2023 Hawai'i Chapter

Scientific Meeting

"Re-emergence" –

'Puka Hou Ana'

3

In-person/Virtual

× *This activity has been designated for 6.5 CME credits and 6.5 MOC points*

Chapter Excellence Award – Gold Winner

(September 2022) I am pleased to announce that our chapter is in receipt of the Gold Level of the 2022 Chapter Excellence Award! The award recognizes truly extraordinary chapters that surpass excellence in chapter management. We are in the company of 47 other outstanding chapters. In order to achieve the Gold Level of the Chapter Excellence Award, chapters must meet twenty Bronze criteria, seventeen Silver criteria and multiple Gold level activities. Criteria include such activities as having a legislative action plan or agenda, holding a volunteerism/community service activity, holding multiple stand-alone meetings, having revenue sources outside of dues and meeting registration fees, implementing a strategic plan, implementing a formal recruitment and retention plan and measuring outcomes, conducting various activities for Medical Students, Residents and Early Career Physicians. I would like to extend a special thanks to those chapter members who assiue(g0 G0y Car)4(ti)o those chapter

Congratulations Alvin N. Furuike, MD, MACP on being awarded Mastership

(October 2022) We are excited to share that the [Mastership/Awards] Committee and the Board of Regents have approved Alvin N. Furuike, MD, MACP to receive Mastership during the 2023 Internal Medicine Meeting in San Diego, California.

Pathways to Fellowships

Andrew Kinimaka, MD ±Chief Medical Resident, Kaiser Permanente, Honolulu, HI
Kuo Lian, MD, FACP - Assistant Professor, Department of Medicine, University RI + DiZDL µ
4XHHQ¶V 0HGLFDO &HQWHU +RQROXOX +,
Evan Lum, MS4 – 4th Year Medical Student John A. Burns School of Medicine, University of + DZD, L µL
Honolulu, HI
Ashley Morisako, MD ±Chief Medical Resident, Kaiser Permanente, Honolulu, HI
Ryon Nakasone, MD, FACP – $VVLVWDQW 3URIHVVRU 'HSDUWPHQW RI 0H
Center, Honolulu, HI
Yoshito Nishimura, MD – 2nd Yr Resident UH Internal Medicine Residency Program, Honolulu, HI
Uzoagu Okonkwo, MD, PhD - Chief Medical Resident, Tripler Army Medical Center, Honolulu, HI

currently the Amer L F D Q + H D O W K , Q V X U D Q F H 3 O D Q ¶ V / L D L V R Q W R W K H
Committee on Immunization Practices (ACIP), a member of the Board of the Oregon Medical Association and serves on the board for Stand for Children.

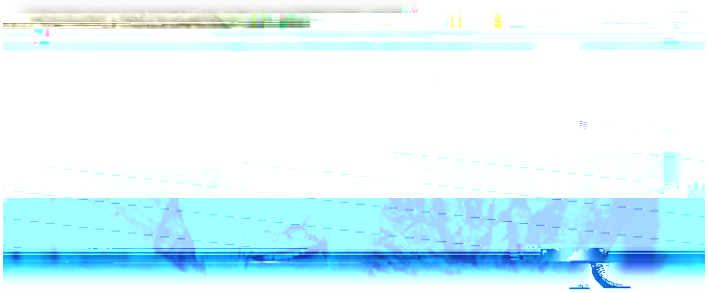
Sarah Kemble, MD – Dr. Kemble received her MD at UCSF, completed her residency in Internal Medicine and Pediatrics at UCLA, and an infectious disease fellowship at Rush University Medical Center. She also is an alumna of the Epidemic Intelligence Service at the Centers for Disease Control and Prevention. After serving as Medical Director for the Communicable Disease Program at the Chicago
' H S D U W P H Q W R I 3 X E O L F + H D O W K I R U I R X U \ H D U V V K H U H W X U
M R L Q H G W K H + D Z D L ‹ L 6 W D W H ' H S D U W P H Q W R I + H D O W K in June September, 2020, she has served as the Acting State Epidemiologist and Chief of the Disease Outbreak Control Division.

New Fellows/Master -

**Alvin N. Furuike, MD, MACP – ***one of five*

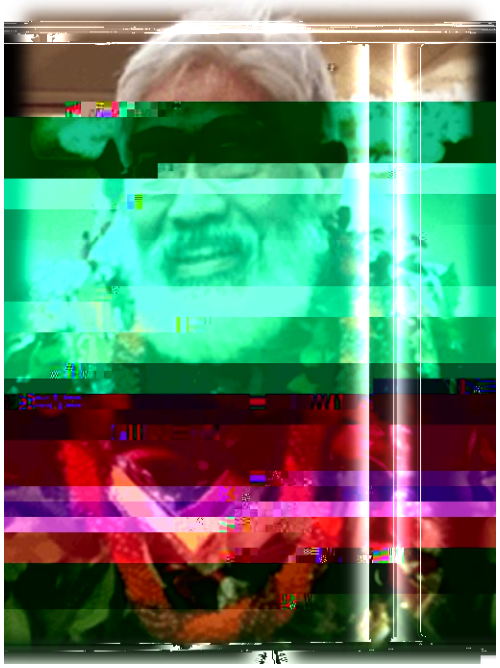
In Memoriam

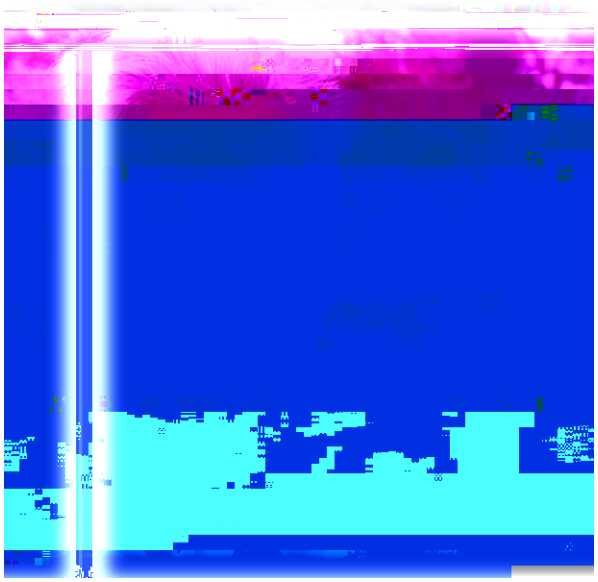
James E. Hastings, MD, FACP
July 4, 2022



William "Bill" Thomas, MD
September 4, 2022

Clayton Chong, MD
November 23, 2022





Noa Emmett Aluli, MD
December 2, 2022

PODIUM PRESENTATIONS

12

9:00 am Podium

PLATELET RECEPTOR BLOCKADE AFTER CLOPIDOGREL DIFFERS IN HAWAII PATIENTS WITH CYP2C19 POLYMORPHISMS

Jan Aurelio, BA[1], Susan Asai, MSN[1], Joo Won Choi, BA[2], Stacy C. Brown, MD[1,2]
[1]The Queen's Medical Center, Neuroscience Institute, Honolulu, HI

9:15 am Podium

PHENOBARBITAL FOR ALCOHOL WITHDRAWAL: SYSTEMATIC REVIEW

Horyun Choi, MD[1], Yoshito Nishimura, MD[1], Bridget Colgan, MD[2],
Harrison Kistler, MD[2], and Francisco Mercado, MD[1,2]
[1]University of Hawaii Internal Medicine Residency Program, Honolulu, HI
[2]Department of Medicine, Tripler Army Medical Center, Honolulu, HI

Background:

In recent years, phenobarbital (PB) has been more recognized as a potential alternative to benzodiazepine (BDZ), which may be beneficial for reduced hospital length of stay and lower complications related to alcohol withdrawal syndrome. However, the level of evidence has been unclear. We aim to explore the evidence of use of PB in alcohol withdrawal syndrome (AWS) via systematic review and provide insights into future research directions.

Methods:

We searched MEDLINE, EMBASE, ClinicalTrials.gov, and WHO ICTRP for observational or interventional studies that compared use of PB monotherapy or adjunct PB along with BDZ to BDZ monotherapy in AWS from inception to September 18, 2022. We followed the PRISMA guidelines for study selection.

