THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

HOSPITAL MEDICINE | MÉDECINE HOSPITALIÈRE

August 2015 Hospital Medicine Newsletter

Dear Community Members,

Thank you for taking an interest in the College of Family Physicians of Canada's (CFPC's) Hospital Medicine (HM) Committee – which is a part of the Section of Communities of Practice in Family Medicine (CPFM). We would like to share with you an update of committee initiatives, relevant topics in the area of hospital medicine, as well as a clinical vignette. Any feedback would be appreciated and can be forwarded to hospitalmedicine@cfpc.ca.

Committee Work Plan

The following are key items from our committee's work plan. We welcome your input on this information as well as through the Needs Assessment Survey link below.

Education

- Reach out to other enhanced skills HM university programs to determine whether they would like their information included on the Hospital Medicine website
- Fostering the development of Enhanced Skills programs in Hospital Medicine
- Creating and/or validating a list of core competencies in Hospital Medicine

Continuing Professional Development

- Program development in sharing of experiences in Hospital Medicine
- Share Family Medicine Forum (FMF) presentations on committee web page
- Distribute Hospital Medicine-specific FMF schedule to database members

Canadian Society of Hospital Medicine's (CSHM) 2015 Annual Conference

The upcoming CSHM Annual Conference will be held in Niagara Falls, ON at the Marriott Gateway on the Falls from September 24 – 27. 2015. Topics include: Patient Safety, Transitions of Care/Handovers, Controversies in Stroke Management, Balancing CHF and Renal Insufficiency.

Articles of Interest

- Comparing Antibiotic Treatment Options for CAP Richard T. Ellison III, MD Reviewing Postma DF et al., *N Engl J Med* 2015 Apr 2; 372:1312
- Hospitalization Is Associated with Changes in Cognition and Brain Structure Brandy R. Matthews, MD Reviewing Brown CH IV et al., Neurology 2015 Mar 11

Needs Assessment Survey

The Hospital Medicine Committee would like your feedback about our work and any initiatives you believe are important for the committee to take on. Your responses will inform the future of the committee's work, and ensure we're on the right path. Please click here to access our needs assessment survey.

Committee web page

For information about the committee, upcoming CPD events, news stories relevant to Hospital Medicine practitioners, and more, please visit http://www.cfpc.ca/Hospital_Medicine/. We encourage you to visit the web

page and provide your feedback and suggestions.

Clinical Vignette

You read about it, but you never really believe until it happens to you…

Mrs. W is a 60 y/o female known for long standing Type 2 DM, Hypertension and Dyslipidemia. She is a hospital employee who you recognize and who knows you. She presents to the ER with an episode of right facial numbness and what sounds like Amaurosis fugax lasting about 5 minutes. She also describes chest pain, retrosternal, which has been occurring seemingly on exertion for the past few months. She had been by seen her family doctor who had organized an echocardiogram which was to be done in one month.

On the day of the incident she experienced a flood in her house. She became upset, at which point she experienced chest pain and then the neurological symptoms. She had been seen by cardiology and neurology in the ER. Her initial work up, including ECG, Troponins, CXR and CT head were all negative. She was subsequently admitted to my service with a diagnosis of CVA, possible angina, and anxiety.

The history was very suggestive of angina-like chest pain, and she certainly had all the risk factors. Her physical exam revealed some weakness of her right arm and leg (4/5) with a possible pronator drift. She was seen by 2 different neurologists, 2 cardiologists, myself and an Internist, as well as a Family medicine resident and a medical student. We all were a bit suspicious about her presentation (considering anxiety to be playing a role), but it was difficult to rule out more serious problems given her risk factors. She was evaluated by Physiotherapy who also noted unilateral weakness and gait difficulties, and the initial plan was to change her to Plavix and apply for stroke rehab.

Given the uncertainty surrounding her presentation, it was decided to perform further testing. She subsequently had a coronary angiogram and an MRI. Both tests were NORMAL. It now seemed that she was in fact experiencing a kind of conversion disorder. Up to this point, she could only walk a few meters with a walker and under the supervision of the physiotherapist. I spoke with her regarding the results of her investigations, and suggested that her symptoms were likely related to anxiety. I also recommended that a psychiatrist be asked to come and evaluate her. Her reaction was calm acceptance. Within 2 days she was essentially walking normally and was discharged from the hospital, with an outpatient psychiatric referral.

Her Family Physician is a colleague of mine and works in the same FMU as I. At that time she was on maternity leave, and the patient had been scheduled to be followed by another one of my colleagues. I decided to see the patient one time in follow up, given the complexity of the recent admission. When she came to see me, she was walking normally. She recounted in greater detail the events of the flood, and it seemed there was even a possible element of PTSD.

She did experience some spasm of her right hand during the visit, and at times her speech was quite abnormal; almost like english was a foreign language, talking with poor grammar! She was awaiting her psychiatric assessment. She seemed to have good insight as to the psychological cause of her physical symptoms. I saw her back at work a couple of weeks after that, with complete resolution of all her symptoms.

In summary, my first real case of a conversion disorder, which was difficult to diagnose because of a number of factors, including the fact that she worked at the hospital, that I knew her, that she has multiple risk factors, and some very “real” weakness. In retrospect, I am not sure I would have done anything differently. Even though there was a significant concern about an anxiety component, it was really only possible to “confront” her after the objective testing was done.

- Dr. Benjamin Schiff

Sincerely,

The Hospital Medicine CPFM Committee, CFPC

Dr. Benjamin Schiff, QC, Hospital Medicine Committee Chair
Dr. Chris Gallant, Atlantic Representative
Dr. Michael Kates, ON Representative
Dr. Robert Kruk, MB/SK Representative
Dr. John Ridley BC/AB Representative