Answering Calls Part 1

1. ER Calls

Patients who may have active TB should be referred to the TB clinic. They do not need to be admitted if they are well enough to be at home.

Patients with the following should usually be admitted:
- Significant Hemoptysis (Pulmonary Div. can also be called for advice)
- Pleural effusions (outpatient work up is really difficult in our system)
- Miliary infiltrates
- No home and a chest film consistent with active TB (regardless of symptoms)
- Possible TB meningitis
- Pneumothorax
- A new oxygen requirement
- Another medical problem that would require an admission anyhow

The ER refers patients in healthlink. Send a message to the MD pool.

If you think the patient has smear positive TB, you can have the ER instruct them to come the next morning with a mask on at 8:30 am. If you are not going to be there, please call the advice nurse and create a referral orders that says:
1. mask
2. obtain sputums x 3 and
3. book within 24-48 hours.

The nursing staff can ask whichever physician has clinic that am, if they want to add the patient on or find a place to put them on the schedule.

If you think the patient may have a community acquired pneumonia or lung abscess, it is still fine for the ER to refer them on the appropriate antibiotics (NO fluoroquinolones).

We also accept referrals for chronic cough or positive TB skin tests. These are not urgent and generally we won’t get a page.

Please ask for a referral to the TB Clinic to be placed with a reliable contact number. We have been unable to locate many patients due to disconnected phones and incorrect addresses. If the film is really bad we have to send the PHD out after the patient.

2. OB Calls

Obstetrics has a policy of placing TSTs during pregnancy and getting chest films at the end of the second trimester. If the patient has an abnormal chest film consistent with TB, then they are referred to the clinic. Ideally sputums are done about 3 months prior to delivery. If we see the patient in clinic, then there will be a dictated note stating that they can room in with the infant if their cultures are negative at the time of delivery. Neonates have the highest risk of progression to active TB if infected.
If a patient with a positive TB skin test and abnormal film is admitted in labor that has not been evaluated by the clinic, they should remain in Airborne Precautions until someone from the TB Clinic can review the chest film and see the patient.

This is another good reason to have Impax at home as these patients are separated from their infant until you look at the film or come do a consult. If the mother has significant fibronodular disease and no sputums and no follow up xrays demonstrating stability, then they need to start TB meds. When the mother is smear negative and the baby has started INH, the two can room in together. This is a judgment call and hopefully you won’t get these while I am out of town.

3. Lab Calls
If it is malaria in a new refugee, have the patient come to the ER and the ID fellow should see them and follow them with the ID team. Other calls are mostly about potasiums and glucoses and other general medical stuff. If the lab thinks they have an MDR case, they will call (but during the day) and you can order pyrosequencing and talk to Gulshan.

4. Anesthesia Calls—We don’t get too many calls as they have my email—but you will get emails when I am gone.
   a. Elective Surgery and an abnormal film c/w TB. Cancel surgery. Obtain sputums. Have patient come to clinic 6 weeks later with a f/u film. Dictate a clearance note. Unfortunately patients wait a long time prior to surgery and then get evaluated by anesthesia at the last moment.
   b. Emergent Surgery—can be done under respiratory precautions with a filter at the end of the ventilator. Generally preferred to be the last case of the day as the ORs are positive airflow. Usually we get called after the surgery.
   c. Urgent surgery often involves some judgment calls. We don’t get consulted on this frequently. We usually need to discuss with the surgeon.