Results:

We included 20 studies which consist of two double-blind, randomized trials and 18 retrospective studies. Among the studies, 9 studies including the two clinical trials were performed in the ED and 11 studies were performed in either general floors or ICU. 5 studies and 8 studies compared use of PB monotherapy to BDZ monotherapy in the ED and either general floors or ICU, respectively. Outcomes used in these studies vary, including intubation rates, need of mechanical ventilatory support, admission rates, and length of stay. Of note, three studies in the ED demonstrated better outcomes in admission rates showing less admission in PB monotherapy groups compared with BDZ monotherapy groups. In addition, PB monotherapy groups have lower mortality rates compared to BDZ monotherapy groups in three general floors or ICU cohorts. However, the studies included in this review were not qualified for meta-analysis due to significant heterogeneity regarding PB dosing, measured outcomes, and AWS severity measurement scales.

Conclusion:

Use of PB in AWS has been focused as a promising alternative to BDZ. Evidence has been emerging that PB may be related to better clinical outcomes compared to BDZ. Future prospective studies would be beneficial for standardization of PB use in AWS.

10:45 am Podium

PROFOUND HYPOMAGNESEMIA IN A PATIENT TREATED WITH LONG-TERM PROTON PUMP INHIBITOR

Chinnawat Arayangkool, MD[1], Joseph Lee, MD[1], Kuo-Chiang Lian, MD, FACP[2]
[1] 8QLYHUVLW\ RI +DZDL¶L ,QWHUQDO 0HGLFLQH 5HVLGHQF
[2] 7KH 4XHHQ¶V Medical Center, Honolulu, HI

Learning Objectives: Review clinical signs and symptoms of profound hypomagnesemia
Recognize proton pump inhibitors as a rare contributor to clinically consequential hypomagnesemia

Case Presentation: A 83-year-old man with gastritis treated with omeprazole and recent acute lacunar stroke presented to the hospital with intractable nausea and vomiting. One week prior to admission, he was admitted with intractable nausea, vomiting, and aphasia. MRI brain revealed an acute to subacute lacunar infarction in the left corona radiata. During hospitalization, his nausea and vomiting was refractory to antiemetic treatment but resolved by the time of discharge. Additionally, he had no residual neurological deficits on discharge. Shortly after discharge, he had recurrence of intractable nausea and vomiting which did not improve with oral antiemetic medication. He had no fever, chills, abdominal pain, changes in stool pattern, or neurologic symptoms.

On presentation, his vitals were normal. Physical exam was unremarkable including a normal abdominal exam and neurological exam. Laboratory testing showed profound hypomagnesemia with serum magnesium less than 0.2 mg/dL. Other electrolytes were unremarkable except for hypokalemia and hypocalcemia. CT abdomen/pelvis with contrast showed gastric wall thickening and cholelithiasis without evidence of cholecystitis. Subsequent esophagogastroduodenoscopy failed to identify a gastrointestinal cause for vomiting. Repeat MRI brain did not reveal a central cause of vomiting.

The patient was treated with multiple doses of IV magnesium sulfate and oral magnesium oxide with prompt improvement of symptoms. However, his serum magnesium level remained persistently low. Urine magnesium indicated increased renal excretion, however this was tested in the setting of ongoing magnesium replacement. After reviewing his medications further, omeprazole was discontinued and replaced with famotidine with subsequent stabilization of magnesium level.

Discussion: The presentation of hypomagnesemia can vary widely but may include nausea, vomiting, arrhythmias, muscle cramping, and paresthesias. Hypomagnesemia is a rare side effect of chronic proton pump inhibitor (PPI) usage. The risk of hypomagnesemia increases with the duration of treatment. It is thought that increased pH within the small bowel leads to decreased affinity of magnesium binding to active magnesium transport channels, such as transient receptor potential melastatin (TRPM) cation channels. Variant alleles of the TRPM6/TRPM7 genes are associated with

11:00 am Podium

THE TAMING OF THE SHREWD HELMINTH: DIAGNOSING SEVERE COLONIC TRICHURIASIS

Brendan Martino, DO[1] and Pedro Manibusan, MD[2]
[1]Department of Medicine Training Program, TAMC, Honolulu, HI
[2]Department of Medicine, TAMC, Honolulu, HI

Introduction:
Helminthic infections are very common worldwide. Common nematode infections include Enterobiasis vermicularis (pinworm) and Trichuris trichiura (whipworm). These are very common especially amount children and travelers to tropical climates. Infection is usually acquired via fecal-oral transmission of parasite eggs which then hatch and mature in the GI tract before being excreted in the feces to infect a new host. Patients can be asymptomatic or present with abdominal cramping, diarrhea, dysentery, and pica depending on disease burden.

Case Presentation:
22-year-old female without significant past medical history presenting with four days of abdominal pain and cramping with associated dark diarrhea. She just returned from a three-week WULS WR ,QGRQHVLD 6KH ZDV LQLWLDOO\ VHHQ E\ KHU 3&
azithromycin. Her diarrhea continued to worsen, and she went to the ED and diagnosed with gastroenteritis and discharged with Imodium. CT abdomen/pelvis was unremarkable. Lab work revealed leukocytosis with significant eosinophilia, and she was sent for stool culture as well as ova and parasite testing which were subsequently negative. However, she was found to have blood in her stool and was referred to GI for endoscopy. Ova and parasite testing was repeated by GI and was negative. She was also found to have worsening leukocytosis and eosinophilia. Upper endoscopy was performed which did not reveal signs of upper GI bleed. She then underwent colonoscopy which revealed copious parasitic worms throughout the colon most concentrated in the cecum and ascending colon with mucosal inflammation. Biopsies were obtained and sent for parasite identification. Given the location and endoscopic appearance of the parasite, Trichuriasis (whipworm) was suspected, and she was treated with three days of albendazole. She responded well to treatment with improvement in her symptoms, resolution of her leukocytosis and eosinophilia.

Discussion:
There are many types of parasitic infections that can present with varying degrees of symptom severity making diagnosis difficult. Symptom onset is often delayed from time of infection by several weeks to months as well. This can further be complicated by the fact that laboratory testing such as ova and parasite as well as advanced imaging studies can often be negative such as this in case. Travel history in the setting of new eosinophilia is key for raising suspicion of helminthic infections and prompting further diagnostic evaluation with PCR and endoscopy for definitive diagnosis. Treatment is tailored to the particular parasitic infection. Common therapies include albendazole, mebendazole and ivermectin which can treat a wide variety of parasitic infections. Good hygiene and proper food preparation practices are also very important in interrupting the cycle of transmission with these parasites and should be stressed to patients, particularly those infected or traveling to endemic areas.

2:00 pm Podium

IMPROVING COMMUNICATION SKILLS AMONGST CLINICIANS THROUGH FORMAL EVIDENCE BASED TRAINING

Gull Mahvish, MD[1]; Gerri Sylvester, MD; Mohammed Ali, MD[1]; Monica Orcine, MD; Susan Christensen, MD; Kellie Kurasaki, MD; Angela Lo, MD; Miquela Ibrao, MPH, MSW; Aida Wen, MD[1,2]; Cody Takenaka, MD[1,2]; Brita Aramaki, MD[1,2]; Kamal Masaki, MD[1,2]

[1] 8QLYHUVLW\ RI +DZDLµL -RKQ, Dept of Geriatric Medicine, Honolulu, HI

[2] 4XHHQ¶V 8QLYHUVLW\ 0HGLFDO *URXS +RQROXOX

Objective: To conduct a quality improvement project assessing whether training using VitalTalk will improve knowledge, skills, and attitudes on communicating with patients and families about serious illness.

Background: Empathic, honest communication between physicians and patients/families is the foundation of shared decision making and patient centered care. Only 14% of physicians report advance care planning discussions with patients and over 60% report they have never received formal training. Multiple models of training exist. VitalTalk provides evidence-based training using simulated patients to train clinicians how to communicate effectively with seriously ill patients and their families.

Methods: $OO JHULDWULFLDQV 1 DW WKH 4XHHQ¶V 8QLYHUV up and University of Hawaii received 4-hour VitalTalk training (July to September 2022) via Zoom or web-based training. After training, geriatricians evaluated the workshop, and completed a retrospective pre-post survey related to skills and comfort level with different communication skills. Additional resources from VitalTalk were provided. Efficacy and incorporation of learned skills into practice will continue to be evaluated at 1 and 3-month follow-up. Data from baseline and 1-month follow-up were analyzed using descriptive statistics and paired t-tests, comparing differences between pre and post scores.

