reduces risk of congenital birth defects such as spinal bifida

Neurology

- This 34 yo female patient messaged me after looking up her MRI results from 2 years ago and is concerned about the findings from the MRI which shows diffuse prominence of the lateral ventricles bilaterally. This was originally ordered by Pain Clinic who told her that the MRI is normal and to follow up with her primary doctor for further questions. The patient has long-standing headaches for the past 20 years relieved by Botox injections and acupuncture. Apparently has no other significant neurological symptoms. Can run 3 miles several times a week without problems. Let me know what you make of the MRI, the response I should give to this patient, and if any further management recommendations.

MRI BRAIN WO CONTRAST

- HISTORY: persistent migraines, requires further evaluation with MRI
- FINDINGS:
- Infarct: No evidence of recent or old infarct.
- Hemorrhage: No evidence of hemorrhage.
- Susceptibility: No abnormal susceptibility artifact in the brain parenchyma.
- T2/FLAIR signal: Normal T2-weighted signal in the brain parenchyma.
- CSF spaces: Diffuse prominence of the lateral ventricles bilaterally. Normal size is at the third and fourth ventricles. Normal sulcal size. Clear basal cisterns. The cerebellar tonsils are at the foramen magnum but do not compress the medulla.
- Vessels: Normal flow-voids in the major proximal intracranial vessels.
- Sinuses/mastoids: Clear paranasal sinuses and mastoids.
- IMPRESSION:
- No evidence of infarct, acute intracranial mass effect, hemorrhage, or hydrocephalus.
- Prominence of the lateral ventricles, nonspecific.
- Signed by: MICHAEL LINETSKY 10/6/2017 11:14 AM

- ===== eConsult Response Below =====
- The findings on the MRI are not concerning. It is a normal variation that does not need further evaluation or treatment. If she has further questions/concerns, we are happy to see her in our clinic.
- Doojin Kim, MD
- 4/30/2019 4:29 PM

OB/GYN

- Question:
- 45yo F is perimenopausal. IUD mirena in place—at what time do you recommend removal of IUD? Can the fact that the IUD is in place confound her menopause status?

OB/GYN

- Answer:

- The patient can have the Mirena IUD in place up to 5 years and during this time her periods may be absent or light. This should not confound the diagnosis of menopause or perimenopause as we usually go by symptoms as well (hot flashes, vaginal dryness, night sweats, changes in mood, or insomnia).
- Generally, most people will stop systemic hormonal birth control methods by the age of 50 to see if perimenopause/menopause has set in. The Mirena IUD has about 20 times less hormone than these systemic methods, and it is progesterone only, so should not mask any climacteric symptoms.

OB/GYN

- Answer:
- I would just wait until the IUD expires before taking it out if she's otherwise not having climacteric symptoms.
- If she is and wants to transition to menopausal hormone therapy, she can see us for discussion.

OB/GYN

HISTORY:

- Patient is 28 years old with a known palpable right breast mass at 10:00, first seen on ultrasound 4 years prior.

ULTRASOUND FINDINGS:

- There is an oval mass with circumscribed margins measuring 5 x 4 x 6 mm seen in the right breast at
- 10 o'clock, subareolar region located 0 centimeters from the nipple. Internal echotexture is hypoechoic. Finding remains unchanged from the prior study.

IMPRESSION:

- Oval mass in the right breast is benign.
- Recommend clinical follow-up and imaging follow up as indicated.
- Based on a modified IBIS risk calculator, this patient has an approximate 26% lifetime risk of developing breast cancer
- BI-RADS Category 2:

OB/GYN

- I am requesting an eConsult from OB/GYN for my 28 y.o. female patient for stable benign palpable breast mass by ultrasound. Breast mass stable since 2015 (4 years prior). See results below. The patient doesn't want removal.
- Do you recommend any further evaluation such as FNA?
- Also, is future surveillance ultrasounds indicated and if so, at what intervals.
- Thanks,
- Daniel Lee, MD

OB/GYN

- Answer:

