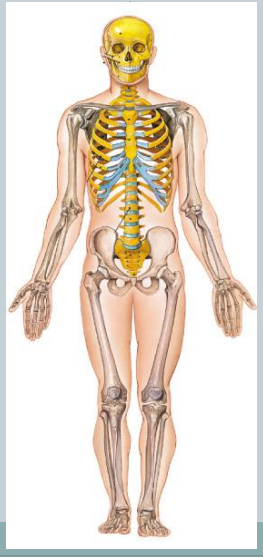
Introduction to Medical- Legal Review

SUSAN B. RAMSEY
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Basic Anatomy Terminology

- **Skull**
- **Vertebral column**
- **Thoracic cage**

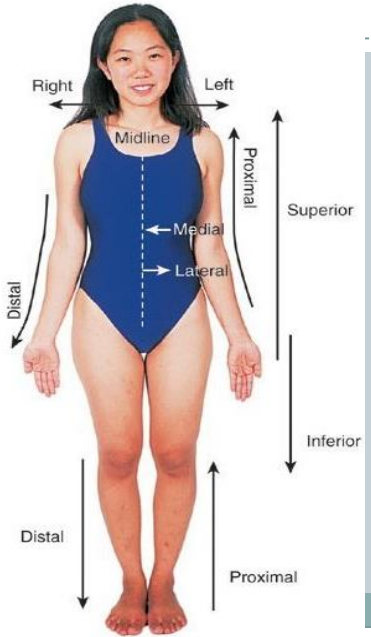


Remaining 126 bones of

- **Pectoral girdle**
- **Pelvic girdle**
- **Attached limbs**

Positions and Directions

Terms of position and direction describe the position of one body part relative to another, usually along one of the three major body planes



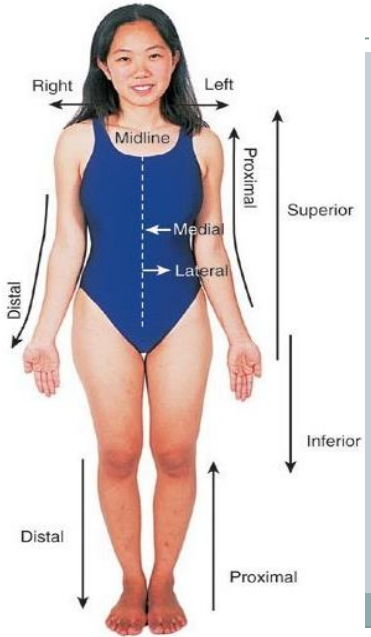
Positions and Directions

Superior

- Refers to a structure being closer to the head or higher than another structure in the body

Inferior

- Refers to a structure being closer to the feet or lower than another structure in the body



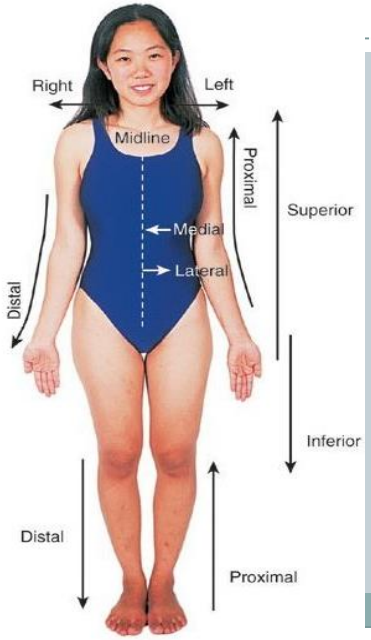
Positions and Directions

Medial

- Refers to a structure being closer to the midline or median plane of the body than another structure of the body

Lateral

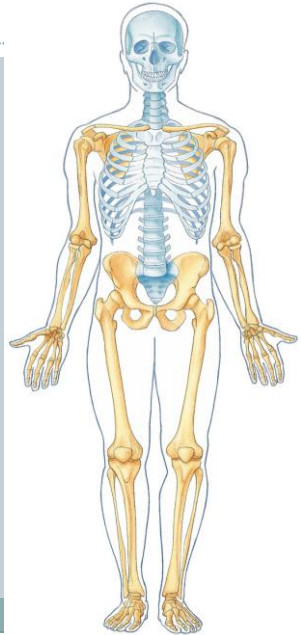
- Refers to a structure being farther away from the midline than another structure of the body



Distal / Proximal
Continued

- When you divide the skeleton into **Axial** (Blue) and **Appendicular** (Yellow) you can better understand the extremities and their roots.

Proximal
Root
Distal



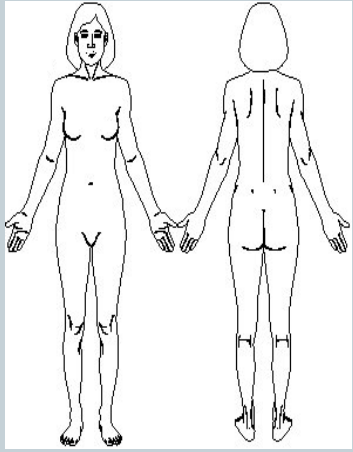
Positions and Directions

Anterior

- Refers to a structure being more in front than another structure in the body

Posterior

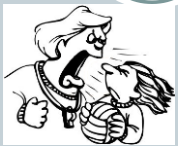
- Refers to a structure being more in back than another structure in the body



Positions and Directions

Ventral

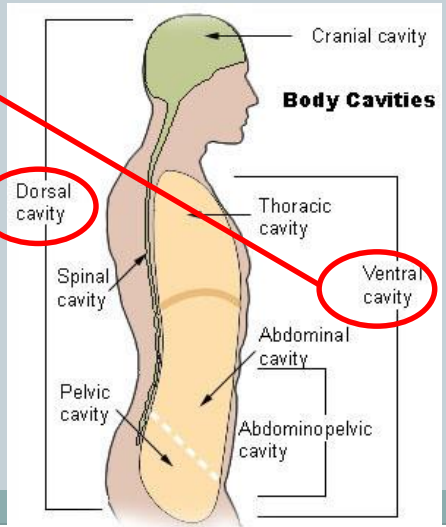
- Towards the front or belly
  - You Vent out or your nose and mouth.



Dorsal

- Towards the back
  - Like the Dorsal fin of a dolphin.





Positions and Directions

Prone

- Lying face down
  - Like a Pro Baseball player sliding into Home.





Supine

- Lying face up
  - Lying on your spine and you can have soup poured into your mouth.

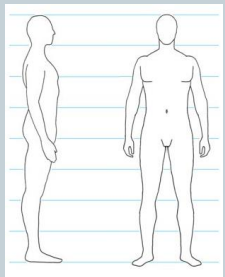


Unilateral

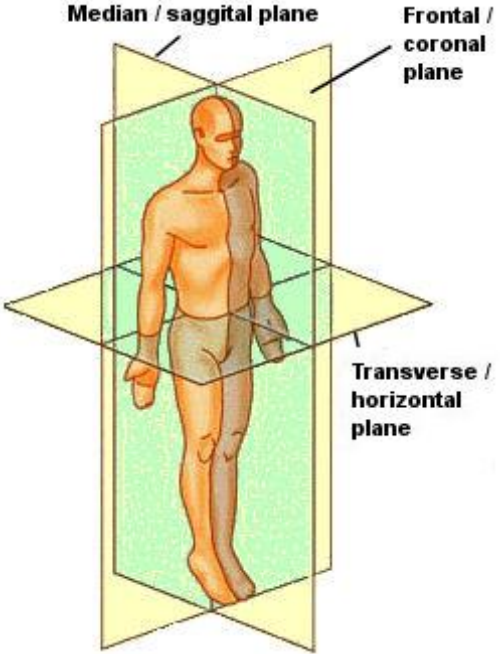
- Pertaining to one side of the body

Bilateral

- Pertaining to both sides of the body

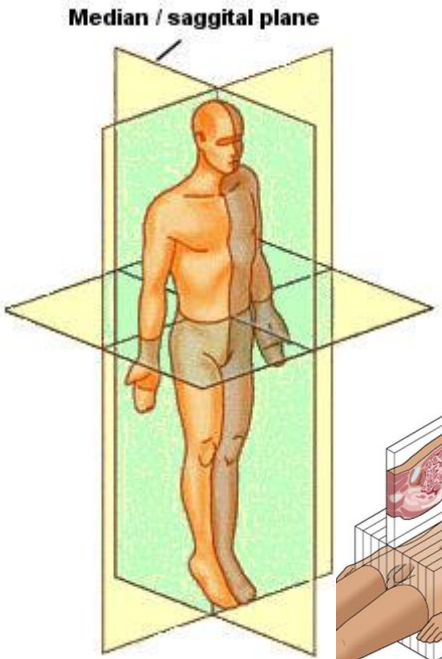


Anatomical Planes



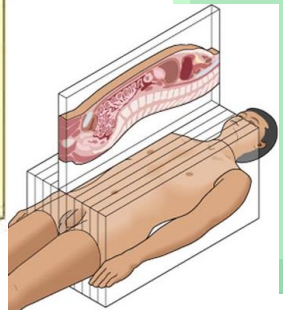
- Fixed lines of reference along which the body is often divided or sectioned to facilitate viewing of its structures
- Allow one to obtain a three-dimensional perspective by studying the body from different views