Results: All participants (100% response rate) completed evaluations. Evaluation scores were rated on a 5-point Likert Scale: 1=poor, 5=excellent. Baseline mean scores on quality of training were high (range 4.45 to 4.95). Aretrospective pre-post questionnaire showed significant improvements in skills in discussing clinical status (3.68 to 4.14, p=0.004), goals of care (3.73 to 4.18, p=0.0018) and advance care planning (3.82 to 4.23, p=0.0038). Results were similar in comfort levels in discussing these subjects. There were also significant improvements in self-assessment of communication skills across eight domains: assessment of patient knowledge (p=0.0004), giving a KHDGOLQH S OW UHVSRQGLQJ WR SDWLH DOLJQLQJ ZLWK SDWLHQW¶V KRSHV DQG VKDUHQJ concerns (p=0.0002), managing uncertainty and conflict (p<0.0001), promoting prognostic awareness (p=0.0018), HOLFLWLQJ SDWLHQW¶ values (p=0.0038), and recommending treatment to support values (p=0.0106). At 1-month follow-up, 18/22 (82%) had used skills gained from training and continued to rate the training highly.

Conclusion: Communication skills are crucial for clinicians to provide patient centered care. Early results suggest that formal evidence-based training improves skills and comfort levels in communicating about serious illness with patients and families. We plan additional PDSA cycles to increase long-term use of these skills.

3:30 pm Podium

LONG COVID ±A CROSS-SECTIONAL STUDY EXPLORING THE PREVALENCE OF POST SARS-COV-2 INFECTION SYMPTOMS AND FUNCTIONAL LIMITATIONS I

Helena Holmgren, MD[1]; Kathryn Choo Loy, MD[1];
Abhinetri Pandula, MD[1]; Elaine Doi, MD[1]; Robin Seto, MD, FACP[1]
[1]Kaiser Permanente Hawaii Internal Medicine Residency Program

Background:

While most people with COVID-19 infection recover after an acute illness, some people have lingering or new symptoms that can last weeks to months. It is estimated that at least one in five Americans who have had COVID-19 infection will develop these long COVID symptoms. The post-acute sequelae of the SARS-CoV-2 condition defined by the CDC is characterized by a wide range of new, ongoing, or returning symptoms due to COVID-19 infection that last 4 weeks or longer.

Methods:

We conducted a cross sectional study to collect data on Native Hawaiian, Pacific Islander and other minority populations on Oahu to understand more about the prevalence of certain symptoms, the severity of these symptoms, and its impact on functional status. From 10/2021 through 10/2022, a convenience sample of patients with prior COVID-19 infection with engagement at one outpatient primary care clinic were recruited to complete a written survey.

Results:

Of the 100 patients that completed the survey, based on their electronic health record data, 28% self-identified race/ethnicity was Native Hawaiian/Other Pacific Islander, 24% Caucasian, 21% Filipino, 8% Japanese, 6% Chinese, 5% Hispanic/Latino, 2% Indian, 2% Korean, 2% Mixed, 1% Vietnamese, and 1% Black. Four or more weeks after initial COVID-19 infection symptom onset, 67% of patients identified one or more ongoing symptom. Of patients that reported long COVID symptoms, 74.6% reported no or negligible functional limitation, 20.9% reported slight functional limitation, and 4.5% reported moderate to severe functional limitations. The most frequently reported symptoms were fatigue (28%), brain fog (26%), insomnia (23%) and muscle/joint pain (21%). Of patients reporting long COVID symptoms and of those reporting functional limitations, the race/ethnicity distribution mirrored that of the overall study population.

Conclusions:

Among the diverse population of Hawaii, we confirm that post-acute sequela of COVID-19 infection impacts our patients. More studies are needed to describe the long-term effects of COVID-19 infections particularly among groups that suffer from poor health outcomes including Native Hawaiians and Other Pacific Islanders.

3:45 pm Podium

THE ROLE OF BIOMARKERS IN PREDICTING HIGH FLOW NASAL CANNULA (HFNC) SUCCESS IN COVID-19 ARDS

Andrew Pham, MD[1], Koichi Keitoku, MD[1], and Reid Ikeda, MD, FACP, FCCP[1, 2]
[1]University of Hawaii Internal Medicine Residency Program, Honolulu, HI
[2]The Queen's Medical Center, Pulmonary and Critical Care, Honolulu, HI

Background: COVID-19 infection can cause severe pneumonia and acute respiratory distress syndrome (ARDS), which is associated with high mortality. Treatment with HFNC can reduce the need for mechanical ventilation and ICU admission. However, factors predicting the success of HFNC at the time of initiation have not been well-characterized. Elevations in serum biomarkers such as C-reactive protein (CRP) and D-dimer have been associated with worse outcomes in COVID-19 infection, but few studies have assessed the predictive value of these biomarkers for successful management with HFNC.

Objective: To determine if CRP, D-dimer, and Ferritin are associated with successful treatment with HFNC in patients with acute hypoxemic respiratory failure due to COVID-19.

Method: :H UHWURVSHFWLYHO\ VWXGLHG FRQVHFXWLYH SDW Medical Center from August 2020 to October 2022 and treated with HFNC for acute hypoxemic respiratory failure due to COVID- SQHXPRQLD 3DWLHQWV GHVLJQDWHG D or on HFNC for post-extubation respiratory failure were excluded. Measurements of CRP, D-dimer, and Ferritin near the time of HFNC application were compared in patients who were intubated and those who were not intubated, using the Wilcoxon rank-sum test.

Result: A total of 329 patients were included in the final analysis. 44% (n=145) were

POSTER PRESENTATIONS

Poster #1

WUNDERLICH SYNDROME: WONDERING HOW IT HAPPENS

Noppawit Aiumtrakul, MD[1], Bryce Tanaka, MD[1] & Travis Watai, MD, FACP[2]
[1]University of Hawaii Internal Medicine Residency Program, Honolulu, HI
[2]The 4XHHQ¶V 0HGLFDO &HQWHU +RQRXOXX +,

Learning Objectives: - Recognize the clinical presentation of Wunderlich Syndrome
- To consider appropriate management of Wunderlich Syndrome

A 56-year-old man with paroxysmal atrial fibrillation on rivaroxaban presented with sudden onset sharp left-sided flank pain started while driving a car. There was radiation to the abdomen and back with associated diaphoresis. His past medical history was significant for a prior left middle cerebral artery occlusion, type 2 DM, morbid obesity status post bariatric surgery, HFrEF, and hypertension. The patient denied recent history of trauma, hematuria, kidney stone, kidney tumor, urinary symptoms, weight loss or fever. He was compliant with rivaroxaban for stroke prevention.

Vital signs were hemodynamically stable. Physical exam was significant for severe tenderness over the left flank. Initial work-up showed hemoglobin of 15.0 g/dL, pyuria with WBC>100/HPF and microscopic hematuria with RBC of 6-20/HPF. CTA aortic dissection protocol illustrated a large left perinephric hematoma with several areas of active extravasation measuring approximately 12.2x12.1x16.1cm. This form of nontraumatic spontaneous perinephric hematoma is consistent with an uncommon clinical syndrome of Wunderlich syndrome.

The patient was in severe pain and required IV hydromorphone for adequate pain control. Urology was consulted and recommended conservative management given stable hemodynamics. With results of his urine culture showing a potential infectious culprit, the patient was started on ceftriaxone and switched to IV ertapenem when sensitivities showed ESBL producing E. coli. Over the next couple of days, his hemoglobin slowly downtrended but stabilized at 9.7 g/dL. Upon discharge, we recommended repeating a CT scan in 2-3 months to assess for possible underlying tumor.

Discussion: Wunderlich syndrome (WS) is a rare clinical syndrome defined by nontraumatic spontaneous renal hemorrhage. The majority of manifestations present with isolated flank pain and are often detected with a non-contrast CT scan. The classical presentation of WS is known as /HQN¶V WULDG LQFOXGLQJ DFXWH IODQN SDLQ SDOSDEOH
neoplasms, vascular disease, cysticy a,22 0 64>-5<004666Agnific xonea4(nd mi)-oficdisG[(-)] TJETQq0.00000

Poster #2

CARDIAC AMYLOIDOSIS

Samer Al Daheen, **MD**[1] and Francisco Mercado, MD, FACP,[2]
[1]Department of Medicine Training Program, TAMC, Honolulu, HI
[2]Department of Medicine, TAMC, Honolulu, HI

Background: Cardiac amyloidosis is previously thought to be a rare disorder characterized by the accumulation of extracellular misfolded protein at the myocardium (1). Cardiac manifestations include thrombogenesis, arrhythmias, conduction disorders, and restrictive cardiomyopathy (2). Involvement of the myocardium in a patient with systemic amyloidosis is a major factor in determining the patient's survival and has the worst prognosis (3-5).