- Dear Dr. Lee,
- Since the mass is unchanged in size it is reasonable to continue monitoring without a biopsy or removal. I recommend annual breast ultrasound unless the patient notices a change in size or any other new symptoms (skin changes, nipple discharge, axillary mass).
- Let me know if you have any questions.
- Jeannine Rahimian

Psychiatry

- Question:
- 60 yo woman with longstanding depression. Has been on citalopram 40mg for 15 years. Uses topiramate as well for migraine prophylaxis. PHQ-9 today was 25. No history of manic or psychotic features. No substance abuse disorder.
- Would you recommend potential augmenting agents for depression vs switching SSRI?

Psychiatry

- Answer:
- It is not uncommon for SSRI meds to lose their efficacy after a period of time. The decision at that time is usually: 1)increase the dose 2)switch to another medication, 3)augment with another medication
- The PHQ-9 indicates her depression is in the “severe” range. It may be useful to have a conversation with her about what specific aspects of her depression are most bothersome.
- Citalopram 40mg is considered in the mid-range of dosing, with 60mg considered the top (any dosing of 40mg or above should be accompanied by an EKG to monitor QTc).

Psychiatry

- Answer:

- If sleep is a problem then augmentation with mirtazapine (7.5mg QHS initially, increasing weekly, if tolerated, to a maximum of 30mg QHS) may be reasonable.
- If daytime fatigue or over-sleeping is a concern, then augmentation with bupropion (typically start at 150mg QAM of the XL formulation) can be reasonable, as would modafinil, or even aripiprazole (2.5mg QAM would be a good place to start). It is important to inquire about family history of bipolar disorder and monitor for behavioral changes of mania.
- The combination of medication intervention and psychotherapy is perhaps the most effective strategy

Psychiatry

- Question:
- 47yo male patient with depression anxiety. He responded very well to escitalopram 20mg but had low libido. He tapered down to 10mg with improved libido and control of depression, but has anger and irritability. I would like to switch to another med with fewer sexual side effects, but Remeron or Wellbutrin are unlikely to control his anxiety and irritability.
- What do you recommend?

Psychiatry

- Answer:

- Actually, Wellbutrin would probably be the best bet in terms of sexual side effects and is often effective for anxiety as well. I would add it on in combination with the Lexapro and see if his libido improves. If not, you can try another SSRI as well because it is not always the same response despite being a serotonergic drug.
- You could start at 75mg and increased up to 150mg or even 300mg if well tolerated. If he does well on the Wellbutrin, you could discontinue the Lexapro if the sexual side effects continue. If sexual side effects seem to improve with the addition of Wellbutrin, leaving him on the combination would be reasonable as well.

Pulmonary

- Question:
- 63 yo F with asthma pretty well controlled on Dulera which she has been on for years. Rinses her mouth after using. Got thrush in Jan/Feb after asthma exacerbation that required prednisone. We would treat thrush with Nystatin, but it would come back with ongoing Dulera.
- Last month I recommended we try PO fluconazole for the thrush, but she never picked it up.
- We're checking CBC, HIV, sugar, etc. So far, all normal. Is there anything else we can do to minimize the risk of thrush? Would it make sense to change her controlled inhaler?

Pulmonary

- Answer:
Possible strategies for decreasing thrush after use of inhaled corticosteroids include:
- Mouth rinsing and tooth brushing after use. Gargling with an alcohol based mouthwash (i.e. Listerine) can also be more effective.
- Use of nystatin mouthwash: this can be used 5X per day once thrush develops and then used daily to a few times per week to keep thrush from coming back
- Fluconazole can be administered to completely treat the thrush

Pulmonary

- Answer:
- Use of a spacer device w/ a steroid MDI can be helpful. The spacer acts to reduce medication to the mouth and helps more medication to the lungs
- Consider changing to an alternate MDI (i.e., Fluticasone/flovent MDI) but would avoid dry powder inhalers (such as Advair, Pulmicort and Asmanex) as the dry powdered inhaler can predispose people to getting thrush, as the powder doesn't dissolve well in water.