Anatomical Planes



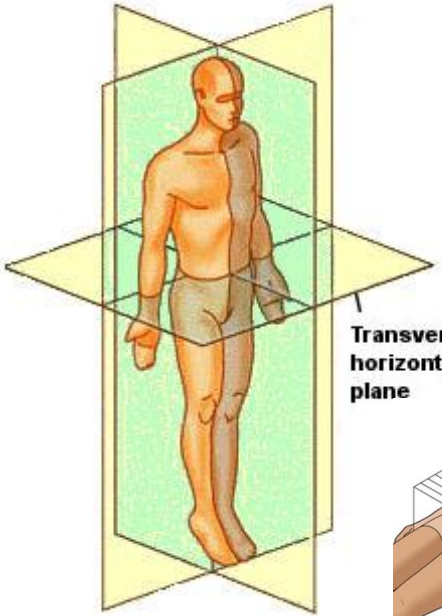
Sagittal plane

- The plane dividing the body into right and left portions
- Midsagittal or median are names for the plane dividing the body into equal right and left halves



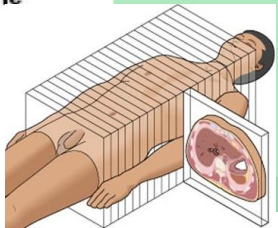


Anatomical Planes



Transverse plane

- The horizontal plane dividing the body into upper and lower portions
- Also called the Horizontal plane



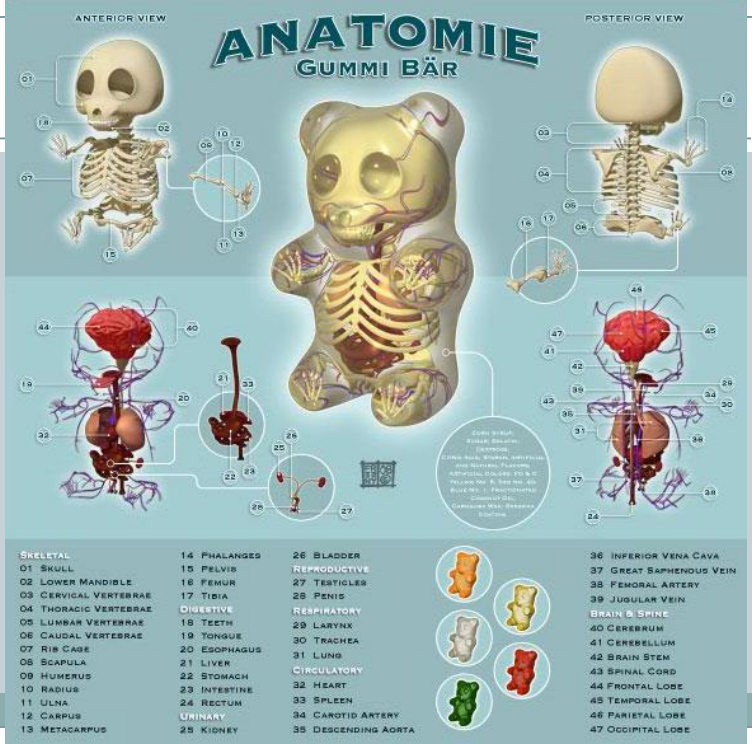


Gummy

Bear Dissection

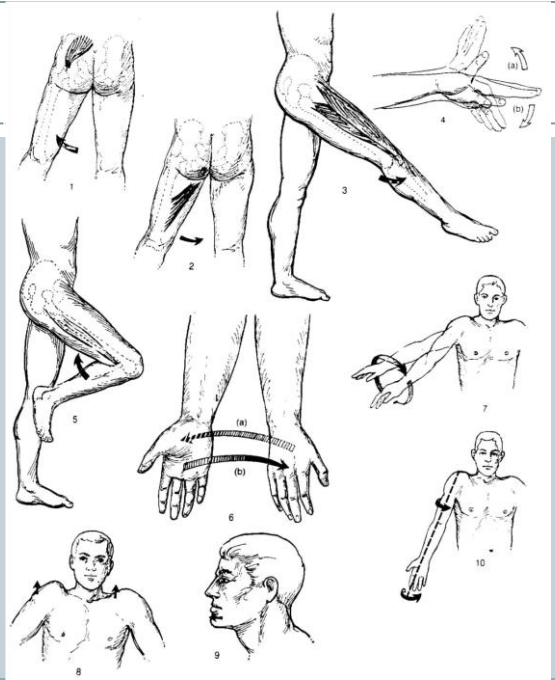
LAB

1. Cadaver Bear
2. Dissecting Tray
3. Scalpel

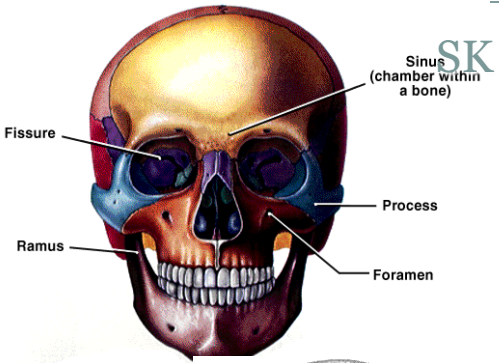


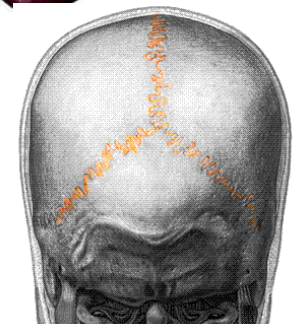
Movements

- Flexion
- Extension
- Hyperextension
- Adduction
- Abduction
- Prontaion
- Supination
- Retraction
- Protraction
- Elevation
- Depression
- Rotation
- Circumduction
- External Rotation
- Internal Rotation
- Inversion
- Eversion
- Dorsiflexion
- Plantarflexion
- Radial Deviation
- Ulnar Deviation
- Opposition



SK



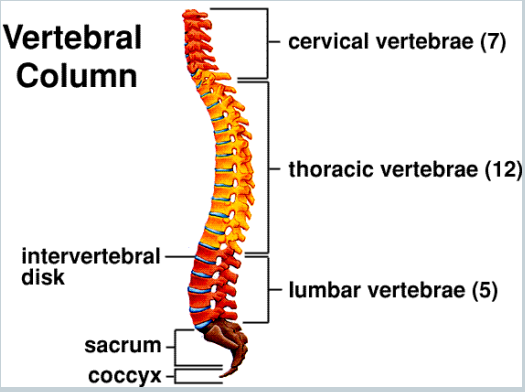


- Cranium vs. facial bones
- Special case: ***hyoid bone***

Sutures:

- Lambdoidal
- Sagittal
- Coronal
- Squamosal

Vertebral Column and Spinal Curvatures



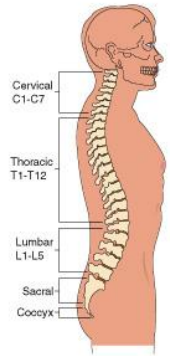
Alternating concave and convex curves

Abnormal curvatures

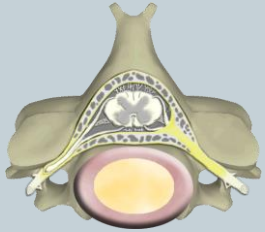
- **Kyphosis**
- **Lordosis**
- **Scoliosis**

Medical Terminology Online Image Bank
© 2001 EMC/Paradigm Publishing

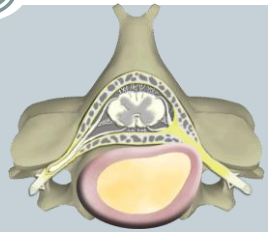
Spinal Column Regions



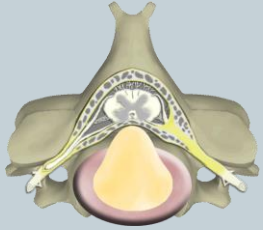
Neck Pain: Disk Herniation



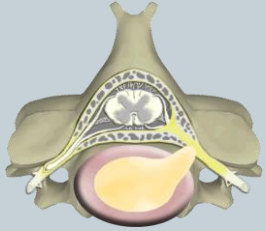
Normal Disk



Bulging Disk



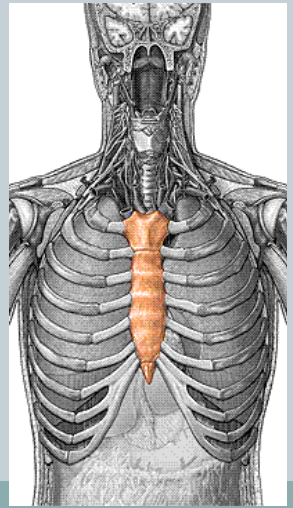
Central Disk Herniation



Lateral Disk Herniation

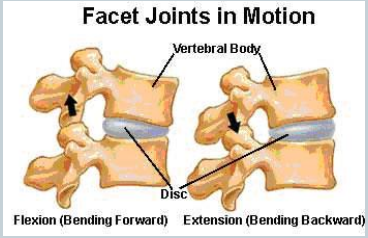
Thoracic Cage

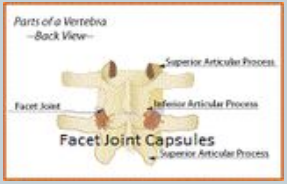
- **Sternum**
- **12 pairs of ribs**
- **True vs. false ribs**
- **Vertebrosternal, vertebrochondral, vertebral**
- **Cracked ribs (composition of rib bone? displaced fractures uncommon, why?)**



Neck Pain: Facet Capsule Injury

The facet joints are held together by ligaments known as the facet capsules.
During a rear-end collision, these ligaments can be stretched or torn.
Injury to these joints can result in referred pain to the back, neck, and head.