Case Summary: Our patient is a 58-year-old Chamorro male with a past medical history of coronary artery disease status post-coronary artery bypass graft surgery in 2016. He presented for evaluation of exertional chest pain. In the ED, the patient had elevated troponin without STEMI on EKG. Coronary and graft angiography revealed patent grafts and unchanged native disease. The echocard9(d (ede c)-2(a)9(r)-3(d)11(i)-4ed)9 n

Poster #4

TB: A BRAIN CANCER LOOK-ALIKE

Karen Chang

Poster #5

MOBILITY DEVICE USE AND FRAILTY PROGRESSION IN COMMUNITY-DWELLING OLDER ADULTS WITH MOBILITY IMPAIRMENT

A. Chau, BS[1], D. Kim, MD

Poster #7

BREAST NODULAR FASCIITIS IN A POSTMENOPAUSAL WOMAN: A CASE REPORT AND REVIEW OF RECENT LITERATURE

Shirley Cheng, BS[1], Briana Lau-Amii, MD, FACS, FSSO[2]
[1]University of Hawaii John A. Burns School of Medicine, Honolulu, HI
[2]Hawaii Permanente Medical Group, Honolulu, HI

Background:

Nodular fasciitis (NF) is a benign soft tissue lesion that can occur anywhere in the body. Its occurrence in the breast is a rare phenomenon, but is clinically important to distinguish from a malignant tumor as they both present as lesions of the breast.

Case presentation:

In this report, we discuss a case of NF of the breast in an elderly woman who presented with an asymmetry of the breast on an annual screening mammogram followed by diagnostic imaging and a core biopsy. Ultimately, excision of the lesion (1.2cm) was the definitive treatment for this patient and histological evaluation confirmed the diagnosis of nodular fasciitis. Additionally, we review the most recent literature on this topic discussing the significance to better understand the characteristics and best treatment course for breast NF.

Conclusion:

The clinical features of breast NF may present similarly to that of a malignant tumor. Accurate diagnosis with immunohistochemistry staining or USP6 FISH analysis is critical to prevent misdiagnosis and overtreatment. Clinician awareness, surgical treatment, and patient education is important for best management of breast NF.

Poster #8

A CASE OF THE "-ITIS": MULTI-SYSTEM ORGAN DYSFUNCTION DUE TO NIVOLUMAB THERAPY

Ethan Charles Chun[1], MD; Philip Verhoef, MD, FACP[2]

1

Poster #9

Poster #10

Poster #11

ATYPICAL MONONUCLEOSIS INFECTION PRESENTING AS ACUTE CHOLESTATIC LIVER INJURY

Yula Yzabelle Geniza, MD[1]; Javier Barranco-Trabi, MD1; Pedro Manibusan, DO[2]
[1]Department of Medicine Training Program, TAMC, Honolulu, HI
[2]Department of Medicine, TAMC, Honolulu, HI

Introduction: Infectious mononucleosis (IM), presents with a triad of tonsillar pharyngitis, fever, and lymphadenopathy. Most commonly caused by Epstein-Barr virus (EBV), is generally self-limited. Transmission is thought to spread mostly by contact with mucous membranes, such as kissing. Atypical presentation of IM is rare, a few literatures notably in pediatric[1] and elderly patients[2] and jaundice were published. We present a case of IM with an unusual presentation in a young adult female that presented as jaundice with hyperbilirubinemia with concomitant liver enzyme elevation consistent with a cholestatic pattern.

Case Presentation: A 26-year-old female presented to the emergency department three weeks after swimming in fresh water with jaundice, icterus and generalized body aches. Five days before presentation, she reported worsening symptoms to include fever, nausea, vomiting and drenching night sweats. Leptospirosis was suspected because of her exposure. She was started on empiric antibiotic treatment. She was afebrile, tachycardic with blood pressure within normal limits. On physical exam, patient had icterus, jaundice, no lymphadenopathy, benign abdominal exam and no hepatosplenomegaly. She had conjugated hyperbilirubinemia on with cholestatic liver enzyme elevation. The hepatitis panel, acetaminophen, and ammonia level were negative. She denies taking medications. The urine drug screen was positive for cannabinoid. A right upper quadrant ultrasound was negative for biliary duct dilation/obstruction. Computed tomography scan of the abdomen was notable for splenomegaly. Monospot and EBV serologies were positive. *DVWURHQWHUROJ\¶V LQSXW ZDV WR GHIHU (QGRVFRSLF 5 Cholangiopancreatography/Magnetic Resonance Cholangiopancreatography because there was no evidence of biliary obstruction the symptoms were consistent with IM from EBV. She improved with supportive care.

Discussion: Viral, alcoholic, medication, autoimmune causes of hepatitis can cause jaundice. Jaundice can be classified as conjugated or unconjugated hyperbilirubinemia. Conjugated hyperbilirubinemia with other liver derangements can be classified into a hepatocellular process and intra vs extra cellular cholestasis. Subsequently, a right upper quadrant ultrasound can detect a dilation of the intra and extra hepatic biliary tree. An appropriate next test would be an abdominal CT. In patients with intrahepatic cholestasis, the diagnosis is made with serological testing and percutaneous liver biopsy.[3]

Conclusion: Differential diagnosis of cholestatic liver injury is broad which requires detailed history. Our case aims to demonstrate the importance of cholestatic liver injury as a rare manifestation of EBV mononucleosis. We can include EBV and a monospot test on a work-up of cholestatic jaundice to save time and resources.

References:

[1] https://pubmed.ncbi.nlm.nih.gov/29364802/
[2] https://pubmed.ncbi.nlm.nih.gov/27037083/
[3] Longo DL, Fauci AS, Kasper DL, Hauser SL, Jameson J, Loscalzo J. eds. Harrison's Principles of Internal Medicine, 18e. New York, NY: McGraw-Hill; 2012.

Poster #12

Poster #13

SMALL CELL LUNG CANCER PRESENTING WITH MECHANICAL FALL

Shuhei Hattori, MD[1], Christina Park, MD[1], and Kuo-Chiang Lian, MD, FACP[2]
[1] 8 Q L Y H U V L W \ R I + D Z D L ¶ L Internal Medicine Residency Program, Honolulu, HI
[2] 4 X H H Q ¶ V University Medical Group, Honolulu, HI

Introduction:

Syndrome of inappropriate antidiuretic hormone (SIADH) is a well-known paraneoplastic phenomenon associated with small cell lung cancer (SCLC). More than 90% of patients with SCLC are elderly current or past heavy smokers. Presenting manifestations may result from local

Poster #14

A HEART STOPPING CASE; YOUNG WOMAN WITH CARDIAC TAMPONADE, RIGHT ATRIAL MASS, AND MILIARY LUNG NODULES

Helena Holmgren, MD[1], Sunghyun Lee, MD[1], Philip Verhoef, MD, FACP[2]
[1] .DLVHU 3HUPDQHQWH +DZDL¶L ,QWHUQDO 0HGLFLQH 5HVL
[2]Hawaii Permanente Medical Group, Honolulu, HI

Introduction: We present the lessons learned from the diagnostic evaluation of a critically ill previously healthy women with cardiac tamponade, right atrial mass, and miliary lung nodules.

Case Presentation: A 37-year-old previously healthy female presented to the ED after a syncopal event. She reported three weeks of progressive cough, dyspnea, and exercise intolerance. She also endorsed night sweats and 10 lb weight loss. Vital signs showed oxygen saturation of 90% on room air, respiratory rate of 112, blood pressure of 106/77, and temperature of 99.0 F. Bedside echocardiogram demonstrated pericardial effusion with tamponade. Pericardiocentesis drained 650 cc bloody fluid with hemodynamic improvement. She had hypoxemic respiratory failure requiring high flow nasal cannula.

Laboratory evaluation was notable for WBC 19.8 (neutrophil predominant), mild AST/ALT elevation. Chest x-ray and CT of the chest demonstrated innumerable tiny bilateral nodules in a miliary pattern. CT of the abdomen and pelvis demonstrated bilateral ovarian masses with mild ascites. Bronchoscopy with bronchoalveolar lavage was unrevealing. All infectious tests including cell free DNA were negative. Autoimmune testing was negative. Subsequent CT guided biopsy of the lung did not show any evidence of infection or malignancy. Transthoracic echocardiogram showed a 3.5 x 3 cm right atrial mass.

To obtain a definitive diagnosis, she underwent a right upper and middle lobe wedge resection with Cardiothoracic surgery. Pathology demonstrated high grade vascular neoplasm consistent with angiosarcoma. During her hospital course, CT with angiography of the chest demonstrated bilateral subsegmental pulmonary emboli. MRI of the brain showed several small cerebral metastases with vasogenic edema. MRI of the thoracic spine demonstrated sub-centimeter T2 and T6 thoracic spine lesions suspicious for metastasis.