Pulmonary

- Question:
- 45 yo male got a CT chest because he had incidental findings of pulmonary nodules after he had a CT Abd s/p perforation from colonoscopy for his polyposis condition.
- His only risk factors are smoking about 2 cigarettes a week for about 15 years quitting 8 years ago.
- Patient is asymptomatic.

Pulmonary

- The patient's CT lung findings are:
- Scattered pulmonary nodules, including the stable sub-6 mm nodule in the right lower lobe. Findings are indeterminate, but likely of low clinical significance. Recommend follow-up low-dose chest CT in 12 months if patient is high risk (smoking history or other known risk factors).
- My question for you is what would you recommend I follow this, such as no follow up needed, repeat CT in a year, etc?

Pulmonary

- Answer:
- I think a repeat low-dose CT in 12 months would be reasonable.
- If nodules are stable or smaller at that time, no further workup would be indicated.

Rheumatology

- Question:
- I am referring a 21yo male to Rheum for evaluation of his chronic back pain started 6 years ago. He has a history of multiple sports injuries, though no inciting accident.
- Pt's main goal is evaluation in ortho/spine clinic, but per ortho, must have rheumatology evaluation first.
- Is in person rheumatology referral needed? He has no evidence of inflammatory arthritis on exam, and normal back XR
- Are there additional labs or imaging studies needed to r/o inflammatory arthritis?

Rheumatology

- Answer:

- The major reason to refer this young man to rheumatology is to evaluate for “inflammatory” back pain. However, you can do this yourself:
- 1) Does he have pain before age 40 (yes)
- 2) Does he have pain that wakes him up only in the later half of the night (i.e., after 2am)
- 3) Does he have >30min of morning stiffness
- 4) Does his pain worsen with inactivity and improve with activity
- If the answer is “yes” to three of these questions, we should see him.

Rheumatology

- Other clinical clues for inflammatory back pain:
- Strong family history
- History of uveitis
- History of inflammatory bowel disease
- History of psoriasis (particularly affecting the scalp)
- Elevated inflammatory markers (esp CRP, but obviously non-specific and insensitive)

Rheumatology

- Based on these questions, if you do not suspect inflammatory back pain, we do not need to see him
- Also Xrays are insensitive, so although the SI joints look normal, he still could have AS. However, I do not recommend obtaining an SI joint MRI in the absence of a strongly suggestive clinical history

Urology

- Question:
- I am requesting an eConsult for my 65 y.o. female patient for recurrent UTI. 9/10/2020
- This patient has a hx of paraplegia c/b neurogenic bladder with straight cathing. She has recurrent UTIs, with most recent urine now resistant to most antibiotics. Do you have recommendations for how we could help this patient prevent more UTIs and possible development of worsening resistance besides proper catheter care? Thank you!

Urology

- Answer:
- It is important to only check for bacteria in the urine when she is symptomatic: fever/chills, bladder pain/dysuria. Odor of the urine or asymptomatic bacterial colonization should not be treated with antibiotics.
- If she is symptomatic, best approach if there is an indwelling catheter is to change the catheter and collect a urine culture from the fresh urine that drains thru the new catheter. Do not collect the urine from the bottom of the foley bag or from an old catheter.

Urology

Tips to prevent bacterial colonization:

- D-mannose 2gms daily to prevent Ecoli
- Hydration >2L water daily
- Catheterizing to achieve drained volumes <400cc. This may mean 4-6x/day and PRN bladder fullness.
- If she cannot catheterize frequently enough, she can come in for a visit and we can discuss a suprapubic tube as another option.
- If hydration and D-mannose don't work, you can start methenamine 100mg BID as bacteriostatic agent or finally suppressive daily antibiotic with nitrofurantoin 100mg daily.

Summary

- Consider using eConsults when you have management questions on patients that do not need to be seen in person by a subspecialist
- Fulfill the Triple Aim: Better health, better patient experience, and lower costs.