Appendicular Division

Girdles with their associated extremities

Pectoral girdle: clavicle and scapula

Upper limb: humerus, ulna, radius, carpal bones, hand

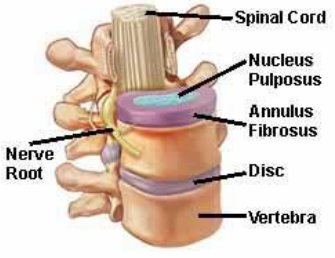
Pelvic girdle: Os coxae

Lower limb: femur, patella, tibia, fibula, tarsal bones, foot



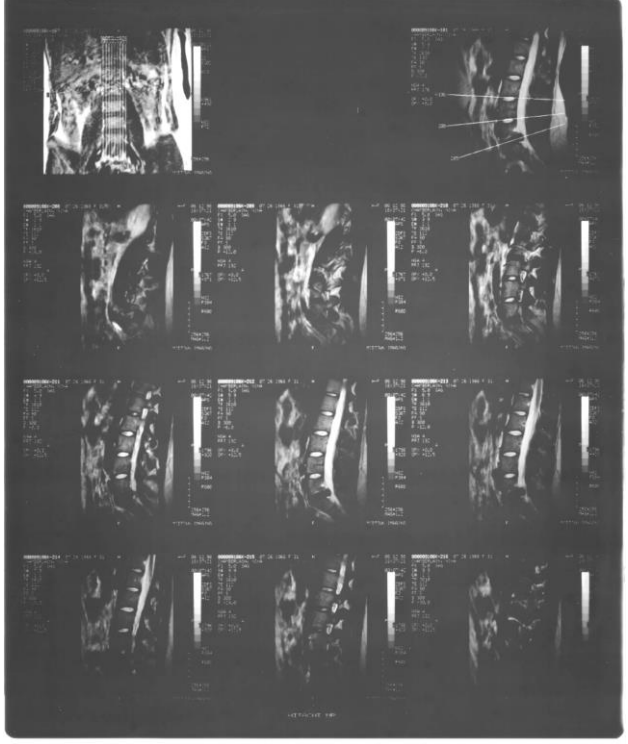
MRI Nomenclature: (PER NASS)

- **Annular fissure:** Focal disruption of anular fibers in concentric, radial or transverse distribution
- **Disc bulge:** *Circumferential*, diffuse, symmetric extension of anulus beyond
  the adjacent vertebral end plates by 3 or more mm, usually due to weakened or lax annular fibers
- **Disc protrusion:** Focal, asymmetric extension of disc segment beyond margin of vertebral end plates into the spinal canal with most of anular fibers intact
- **Disc extrusion:** Focal, asymmetric extension of disc segment and / or nucleus pulposis through the annular containment into the epidural space
- **Disc sequestration:** Extruded disc segment that is detached from original with migration into the canal
- **Disc degeneration:** Irreversible structural and histiological changes in nucleus seen on MRI T2WI images (commonly associated with bulge)


Spinal Cord
Nucleus Pulposus
Annulus Fibrosus
Nerve Root
Disc
Vertebra

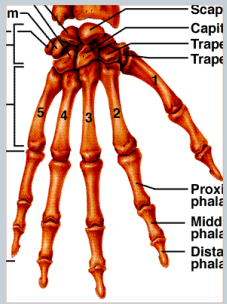
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The Hand

- **Metacarpals:** bones in palm of hand
- **Numbered from lateral to medial**
- **14 Phalanges**
- **Numbering same as with metacarpals, additionally: proximal, middle and distal phalanx**
- **Pollex has only two phalanges**

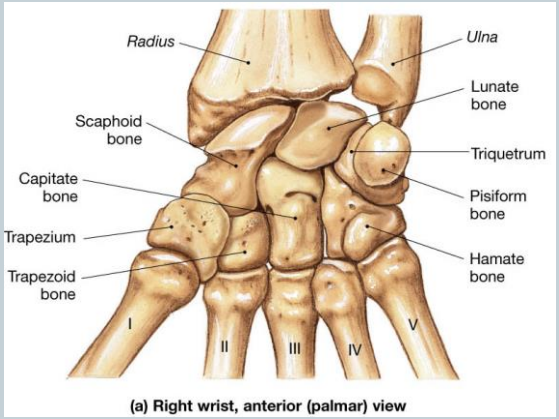


8 carpal (or wrist) bones:

From lateral to medial, first proximal then distal

Sally Lowers Tim's Pants, Then Things Can Happen

- **Scaphoid (Navicular)**
- **Lunate**
- **Triquetrum**
- **Pisiform**
- **Trapezium**
- **Trapezoid**
- **Capitate**
- **Hamate**



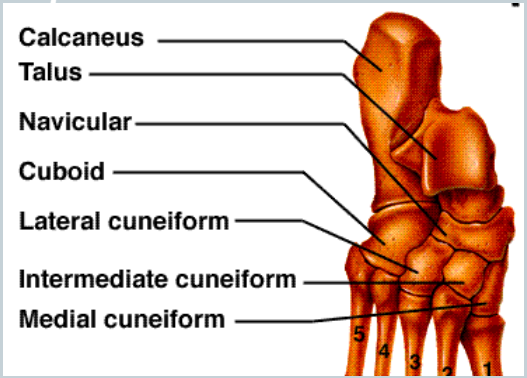
(a) Right wrist, anterior (palmar) view

7 tarsal (or “ankle”) bones:

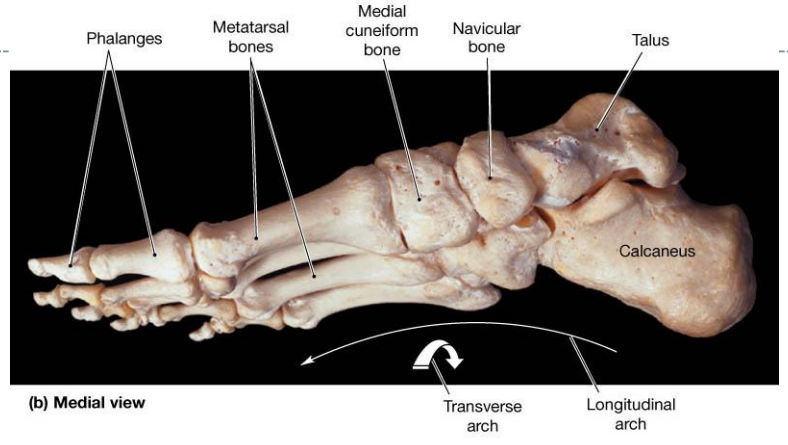
Posterior third of foot
From lateral to medial, first proximal then distal

Cute Tina Never Could Cooperate

- **Calcaneus**
- **Talus**
- **Navicular**
- **Cuboid**
- **3 Cuneiforms (lateral, intermediate, medial)**



Foot



- **Naming and numbering of metatarsals and phalanges analogous to hand**
- **Hallux has only two phalanges**

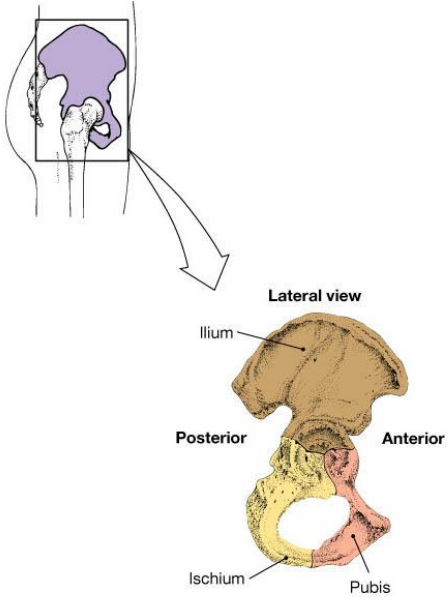
Two os coxae are made up of 3 fused bones each

1. ileum
2. ischium
3. pubis

Compare

Male and female pelvis

True and false pelvis



- **Femur:** surgical vs. anatomic neck *(also know major bone markings)*
- **Patella:** large sesamoid bone (patellar ligament)
- **Tibia:** medial; fibula: lateral, not weight bearing
- **The real ankle bones are the malleoli**

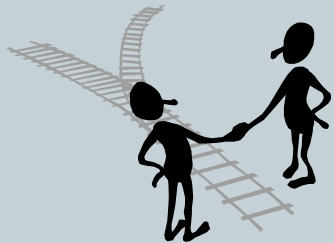
Basic Medical Terminology

Medical Terminology
Mispronunciations

- Artery - The study of fine paintings.
- Barium - What you do when CPR fails.
- Benign - What you are after you be eight.
- Coma - A punctuation mark.
- Morbid - A higher offer.
- Urine - opposite of you're out.
- Tablet - A small table.