She subsequently initiated chemotherapy with gemcitabine and docetaxel followed by doxorubicin without any evidence of disease response. She received gamma knife radiation to brain metastasis. Unfortunately, she had hemorrhagic conversion of the brain metastasis and passed away five months after initial presentation.

Discussion: Angiosarcoma is a rapidly growing malignancy arising from blood or lymphatic vessels. Although rare, angiosarcomas are the most common primary cardiac tumor and often occur in the VHWWLQJ RI SULRU UDGLDWLRQ H[SRVXUH $V VHHQ LQ WKLV right atrium. Due to the nature of the disease including hematogenous metastatic spread, angiosarcomas can cause a miliary pattern of lung nodules in addition to other patterns. Unfortunately, cardiac angiosarcomas have a high prevalence of distant metastasis at the time of diagnosis and carry a poor prognosis.

This case demonstrates the extensive evaluation required to diagnosis cardiac angiosarcoma. We learned the importance of simultaneously stabilizing her critical condition while pursuing diagnostic workup.

Poster #15

Poster #16

PROLONGED COVID-

Poster #17

NEW-ONSET COMPLETE HEART BLOCK FOLLOWING RECENT COVID-19 INFECTION

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Atrioventricular (AV) block is caused by a delay in electrical cardiac conduction between the atria and ventricles. Complete heart block (CHB) is a severe manifestation of this wherein communication between the atrial and ventricles is completely severed. Infection is recognized as an important cause of AV block, often resulting from myocarditis. COVID-19 often causes myocardial injury and may manifest as heart failure, acute coronary syndrome, myocarditis, and conduction abnormalities, among others. AV block is a suspected consequence of COVID-19 and may present in patients without active myocarditis.

A 68-year-old man with a past history of hypercholesterolemia presented to the emergency department with one month of dyspnea on exertion. His recent history was notable for acute COVID-19 infection one month prior to the current presentation, and at the time he was symptomatic with only cough and rhinorrhea. These symptoms improved with supportive care and he completed a ten-day quarantine. However, he subsequently complained of gradually worsening dyspnea on exertion. He had no history of cardiovascular disease. The physical exam was notable for junctional escape rate in the 40s with preserved hemodynamics; he had an otherwise normal cardiac and pulmonary examination. Laboratory results showed normal serum electrolytes, thyroid function tests, and cardiac-specific troponin levels. In addition, an echocardiogram showed a normal left ventricular ejection fraction of 55% and no wall motion abnormalities or valvular abnormalities. A 12-lead ECG demonstrated A-V dissociation consistent with CHB. He underwent dual-chamber pacemaker placement and noted immediate improvement in his symptoms post-procedurally. At two-week outpatient follow-up, the patient remained symptom-free.

We present a patient with CHB manifesting as dyspnea on exertion occurring in the setting of recent COVID-19 infection. The etiology of the CHB remains unclear, although we speculate that it may be due to COVID-19 due to its temporal association. Cardiac ischemia and active myocarditis are less likely, owing to normal cardiac troponins, unremarkable echocardiogram, absence of chest pain or ST-T changes on EKG, but idiopathic age-related degeneration of the

Poster #18

A CASE OF CLINICALLY ISOLATED SYNDROME MANIFESTING AS OPTIC NEURITIS

Landon Kozai, MD[1], Kevin Benavente, DO[1], Christina Park, MD[1],
Tory Czech, MD[1], and Kuo-Chiang Lian, MD, FACP[2]
1

Poster #19

CHATTERJEE PHENOMENON: A DEMONSTRATION OF CARDIAC MEMORY IN PACED RHYTHMS

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While T wave inversions (TWI) in electrocardiograms (EKG) are commonly associated with certain cardiac pathologies, it is rarely associated with cardiac memory. This rare cause of TWI is usually the result of either a ventricular paced rhythm or in patients with a known history of tachycardic rhythms. This abnormal conduction induces alterations in both early and late myocardial activation potentials leading to cardiac remodeling and heterogenous depolarization and has been coined the Chatterjee phenomenon.

Case:

A 76-year-

Poster #

Poster #21

USE OF AN OVER-THE-SCOPE CLIP IN MANAGING ADULT ANASTOMOTIC ULCER BLEEDING

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Introduction:

Anastomotic ulcers (AU) following surgical procedures such as ileocolonic resection in patients without Crohn Disease are a rare occurrence. The overall incidence of AUs among both adult and pediatric patients is estimated to be between 0.3%-8%. Primary symptoms include abdominal pain, iron deficiency anemia, and evidence of gross or occult gastrointestinal (GI) bleeding. However, effective treatment options are lacking, and physicians often resort to resecting the affected AU with re-anastomosis of the ileocolonic region. To date, no study has reported the use of an over-the-scope clip (OTSC) in the successful closure of an AU in an adult patient to treat recurrent bleeding.

Case Report:

The patient is a 67-year-old woman with a past medical history of pulmonary fibrosis, rheumatic heart disease, status post mitral commissurotomy and mechanical mitral valve replacement; with warfarin, atrial fibrillation, benign colon mass, status post colostomy, and history of two recurrent episodes of ileocolonic anastomosis bleeding. She presented to the emergency department with SURJUHVVLYHO\ EORRG-FRORUHG ´RQ WKH 3SOXHU WKUHH GD\ warfarin. Laboratory studies conducted on her day of presentation identified glucose: 122 mg/dL, RBC: 3.21 million/L, Hgb: 9.1 g/dL, Hct: 28.2%, PT: 29.2 seconds, PTT: 37.4 seconds, and INR: 2.9. Same day computed tomography angiogram for acute gastrointestinal bleeding revealed a lack of active gastrointestinal tract bleeding. She had no antibiotic exposures or changes in diet and was admitted for an in-

Poster #22

FALSE POSITIVE? TWO CASES OF PERSISTENTLY ELEVATED TROPONIN I WITHOUT CLINICAL EVIDENCE OF CARDIAC INVOLVEMENT

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Introduction: With the widespread adoption of high sensitivity troponin assays, clinicians must recognize elevations can be caused by several cardiac and noncardiac conditions. Growing HYLGHQFH LQ DGXOW SRSXODWLRQV GHPRQVWUDWHV ³WUX heterophile antibodies, hemolysis, and fibrin interference. We add to this body of literature with two cases in adolescents of persistently elevated high sensitivity troponin I without cardiac involvement.

Case 1: A 16-year-old male with situs inversus total is presented with non-exertional, right-sided chest tightness beginning while he was sitting in class. He denied radiation, palpitations, shortness of breath, nausea, diaphoresis, constitutional symptoms, or preceding upper respiratory infection. He had no prior episodes of chest pain, had otherwise been healthy, and had not received COVID-19 vaccination. Labs were significant for high sensitivity troponin I 1811, ESR 19, CRP 0.2, SARS-COV-2 PCR negative, SARS-COV2-Ab positive, and Heterophile antibody negative. ECG demonstrated clear j-point ST elevations consistent with early repolarization. Telemetry did not demonstrate arrhythmia. Echocardiogram was normal (apart from dextrocardia), and cardiac MRI did not demonstrate myocardial enhancement, pericardial effusion, or pericardial thickening. 1 month after his initial presentation, high sensitivity troponin I remained elevated at 1750. Cardiac troponin T sent to an outside lab returned negative.

Case 2: A 16-year-old male presented with sternal chest pain that woke him from sleep. He denied radiation, diaphoresis, nausea, SOB, palpitations, constitutional symptoms, or preceding upper respiratory infection. He reported several episodes of similar chest pain occurring c29 Tm0 ges wrspir

Poster #23

AN UNUSUAL CAUSE OF RECURRENT IDIOPATHIC SMALL BOWEL OBSTRUCTION

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A 66-year old caucasian woman was referred for partial small bowel obstruction (SBO). The patient had been experiencing diffuse crampy abdominal pain, diarrhea and hives over the past several weeks for which an allergist and dermatologist had prescribed prednisone 10mg/d, cetirizine 10mg/d, and ranitidine 150mg/d. She then developed severe diffuse abdominal cramps with nausea and vomiting and went to the Emergency Department. CT abdomen showed partial SBO with a small bowel transition point. The SBO resolved within days with conservative management. An EGD and colonoscopy with biopsies were performed and were unremarkable but a pillcam study showed non-raised pigmented spots in the distal small bowel. Urine 5-HIAA and blood tryptase levels were normal but a urine histamine level was 9-times the upper limit of normal.