Word Roots (WR)

- Usually derived form Greek or Latin
- Frequently indicates a body part
- Most medical terms have one or more word roots



Greek Word	*Word Root*
Kardia (heart)	**Cardi**
Gaster (stomach)	**Gastr**
Hepar (liver)	**Hepat**
Nephros (kidney)	**Nephr**
Osteon (bone)	**oste**

Combining Forms (CF)

- Combining Form (CF) is a Word Root (WR) plus a vowel, usually an “o”
- Usually indicates a body part

Combining Forms Examples

- Cardi/ + o = cardi/o — heart
- gastr/ + o = gastr/o — stomach
- hepat/ + o = hepat/o — liver
- nephr/ + o = nephr/o — kidney
- oste/ + o = oste/o — bone

Suffixes

- Word Ending
- Suffix usually indicates a procedure, condition, disease, or part of speech
- Usually derived from Greek or Latin

Examples of Suffix

- Arthr/o -centesis Arthrocentesis
  joint *puncture* *puncture of a joint*
- throac/o -tomy Thoracotomy
  chest *incision* *incision of the chest*
- gastr/o -megaly Gastromegaly
  stomach *enlargement* *enlargement of the stomach*

Prefixes



- Word element located at the beginning of a word
- Changes the meaning of the word
- Usually indicates a number, time, position, direction, color, or sense of negation

Examples of Prefix

- A- mast -ia
  without breast condition
- hyper- therm -ia
  excessive heat condition
- intra- muscul -ar
  in muscle relating to

Basic Rule One

- A WR (word root) is used before a suffix that begins with a vowel.
  Scler/ + osis = sclerosis

Basic Rule Two

- A combining vowel is used to link a WR to a suffix that begins with a consonant and to link a WR to another WR to form a compound word
  colon/o + scope = colonscope
  osteo/ o/ chondr/ itis = osteochondritis

Defining Medical Words

- First, define the suffix or ending
- Second, define the prefix, or beginning
- Third, define the middle

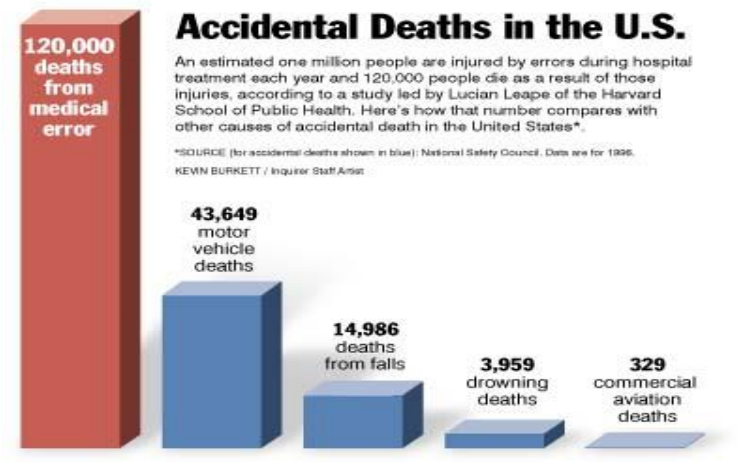
DECIPHERING COMMON MEDICIAL TERMINOLOGY AND ACRONYMS

- Discogram
  - Disc(o) is a word root referring to an intervertebral disc.
  - -gram is the suffix meaning a record or picture.
  - When put together, the term discogram means a record or picture of an intervertebral disc.
- Discectomy
  - Disc(o) is a word root referring to an intervertebral disc.
  - -ectomy is the suffix denoting a surgical operation or removal of a body part.
  - When put together, the term discectomy means the surgical operation or removal of an intervertebral disc.
- Laminectomy
  - Lamina is a word root referring to the lamina of the spine.
  - -ectomy is the suffix denoting a surgical operation or removal of a body part.
  - When put together, the term laminectomy means the surgical operation or removal of the lamina of the spine.

Medical Malpractice



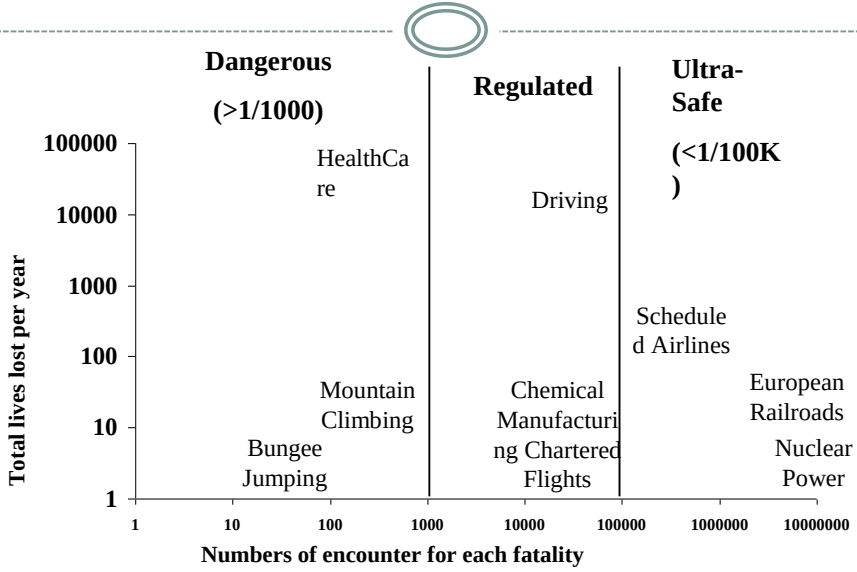
Estimated Deaths Due to Medical Error



Source – The Philadelphia Inquirer

How Hazardous Is Health Care?

(Modified from Leape)

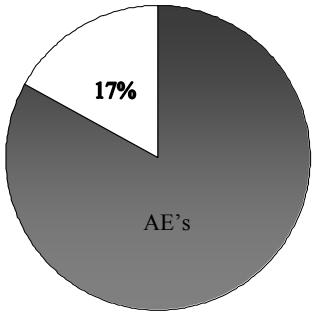


Deaths due to Medical Error

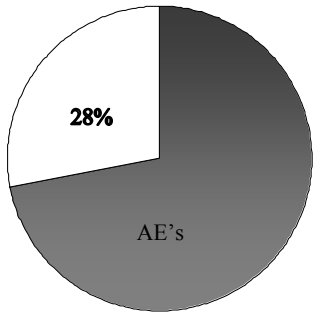
- 44,000 to 98,000 unnecessary deaths each year
  - More Americans are killed in US hospitals every 6 months than died in the entire Vietnam War
  - Death rate equivalent to three “jumbo” jet crashed every two days

Percent of Injuries due to Negligence (Adverse Incidents)

California Medical Insurance Feasibility Study

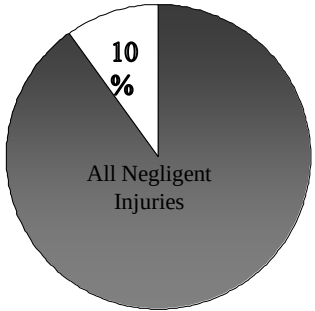


Harvard Medical Practice Study

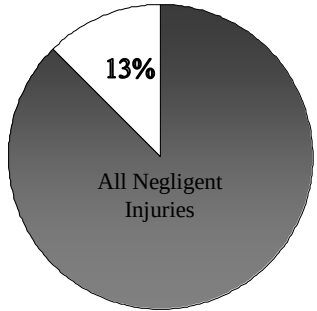


Percent of Negligent Injuries that File a Claim

California Medical Insurance Feasibility Study

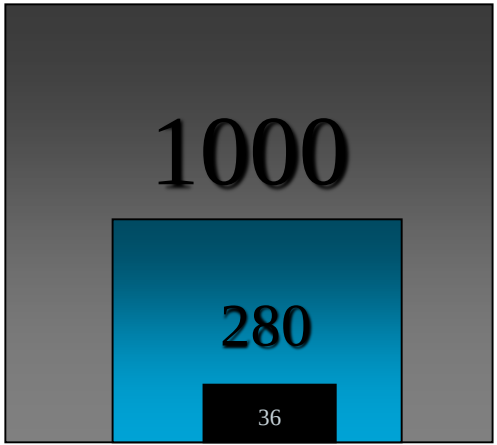


Harvard Medical Practice Study



A few say…

- 42% of public report a medical error
- 66% reported serious consequences such as severe pain, substantial loss of time at work or school, disability or even death
- Only 6% had sued



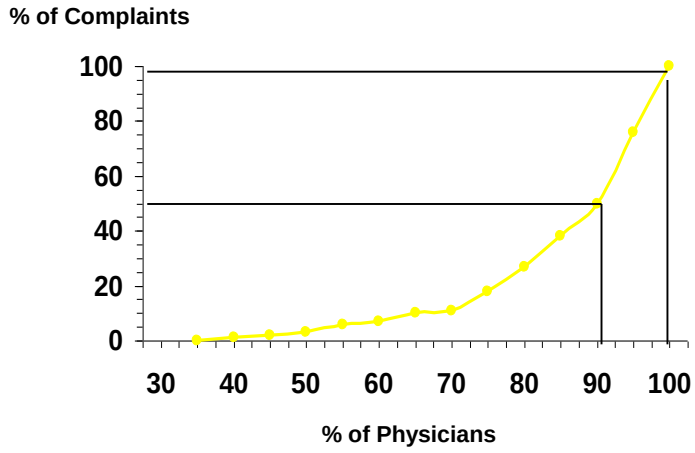
All Injuries

All Negligent Injuries

Files a Claim

13% of Negligent Injuries Results in a Claim

Nine Percent of Physicians Account for Fifty Percent of the Complaints



Source – Hickson, 2002

Misdiagnosis or Failure to Diagnosis

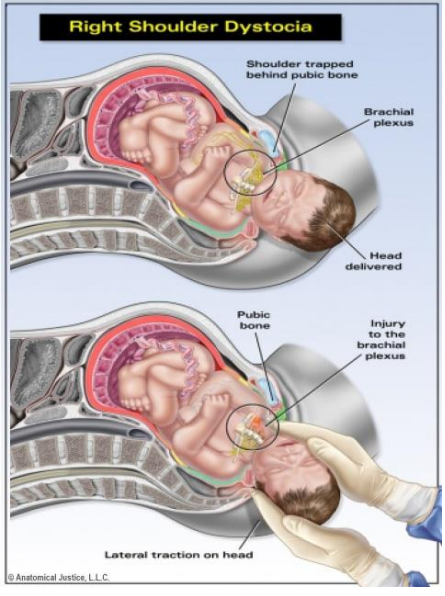
These cases involve the failure of a health care provider to correctly diagnosis a problem, or the failure to diagnosis it at all. Unfortunately one of the most common failure to diagnosis claims is the failure to diagnosis cancer .



Birth Injuries

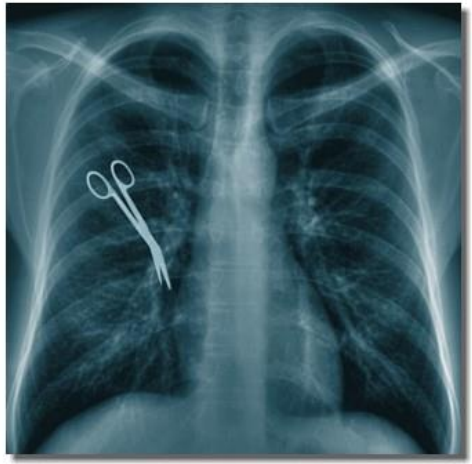
Injuries to an infant as a result of the actions of the obstetrician or obstetrical staff can result in a number of different outcomes for the child. Ranging from a permanent neurological problem, i.e. Erb's palsy to more devastating injuries to the infant resulting in severe brain damage and cerebral palsy.

Failure to properly anticipate and deliver an infant encountering a shoulder dystocia is one such example.



Surgical Errors

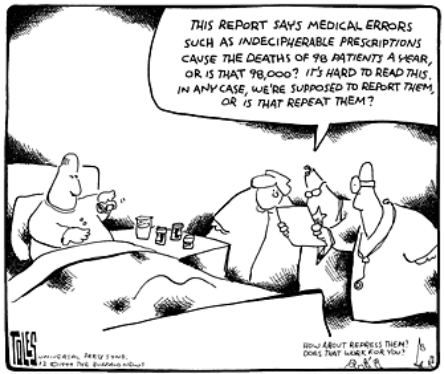
Cases involving surgical errors can involve a number of different scenarios. Examples, as demonstrated here- the instrument left behind, performing the wrong procedure on the patient, amputating the wrong limb; to performing procedures the surgeon or surgical team is not adequately trained to perform.



Prescription Errors

Medication errors are among the most common medical errors, harming at least 1.5 million people every year, says a new report from the Institute of Medicine of the National Academies. .

Studies indicate that 400,000 preventable drug-related injuries occur each year in hospitals. Another 800,000 occur in long-term care settings, and roughly 530,000 occur just among Medicare recipients in outpatient clinics. The committee noted that these are likely underestimates. Unfortunately, some believe that these types of mistakes are on the rise.



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Resources for General Medical Information

Medical School Libraries

Nursing School Libraries

Allied Health Care Libraries

- Basic Texts- Such as Merck Manual; Dorland's Medical Dictionary; Gray's Anatomy
- Specialized Textbooks: Obstetrics; Orthopedics; Oncology.
- Online Medical Research: Medscape; Evidence – Based Medicine (http:hiru.hirunet.mcmaster.ca/ebm/ (McMasters University has an online tutorial)

InfoPOEM: Negative CT scan to rule out PE equal to angiography - Message (HTML)

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From: Daily InfoPOEMs [poems@infopoems.com] Sent: Mon 7/11/2005 7:35 AM
To: sms6u@virginia.edu
Cc:
Subject: InfoPOEM: Negative CT scan to rule out PE equal to angiography

InfoPOEMs
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Negative CT scan to rule out PE equal to angiography

Clinical question
Can clinicians rely on a negative computed tomography scan to rule out suspected pulmonary embolism?

Bottom line
A negative computed tomography (CT) scan is as accurate as pulmonary angiography in ruling out suspected pulmonary embolism (PE). Clinicians should strongly consider using clinical decision rules to accurately assess the pretest probability of PE in a individual patient, and then interpret diagnostic tests in light of this probability. For example, a negative CT in a low-risk patient rules out PE, while a negative CT in a high-risk patient may require further confirmation. (LOE = 2a-)

Reference
Quiroz R, Kucher N, Zou KH, et al. Clinical validity of a negative computed tomography scan in patients with suspected pulmonary embolism. A systematic review. JAMA 2005; 293:2012-17.

Study design: Systematic review

Setting: Various (meta-analysis)

Synopsis
Previous studies question the value of using CT scanning alone to rule out suspected PE. These investigators thoroughly searched multiple databases -- including MEDLINE, the Cochrane Registry of Controlled Trials, and Science Citation Index -- and relevant journals for English language articles meeting selection criteria. Included studies used contrast-enhanced CT as the initial triage test to rule out the diagnosis of acute PE, had an appropriate clinical follow-up of at least 3 months, and a prospective design. The gold standard to establish the validity of testing to rule out PE was the rate of subsequent venous thromboembolic events (VTE) after anticoagulation therapy was withheld. Two reviewers independently abstracted data and a third party arbitrated discrepancies. From the initial search that found 22 studies, 15 studies evaluating a total of 3500 patients met the minimal inclusion criteria. Seven of these 15 met the criteria for level 1 diagnostic studies. Three different CT modalities were evaluated, including single-slice CT, multidetector-row (helical) CT, and electron-beam CT. Patient follow-up ranged from 3 months to 12 months. The overall negative likelihood ratio of a VTE after a negative CT scan for PE was 0.07 (95% CI, 0.05 - 0.11). There was no significant difference in the risk of a subsequent VTE based on the type of CT modality used. Compared with studies that used chest CT imaging only, the risk of subsequent VTEs in studies using additional imaging tests prior to chest CT was not significantly reduced. The reported negative likelihood ratio in this analysis compares favorably with that reported for pulmonary angiography (Henry JW, Relyea B, Stein PD. Chest 1995; 107:1375-78). A formal analysis found no evidence for significant publication bias, but there was some minimal heterogeneity among the results of the various trials.

Fw: Epidemiologic Consequences of Hurricane Katrina: A Newsmaker Interview - Message (HTML)

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From: Scott M. Strayer, MD, MPH [sstrayer@adelphia.net] Sent: Mon 9/26/2005 5:43 PM
To: Scott M. Strayer
Cc:
Subject: Fw: Epidemiologic Consequences of Hurricane Katrina: A Newsmaker Interview

Medscape from WebMD
Daily News

Monday, September 26, 2005

Ensure delivery - add Medscape_Daily_News@mp.medscape.com to your address book.

Hurricane Aftermath



Epidemiologic Consequences of Hurricane Katrina: A Newsmaker Interview With Raoult Ratard, MD

Despite concerns about epidemics of cholera, typhoid, malaria, and yellow fever emerging from the flood waters, the greatest risk is the possible outbreak of gastrointestinal disease in shelters, according to the chief epidemiologist for Louisiana.

Medscape Medical News 2005

News CME

Live Attenuated Influenza Vaccine May Be Safe and Effective in Children

In a large, open-label study, trivalent LAIV also did not increase the risk of asthma events, so the authors suggested reassessment of the lower age limit for use of LAIV-T.