Over the next two years, she was hospitalized for two more episodes of SBO. With each episode of SBO, her CT scans showed transition points at different locations in her small bowel, making adhesions unlikely causes of SBO. She had no history of prior abdominal surgeries or pelvic inflammatory disease. Allergy testing and avoidance were unable to prevent hives or episodes of abdominal pain.

She was referred to an expert at a major medical institution for evaluation for suspected mast cell disease. Mutation testing for KIT D816V from a bone marrow biopsy was negative for mutation and systemic mastocytosis but she was felt to have Mast Cell Activation Syndrome (MCAS). She was advised to go on a starch- and sulfate- free diet.

The diet did not help so the patient was started on cromolyn 200mg po QID. Over the subsequent 5 years, her abdominal pains diminished and she only had symptoms of SBO once and no hospitalization was required. Unfortunately, her hives were not completely alleviated and trials of prednisone and cyclosporine were ineffective.

The patient was diagnosed with Idiopathic MCAS, a condition in which the patient experiences repeated episodes of the symptoms of anaphylaxis ±allergic symptoms such as hives, swelling, low blood pressure, difficulty breathing and severe diarrhea. High levels of mast cell mediators are released during those episodes. Histopathological diagnosis from non-bone marrow tissues of MCAS can be tricky since mast cells can rapidly degranulate.

There are previous reports of SBO due to MCAS, which are felt to be due to tissue edema, but this is the first case in which recurrent SBO was successfully alleviated with cromolyn. Further studies are required to study the long-term efficacy of cromolyn and avapritinib in patients with severe problems due to MCAS.

Poster #24

A RARE PRESENTATION OF NEW ONSET OCCIPITAL SEIZURES IN DIABETIC KETOACIDOSIS

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Case:
A 73-year-old male with a past medical history of type 2 diabetes and HSV Zoster infection was DGPLWWHG IRU SHUVLVWHQW GL]]LQHVV IRU WZR ZHHNV Z PRYLQJ´ +LV ZLIH DOVR QRWLFHG SURO DSSHW WH IDW LJ seen in the ED. On neurological examination, the patient was alert and oriented, with left hemianopsia, decreased sensation over his left V1-V3 region, left-sided neglect, left arm pronator drift, and left hemibody weakness (4+/5). Speech was fluent, no facial droop was present, and there were no abnormalities with reflexes, coordination, or gait. Examiner then witnessed a 1-minute episode of left arm jerking; the patient was conscious throughout with no gaze preference. Labs revealed diabetic ketoacidosis (DKA) with an initial glucose of 487, serum osmolality of 304, pH 7.32, bicarbonate of 26, anion gap of 29, B-hydroxybutyrate of 3.51, and 1+ ketones/4+ glucose in the urine. CT head was negative for hemorrhage or ischemia, and MRI brain was only notable for right P2 stenosis. Continuous EEG monitoring revealed focal motor seizures of right occipital onset with spread. The patient was treated with hydration and insulin, but he continued to seize after the glucose normalized, requiring treatment with Keppra and subsequently Phosphenytoin. The patient was discharged with Keppra and a basal/bolus insulin regimen. At the time of discharge, all neurologic deficits had resolved except for the left hemianopsia.

Discussion:
In rare cases such as this, hyperglycemia can present with neurologic findings that mimic a stroke. In our patient whose multiple deficits could not be localized to a specific region, hyperglycemia-induced seizures likely led to global cerebral dysfunction. The transient nature of his deficits may VXJJHVW D 7RGG¶V SKHQRPHQRQ

The mechanism of hyperglycemia-induced seizures is incompletely understood. Previously, the mechanism was thought to be via the hyperosmolality of DKA causing brain cells to accumulate intracellular osmolytes. More recent theories suggest that fluctuations in cerebral blood flow causing a hypoperfusion and reperfusion injury with vasogenic edema, in combination with an inflammatory reaction disrupting the blood brain barrier, is the underlying mechanism. Some studies have also suggested that preexisting lesions (such as an area of prior ischemia or encephalomalacia) may predispose patients with hyperglycemia to focal seizures.

Conclusion:
This case illustrates the importance of recognizing uncommon neurologic presentations and complications of DKA. Treatment focuses on glucose lowering, though anti-epileptic medications may be required.

Post

Poster #27

PRIMARY EFFUSION LYMPHOMA (PEL): VIGILANCE IS KEY TO DIAGNOSIS

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Introduction:
PEL is a rare large B-cell lymphoma caused by human herpesvirus type 8 (HHV-8), often associated with human immunodeficiency virus (HIV) infection. PEL presents as effusion affecting the pleural, peritoneal, or pericardial space, typically without a detectable mass. A common presentation is an immunocompromised male with shortness of breath and pleural effusion on imaging. For our case, we present a rare case of PEL in an immunocompetent individual with initial workup negative for malignancy.

Case Presentation:
A 90-year-old male with a history of chronic kidney disease, diabetes mellitus, and hypertension presented with shortness of breath. Computed tomography (CT) of the chest showed moderate left pleural effusion and a 3 mm nodule in the right upper lobe (RUL). Left-sided thoracentesis indicated that the effusion was exudative and monocyte-predominant. However, cytology did not find evidence of malignant cells and cultures had no growth. The patient later presented with dyspnea and bilateral lower extremity edema. Chest x-ray demonstrated an enlarged heart, along with recurrence of left pleural effusion. Electrocardiogram revealed atrial flutter and results were significant for elevated Troponin and B-Natriuretic Peptide of 294. Echocardiogram was unremarkable and he was managed with diuretic therapy. He also underwent repeat left-sided thoracentesis, but cytology was not investigated as his symptoms were suspected to be secondary to acute decompensated heart failure. The patient present ed again with dyspnea and chest x-ray displayed bilateral pleural effusions. Repeat CT chest showed a stable 4 mm ground-glass nodule in the RUL. Right-sided thoracentesis was performed. Cytology of the pleural effusion exhibited abnormal cells with enlarged regular nuclei and prominent nucleoli, positive for CD45/LCA, CD30, and HHV-8, consistent with PEL. Positron emission tomography (PET) scan revealed pericardial hypermetabolism suggesting pericardial involvement, but no evidence for nodal or solid organ involvement. The patient opted not to proceed with chemotherapy. A right indwelling tunneled pleural catheter was placed due to rapid symptomatic pleural fluid re-accumulation.

Conclusion:
The diagnosis of PEL is confirmed with fluid or biopsy demonstrating large, multinucleated lymphoid cells expressing markers such as CD45. Although it most commonly presents in young males with advanced HIV, it can occur in elderly immunocompetent patients infected with HHV-8, such as our patient. It should be noted that the initial cytology for our patient did not identify any malignant cells. Another case report of a patient with confirmed diagnosis of PEL had thoracentesis with cytology that was also negative for malignancy. It is likely that initial cytology may miss PEL, and a high index of suspicion is key for timely diagnosis.

Poster #28

A CASE OF GLEICH SYNDROME (EPISODIC ANGIOEDEMA WITH HYPEREOSINOPHILIA): UNDERSTANDING ITS CONTEXT WITHIN THE FRAMEWORK OF EOSINO

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Introduction:

Poster #29

ACUTE CEREBROVASCULAR EVENTS ASSOCIATED WITH COVID-19 INFECTION IN A MULTI-ETHNIC POPULATION IN HAWAII

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Introduction/Rationale:

Coronavirus disease 2019 (COVID-19) has been associated with an increased risk of acute cerebrovascular events (ACE). Disparities in COVID-19 outcomes by race and ethnicity have also been described. We sought to characterize and describe the multi-ethnic population of COVID-19 patients with associated stroke or transient ischemic attack (TIA) presenting to our tertiary medical center in Honolulu, HI.

Methods:

We performed a retrospective, cross- V H F W L R Q D O V W X G \ R I D G X O W S D W L H Q W our tertiary medical center between January 2020 and May 2022 with COVID-19 infection confirmed by positive severe acute respiratory syndrome coronavirus 2 reverse transcriptase ± polymerase chain reaction test. Patients with cerebrovascular disease in their chart problem lists were identified. We then conducted manual chart review to confirm diagnoses of acute ischemic stroke, hemorrhagic stroke, or TIA. Patients were excluded if the ACE occurred more than 30 days before or after COVID-19 diagnosis. Outcome data as well as demographic and medical variables known to be associated with cerebrovascular disease were collected.

Results:

A total of 5911 patients were included (mean age 63.71± 19.2], female 2635 [44.6%]). Among these, 112 (1.9%) patients developed ACE within 30 days of positive COVID test. Out of the patients who had ACE, 93 patients had ischemic stroke, 13 had hemorrhagic stroke and 5 patients had TIA. Patients with ACE had a mean age of 68.2 and majority were male (60.7%). These patients were predominantly Filipino (36.6%), White (16.1%), and Native Hawaiian (13.4%). 40.2% were admitted to the intensive care unit. The mortality rate was 13.4%. 33% were discharged to a destination other than home.