Medscape Medical News 2005

Cardiology



Guidant Says Two Models of Pacemakers Could Fail

Guidant Corp. said on Thursday it has identified two separate problems with two models of its implantable pacemakers that could lead to device failure.

Reuters Health Information 2005

Advertisement

ESRD & Hyperphosphatemia

Elevated phosphorus in your end-stage renal disease patients may lead to:

- Secondary hyperparathyroidism
- Tissue calcification
- Renal bone disease
- Increased morbidity/mortality



DynaMed Powered by EBSCOhost Weekly Update

About DynaMed

April 27, 2007 Volume 2 Issue 18

DynaMed Systematic Literature Surveillance

During the week ending April 27, 2007

Approximately **981** articles were considered for inclusion in DynaMed and **249** met criteria for inclusion.

Based on the criteria of selecting 'articles most likely to change clinical practice,' one article of significant interest is included in this weekly update.

Treatment of Hypertension

Beta-blockers are not indicated as first line therapy for hypertension (**grade B recommendation [inconsistent or limited evidence]**), based on a systematic review of 13 randomized trials of beta-blockers as monotherapy or first-line therapy for hypertension in 91,561 adults. Beta-blockers were associated with an increased risk of mortality (NNH 200), cardiovascular disease (NNH 77) and stroke (NNH 166) vs. calcium-channel blockers and an increased incidence of stroke (NNH 66) vs. renin-angiotensin inhibitors. However, beta-blockers were associated with a decreased incidence of stroke (NNT 200) and cardiovascular disease (NNT 143) vs. placebo or no treatment; there was no difference when compared with diuretics. The review was limited by confounding by the use of additional medications in the original trials (Cochrane Library 2007 Issue 1:CD002003).

DynaMed Weekly Update Podcast

New summary added to DynaMed:

- Arthritis - differential diagnosis

DynaMed would like to thank:

- Dr. Russel Kirkby for writing Arthritis - differential diagnosis

Critically Revised Summary

(with documentation of systematic MEDLINE search results)

- Nodular fasciitis (NF)

We are seeking a reviewer for:

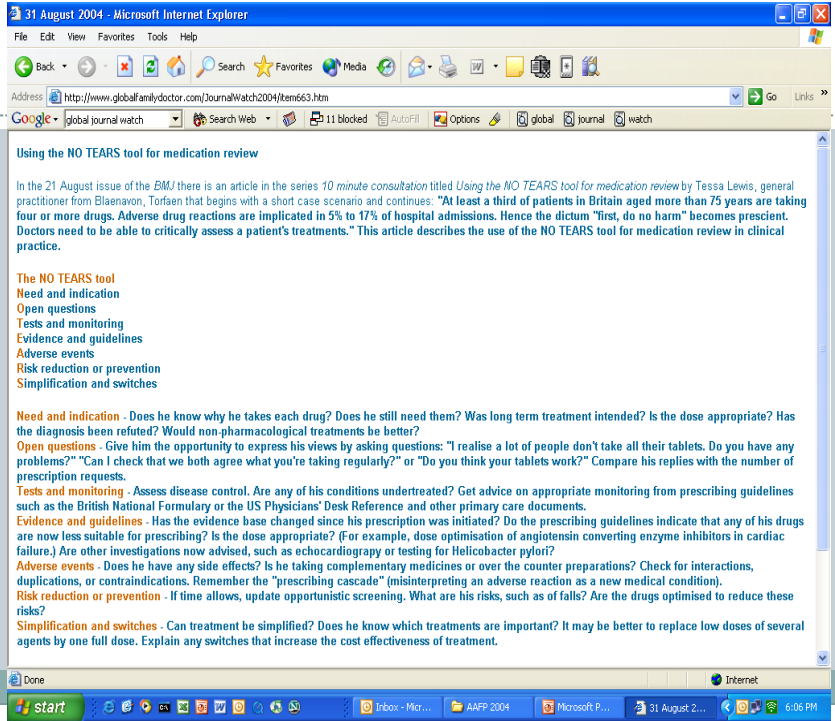
- Nodular fasciitis (NF)

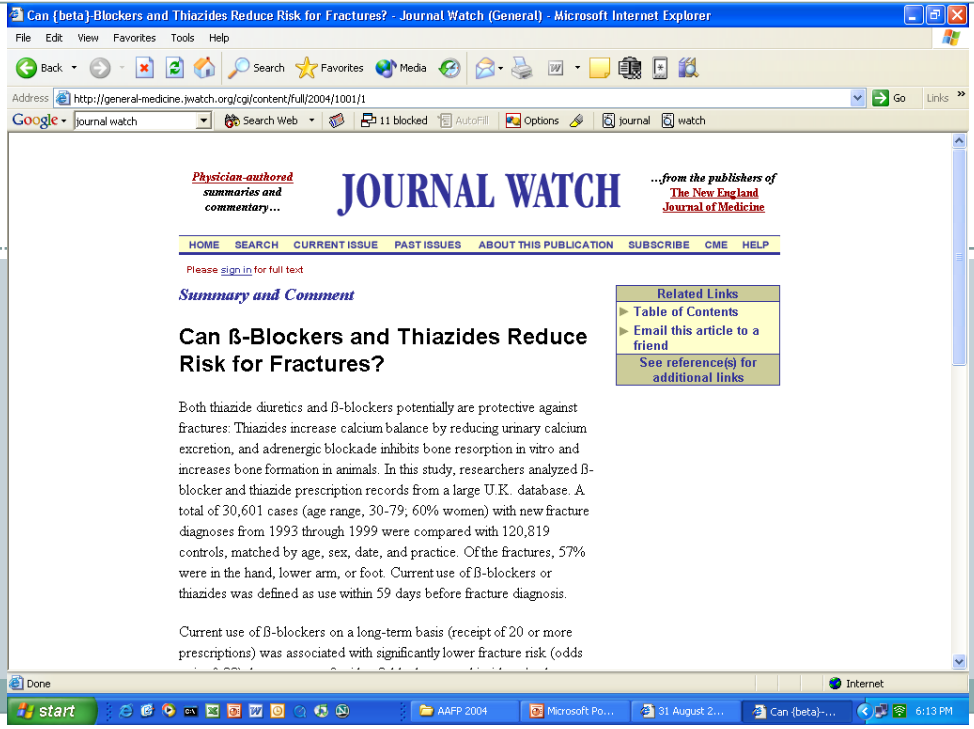
Full Text Linking Now Available!

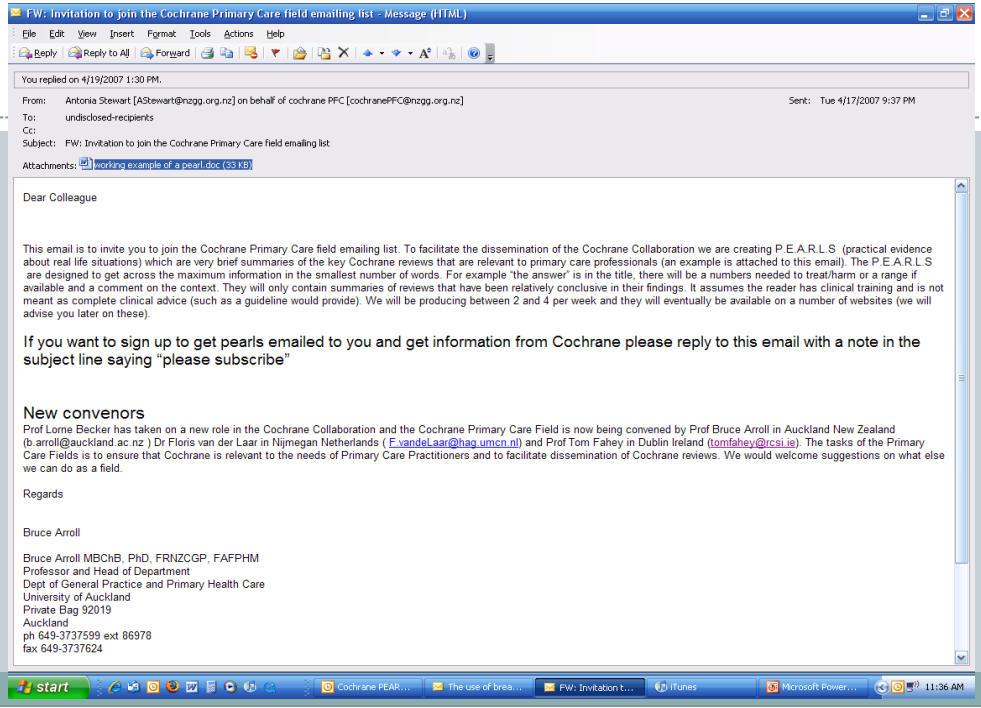
DynaMed Linking to EBSCOhost Full Text Articles - Click Here

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Tuesday 31 August 2004
Journal Watch
Diabetic as well as pre-diabetic women have impaired cognitive performance and greater risk of developing cognitive impairment Neurology
Xuezhikang, an extract of Cholestin, effectively improved preprandial and postprandial endothelial function through its potent antiinflammatory and lipid-lowering effects Circulation
Three reviews of different approaches to osteoarthritis of the knee and joint pain Bandolier
Lutein and age-related macular degeneration Bandolier
UK prevalence of irritable bowel syndrome over 10%, more in women - quality of life significantly reduced BJGP
Using the NO TEARS tool for medication review BMJ
Clinical Reviews
Allergen immunotherapy Am Fam Physician
Tips for learning and teaching evidence-based medicine CMAJ
Global Daily News
Click here for the latest news
Recent GFD Updates
Asia Pacific Family Medicine Now online in full text
Wonca News June 2004
Evidence-Based Health Care Websites of the Month Canada Guidelines Advisory Committee, AETMIS
POEMs USPSTF: Screen for alcohol misuse
eMedicine Nail changes after cast immobilization in a 30-year-old man who fractured his right wrist
Disease Alerts Avian influenza: H5N1 detected in pigs in China; Hepatitis E in Chad
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Using the NO TEARS tool for medication review
In the 21 August issue of the BMJ there is an article in the series 10 minute consultation titled Using the NO TEARS tool for medication review by Tessa Lewis, general practitioner from Blaenavon, Torfaen that begins with a short case scenario and continues: "At least a third of patients in Britain aged more than 75 years are taking four or more drugs. Adverse drug reactions are implicated in 5% to 17% of hospital admissions. Hence the dictum "first, do no harm" becomes prescient. Doctors need to be able to critically assess a patient's treatments." This article describes the use of the NO TEARS tool for medication review in clinical practice.
The NO TEARS tool
Need and indication
Open questions
Tests and monitoring
Evidence and guidelines
Adverse events
Risk reduction or prevention
Simplification and switches
Need and indication - Does he know why he takes each drug? Does he still need them? Was long term treatment intended? Is the dose appropriate? Has the diagnosis been refuted? Would non-pharmacological treatments be better?
Open questions - Give him the opportunity to express his views by asking questions: "I realise a lot of people don't take all their tablets. Do you have any problems?" "Can I check that we both agree what you're taking regularly?" or "Do you think your tablets work?" Compare his replies with the number of prescription requests.
Tests and monitoring - Assess disease control. Are any of his conditions undertreated? Get advice on appropriate monitoring from prescribing guidelines such as the British National Formulary or the US Physicians' Desk Reference and other primary care documents.
Evidence and guidelines - Has the evidence base changed since his prescription was initiated? Do the prescribing guidelines indicate that any of his drugs are now less suitable for prescribing? Is the dose appropriate? (For example, dose optimisation of angiotensin converting enzyme inhibitors in cardiac failure.) Are other investigations now advised, such as echocardiograpy or testing for Helicobacter pylori?
Adverse events - Does he have any side effects? Is he taking complementary medicines or over the counter preparations? Check for interactions, duplications, or contraindications. Remember the "prescribing cascade" (misinterpreting an adverse reaction as a new medical condition).
Risk reduction or prevention - If time allows, update opportunistic screening. What are his risks, such as of falls? Are the drugs optimised to reduce these risks?
Simplification and switches - Can treatment be simplified? Does he know which treatments are important? It may be better to replace low doses of several agents by one full dose. Explain any switches that increase the cost effectiveness of treatment.
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Can ß-Blockers and Thiazides Reduce Risk for Fractures?
Both thiazide diuretics and ß-blockers potentially are protective against fractures: Thiazides increase calcium balance by reducing urinary calcium excretion, and adrenergic blockade inhibits bone resorption in vitro and increases bone formation in animals. In this study, researchers analyzed ß-blocker and thiazide prescription records from a large U.K. database. A total of 30,601 cases (age range, 30-79; 60% women) with new fracture diagnoses from 1993 through 1999 were compared with 120,819 controls, matched by age, sex, date, and practice. Of the fractures, 57% were in the hand, lower arm, or foot. Current use of ß-blockers or thiazides was defined as use within 59 days before fracture diagnosis.
Current use of ß-blockers on a long-term basis (receipt of 20 or more prescriptions) was associated with significantly lower fracture risk (odds
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FW: Invitation to join the Cochrane Primary Care field emailing list - Message (HTML)

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Reply | Reply to All | Forward

You replied on 4/19/2007 1:30 PM.

From: Antonia Stewart [AStewart@nzgg.org.nz] on behalf of cochrane PFC [cochranePFC@nzgg.org.nz] Sent: Tue 4/17/2007 9:37 PM

To: undisclosed-recipients

Cc:

Subject: FW: Invitation to join the Cochrane Primary Care field emailing list

Attachments: working example of a pearl.doc (33 KB)

Dear Colleague

This email is to invite you to join the Cochrane Primary Care field emailing list. To facilitate the dissemination of the Cochrane Collaboration we are creating P.E.A.R.L.S (practical evidence about real life situations) which are very brief summaries of the key Cochrane reviews that are relevant to primary care professionals (an example is attached to this email). The P.E.A.R.L.S are designed to get across the maximum information in the smallest number of words. For example "the answer" is in the title, there will be a numbers needed to treat/harm or a range if available and a comment on the context. They will only contain summaries of reviews that have been relatively conclusive in their findings. It assumes the reader has clinical training and is not meant as complete clinical advice (such as a guideline would provide). We will be producing between 2 and 4 per week and they will eventually be available on a number of websites (we will advise you later on these).

If you want to sign up to get pearls emailed to you and get information from Cochrane please reply to this email with a note in the subject line saying "please subscribe"

New convenors

Prof Lorne Becker has taken on a new role in the Cochrane Collaboration and the Cochrane Primary Care Field is now being convened by Prof Bruce Arroll in Auckland New Zealand (b.arroll@auckland.ac.nz) Dr Floris van der Laar in Nijmegan Netherlands (F.vandeLaar@hag.umcn.nl) and Prof Tom Fahey in Dublin Ireland (tomfahey@rcsi.ie). The tasks of the Primary Care Fields is to ensure that Cochrane is relevant to the needs of Primary Care Practitioners and to facilitate dissemination of Cochrane reviews. We would welcome suggestions on what else we can do as a field.

Regards

Bruce Arroll

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Professor and Head of Department
Dept of General Practice and Primary Health Care
University of Auckland
Private Bag 92019
Auckland
ph 649-3737599 ext 86978
fax 649-3737624

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Anticholinergics are effective for overactive bladder syndrome in adults

Clinical Question	Should I use anticholinergics to treat overactive bladder syndrome with medication in adults
Bottom Line	The use of anticholinergic drugs by people (men and women) with overactive bladder syndrome results in statistically significant improvements in symptoms, and a modest improvement in quality of life. On average people taking anticholinergic medications had about 5 less trips to the toilet and 4 less leakage episodes every week. (NNT 4 to 8)
Context	About 16% of adults have symptoms of overactive bladder syndrome (urgency with frequency and/or urge incontinence).
Caveat	About 1 in 3 people taking the drugs reported a dry mouth but for most this was not sufficiently troublesome for them to stop treatment. NNH 1 to 10. It is not clear whether any benefits are sustained during long-term treatment or after treatment stops.
Reference	Nabi G et al. Anticholinergic drugs versus placebo for overactive b syndrome in adults. Co Reviews, 2006, Issue 4.
Date written (author)	Jan 2007 (BMcAvoy)

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Clinical Decision Making Research Tools (Also resources for Medical Information)

- InfoPoems---www.infopoems.com
- Peer View Institute--- www.peerview-institute.org/
- Journal Alerts--- www.globalfamilydoctor.com/dailyalerts/main.htm
- Medscape Best Evidence (http://hiru.mcmaster.ca/MORE/HowRatingsAreUsed.htm)
- MDLinx
- BMJ Updates (http://bmjupdates.mcmaster.ca)
- First Watch (www.jwatch.org)
- Cochrane PEARLS
- First Consult— www.firstconsult.com
- InfoPoems
- Up To Date--- www.uptodateonline.com
- DynaMed--- www.dynamicmedical.com/
- Medscape--- www.medscape.com
- Database of Abstracts of Reviews of Effectiveness DARE--- http://agatha.york.ac.uk/darehp.htm
- Translating Research Into Practice (TRIP)--- www.tripdatabase.com

EBM IN AFP
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Sources for Evidence-Based Medicine

AAFP's Commission on Continuing Professional Development (COCPD) designates CME clinical content as evidence-based (EB CME) if it is presented with practice recommendations supported by evidence that has been systematically reviewed by an AAFP-approved, evidence-based medicine (EBM) source. Sources that consist exclusively of systematic evidence reviews are designated with an EB CME logo.