Discussion:

In a multi-ethnic population of COVID-19 patients presenting to a tertiary medical center in Honolulu, HI, ACE occurred in 1.9% of patients. Patients with ACE trended toward higher ICU admission and mortality rates. Future studies aim to further characterize stroke subtypes in this population and determine associated risk factors and outcomes.

Poster #30

A CASE OF DISGUISED LATE-STAGE DIFFUSE LARGE B-CELL LYMPHOMA PRESENTING WITH SEVERE TYPE B LACTIC ACIDOSIS

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Introduction: Most reported cases of type B lactic acidosis are associated with hematologic malignancies, including lymphomas. Cases of large B-cell lymphoma (DLBCL) specifically, leading to type B lactic acidosis, are both scarce and poorly understood. Herein, we present a unique case of late stage DLBCL and secondary chroni

Poster #31

CHARACTERISTICS OF OLDER ADULTS WITH POSITIVE NEUROCOGNITIVE SCREENS IN THE GERIATRIC ED

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Background:

The older adult population has a higher risk for developing neurocognitive disorders and is rapidly increasing worldwide, leading to increased use of emergency services. Geriatric Emergency Departments (GEDs) with specialized geriatric nurses can improve the identification of neurocognitive disorders and change clinical management. The purpose of this study is to describe characteristics of older adults with positive neurocognitive screens, and determine

Poster #32

POSTERIOR CIRCUMFLEX HUMERAL ARTERY

Poster #33

CT-BASED SCREENING FOR MODERATE TO SEVERE HEPATIC STEATOSIS IN A MULTIETHNIC POPULATION

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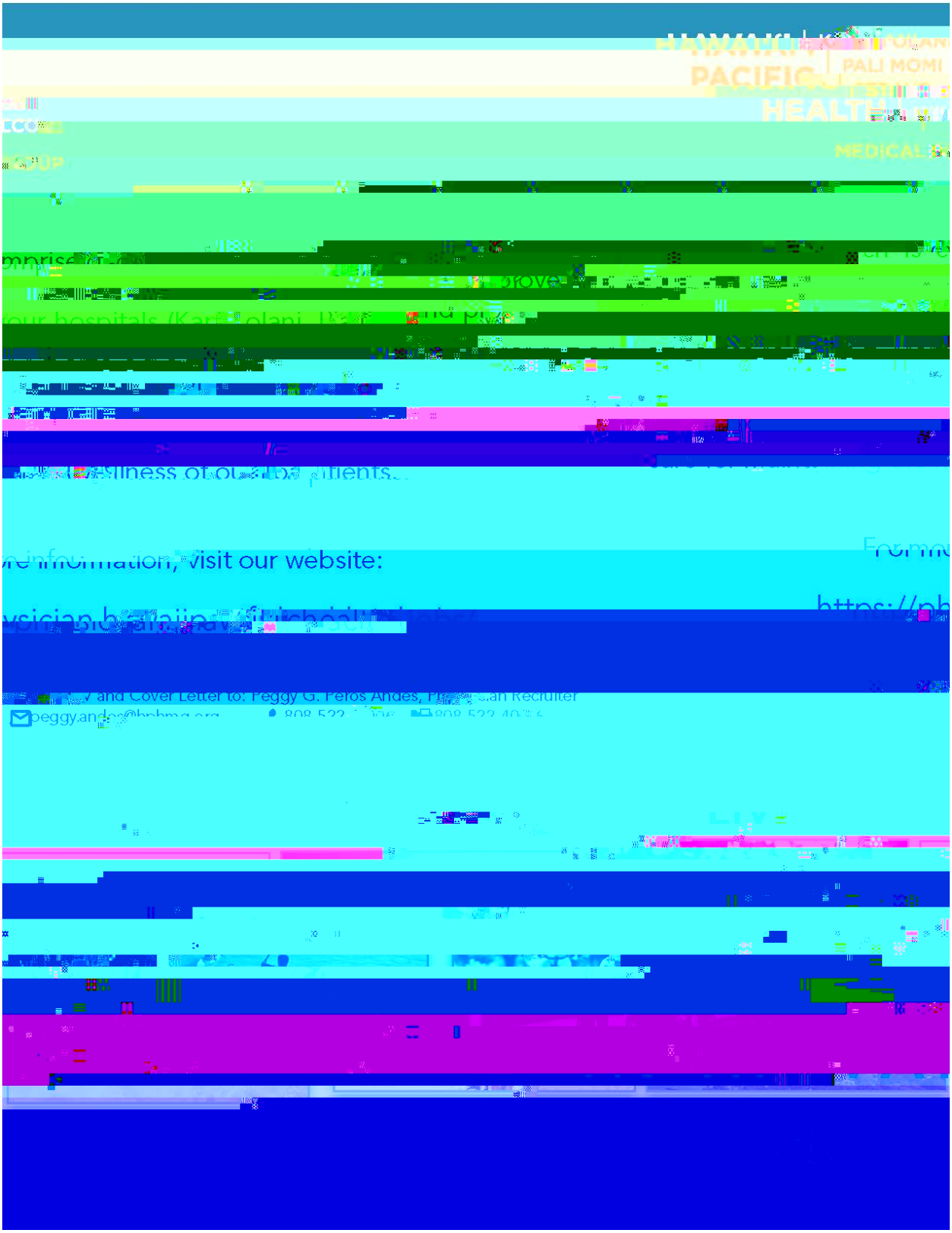
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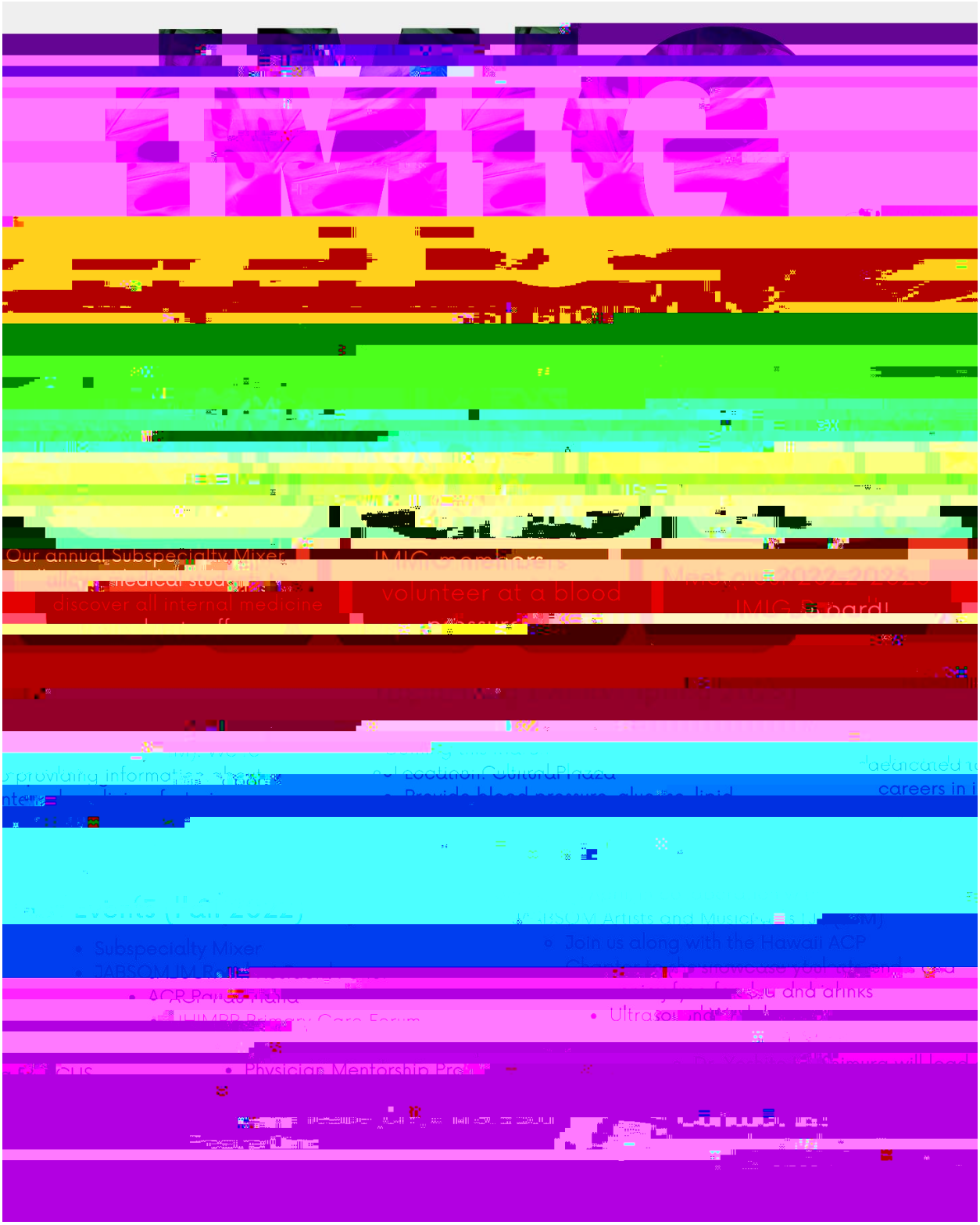
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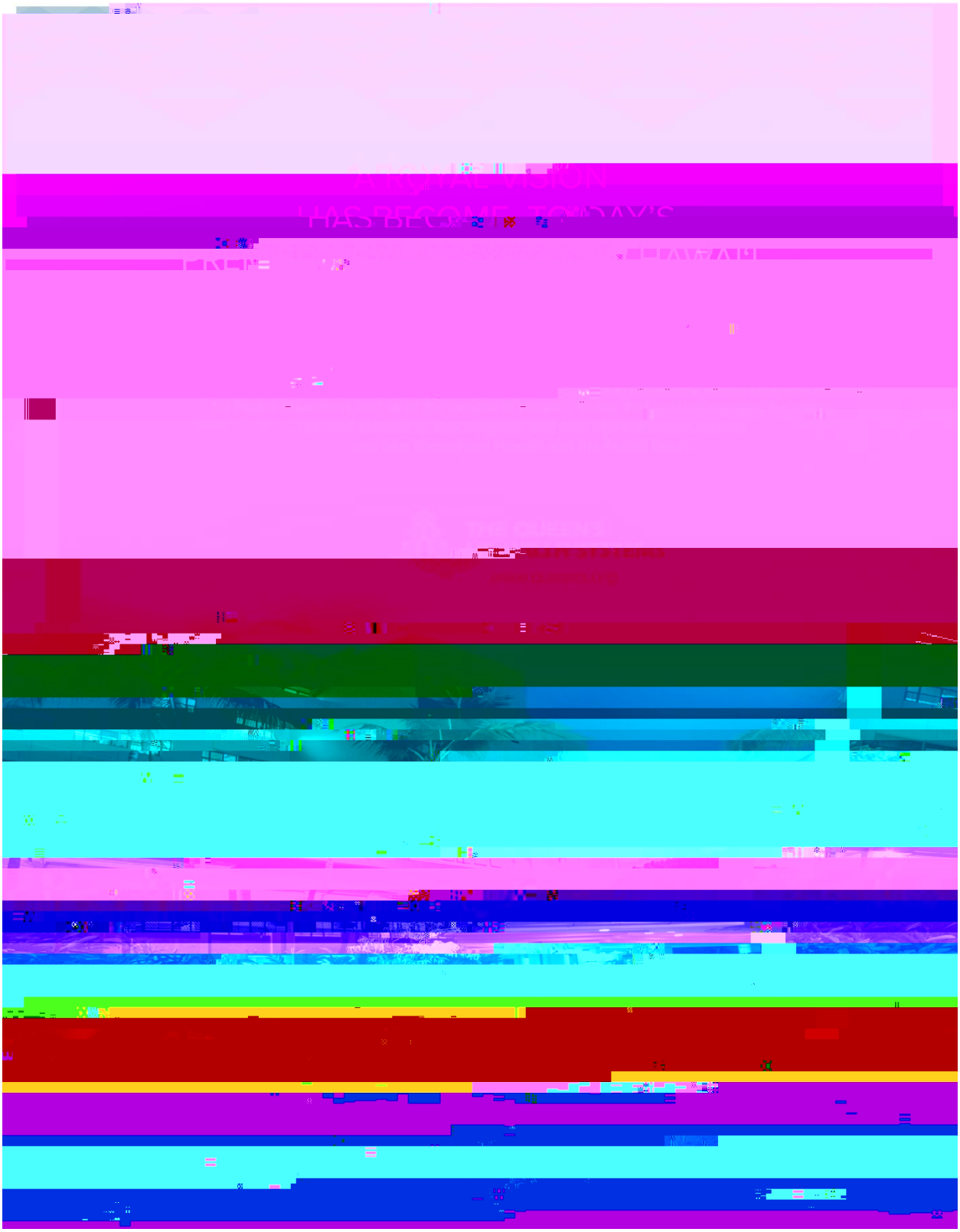
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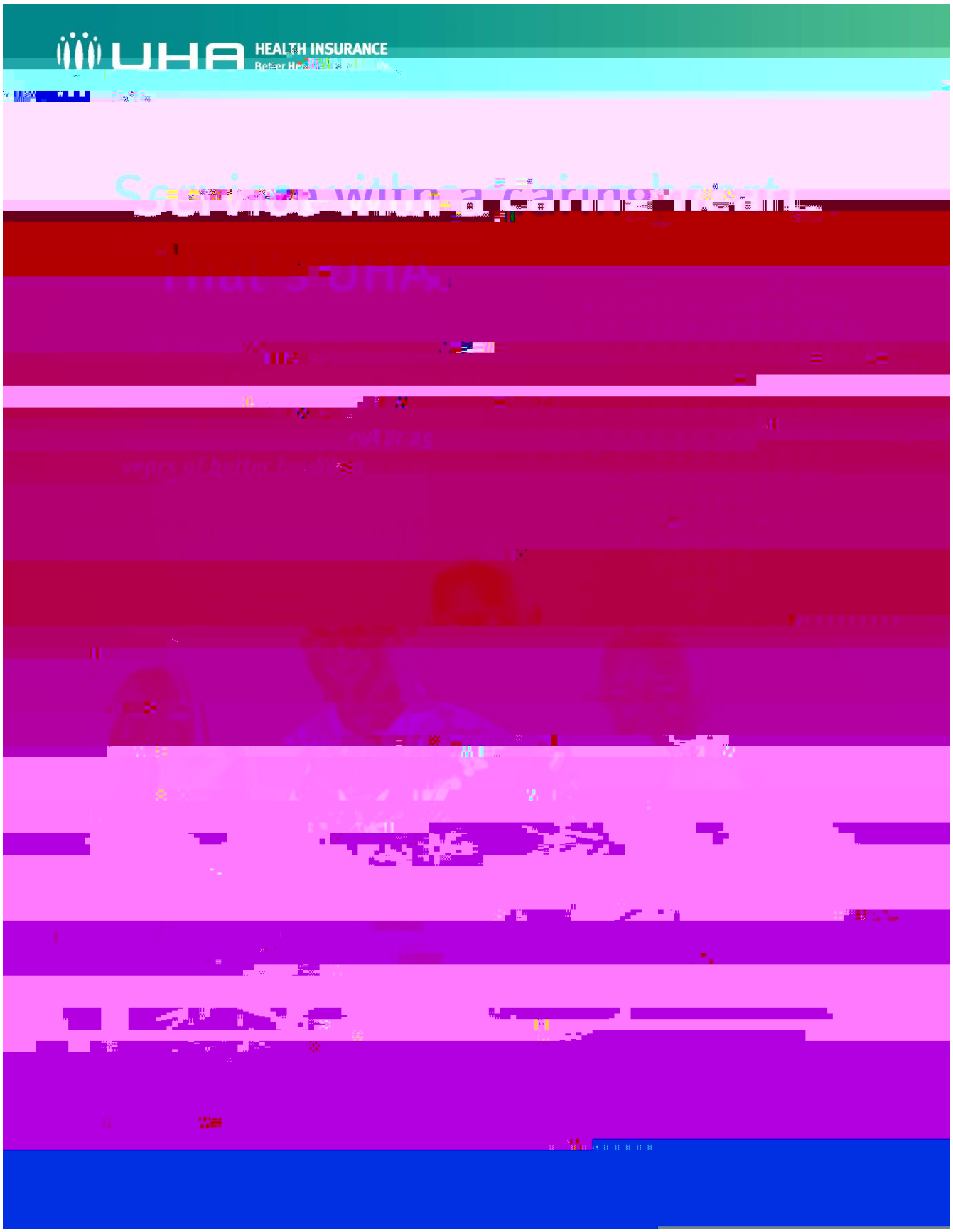
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