Evidence-Based Answers to Clinical Questions

EB CME Clinical Evidence, BMJ Publishing Group
http://www.clinicalevidence.com

Clinical Queries on PubMed
http://www.ncbi.nlm.nih.gov/entrez/query/static/clinical.html

EB CME Cochrane Database of Systematic Reviews
http://www.cochrane.org
[Abstracts free, subscription required for complete reviews]

EB CME Database of Abstracts of Reviews of Effectiveness (DARE)
http://agatha.york.ac.uk/darehp.htm

DynaMed
http://www.dynamicmedical.com

InfoPOEMs (including JFP POEMs)
http://www.infopoems.com

TRIP (Translating Research Into Practice)
http://www.tripdatabase.com

Evidence-Based Summaries of Recent Research

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EVIDENCE-BASED CME

- Categories, Definitions & Criteria
- Guidelines & Requirements
- Faculty Responsibilities (*Microsoft Word file)
- Faculty Documentation (*Microsoft Word file)
- Development Flow Chart
- Sources for EB CME Designation
- FAQs about EB CME
- Practice Recs
- Designation Statements and Logos

(*Microsoft Word file. More information on downloading files.)

Evidence-Based CME

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In 2002, the AAFP began to phase in new criteria for evaluating and categorizing the clinical content of CME. CME providers have an option to incorporate the principles of evidence-based medicine into CME. This represents an opportunity to offer physicians a completely new dimension in CME. The AAFP strongly believes an evidence-based approach to CME will help ensure the validity of CME clinical content and lead to improved medical practice and patient outcomes. **Evidence-based CME is optional.** AAFP encourages CME providers to incorporate it incrementally into their CME activities.

As of January 1, 2005, CME activities receiving the AAFP evidence-based CME (EB CME) designation will earn double credit for the portion designated as EB CME. The AAFP's Commission on Continuing Professional Development believes that 2 for 1 credit for physicians will elevate the use and recognition of this type of enhanced CME, and that it demonstrates the added value of CME based on evidence.

Consider a CME activity approved for 14 Prescribed credits, 10 of which are designated as EB CME. The EB CME portion would double in credit, making the grand total of 24 Prescribed credits available for physicians to claim. (4+10+10=24 credits)

CME faculty who develop EB CME activities may receive double credit, equivalent to that awarded to the learners when the content is presented the first time. AAFP members may self-report Prescribed credit for teaching limited to 60 credits per election cycle.

Please review the Faculty Responsibilities in Designing EB CME Content (Microsoft Word file: 1 page/91 KB. More information on downloading files.) form that lists step by step what each faculty member needs to do when developing EB CME content.

For each topic requesting EB CME designation, the CME provider must

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CME From The Journals You Trust

SHOP CATALOG

Resources For General Medical Information

Medical School Libraries

Nursing School Libraries

Allied Health Care Libraries

- Basic Texts- Such as Merck Manual; Dorland's Medical Dictionary; Gray's Anatomy
- Specialized Textbooks: Obstetrics; Orthopedics; Oncology.
- Online Medical Research: Medscape; Evidence – Based Medicine (http:hiru.hirunet.mcmaster.ca/ebm/ (McMasters University has an online tutorial)

DECODING COMMON MEDICAL TERMINOLOGY

- Medication prescription: "Take 1 tab po qid pc and hs"
  - "Take 1 tablet by mouth 4 times a day, after meals and at bedtime."
    - po(per os) means by mouth.
    - qid(quater in die) means 4 times a day.
    - pc(post cibum) means after meals.
    - hs(hora somni) means at bedtime.
- Other common acronyms are:
  - Bid(bis in die)- twice a day
  - Tid(ter in die)- three times a day
  - Prn(pro re nata)- as needed
  - C(cum)- with

Deciphering Medical Records- What to Look for

- First, You need to know what is suppose to be there
- Admission Records- ER or Direct Admission
- Physician Notes
- Nurses and other Health care Providers; I.e. PT, OT, dietician
- Consultations – other specialists..
- Physicians Orders
- Radiology; Lab's; Procedure Notes; Anesthesia records
- Medication records
- Discharge Summary

DECIPHERING COMMON MEDICIAL TERMINOLOGY AND ACRONYMS

- Other medical acronyms or abbreviations commonly found in the medical record pertain to activities, a place in the body or in the hospital, a type of test, a person's credentials, etc. These abbreviations are usually an abbreviation of a term in the English language.

WHAT MEDICAL RECORDS CAN TELL YOU

- Smoking history
  - If a client who sustains a spine injury has a history of smoking, a treating physician may document that information in his/her notes because smoking has a direct effect on the healing process of spine.
  - It is important to look for evidence of smoking throughout the medical record because of smoking's negative impact on bone healing as well.
    - The client may not list a history of smoking in the admission orders or health history, but a nurse may document in the nurse's notes if the client is found leaving the unit to smoke.

WHAT MEDICAL RECORDS CAN TELL YOU

- Client's lifestyle and habits
  - Can be found in the history and physical, nurse's notes, doctor's office notes.
  - If a client regularly engages in risky activities, that information could be taken into consideration when assessing injury.
    - The risky behavior could mean additional wear and tear on the client's body, possibly making him/her more susceptible to injury.
    - It could also mean an additional injury after the initial claimed injury.

WHAT MEDICAL RECORDS CAN TELL YOU

- Client's occupational history
  - Can be found in the admission record, history and physical, doctor's office notes, and possibly the ER record.
  - If the client's occupation is one that is physically demanding or might increase the normal wear and tear on a person's body
    - It could make him/her more susceptible to injury.
    - It could also mean an additional injury after the initial claimed injury.
    - The client may have to stop working after the injury if his/her job is too physically demanding.

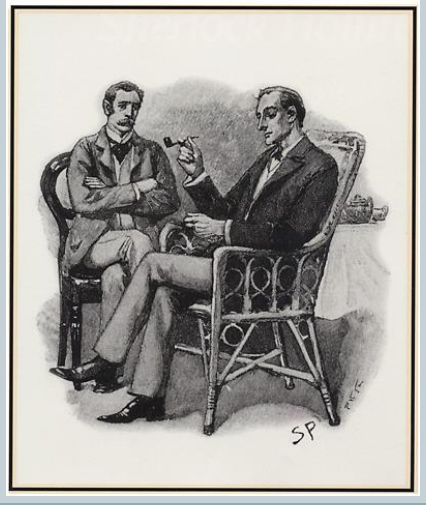
WHAT MEDICAL RECORDS CAN TELL YOU

- The client's current medical treatment and whether the client is compliant to suggested medical treatment.
  - The details are usually found in the treating physician's office record, and possibly the physician's notes in the hospital record.
  - If a client has not been compliant to his/her suggested medical treatment
    - it might shed a negative light on the client as well as the case.
    - it could mean that he/she will not follow through with suggested medical treatment in the future.

WHAT MEDICAL RECORDS CAN TELL YOU

- **Other Details Found in a Medical Record or Hospital Chart.**
  - Lab results, radiology reports, cardiology reports, and consult information can be found throughout the medical record in their respective sections.
    - Lab results can show a multitude of details from preexisting medical conditions to alcohol and drug levels.
    - Radiology reports can show the actual injury the client might have sustained and give the details of the injury.
    - Consult information can be valuable when trying to follow the course of care of a client and can also outline the suggested medical treatment.

What a Medical Bill Can Tell You



- Evidence of tampering with a medical record
  - Missing documents are one sign of tampering.
    - If a test is ordered in the doctor's orders or is charged for in the billing statement but the results are not in the chart, this might be an alert signal.
  - Information that has been added, crossed out, or changed in any way, this might be an alert signal.
    - If a document is copied and sent to another treating physician or facility, it is important to compare the original and the copies.
    - There is an acceptable timeframe that a hospital chart is allowed to be corrected after the initial charting.
  - Nurses commonly end their note by drawing a line through the rest of the charting space to their name. Check those details.
  - Tampering of a medical record is very difficult if not impossible to defend because the entire document loses credibility.

WHAT MEDICAL RECORDS AND HOSPITAL CHARTS CAN TELL YOU

- Electronic medical records
- Are being utilized more and more in many hospitals and healthcare facilities.
- Each documentation entered on the chart is recorded in a tracing log, leaving a trail of who entered what.
  - Often times the detailed tracing log is only available to be viewed at the facility using that facility's specific program and does not necessarily show up on the printed version.
  - If tampering of the EMR is suspected, viewing the entire tracing log may be useful.

WHAT MEDICAL RECORDS CAN TELL YOU

- Summary
  - Medical records and hospital charts can give a detailed description of the client that can determine the outcome of a case.
  - All of the procedures, lab and radiology reports, and medical expenses, as well as the healthcare providers involved in the client's care can be found in the medical record and hospital chart.
  - It is important to examine an entire medical record and hospital chart to form an educated opinion of a case.

Medical time lines – Medical Chronologies

- **SERVICE DATE PROVIDER COMPLAINT ASSESSMENT TREATMENT**
- 12/28/2009 Palm Beach County Fire Rescue 72 (Rescue 73 also responded) Motor Vehicle vs. Motorcycle ***"Moped type vehicle vs. vehicle-multi system trauma"*** Neck-other; Upper Extremity-Fracture, Pal (palpable?); ***Abdomen-Abrasions, Contusions, Other***; Lower Extremity-Fracture, Pal; ***Foot-Abrasions, Fracture***; Back board/C-collar/Spinal immobilization/Splint and traction. GCS-13 upon arrival increased to 14 [Best GCS 15] Driver wearing helmet Meets Trauma criteria "Red-2 or more long bone fractures" Trauma alert called 19:01 priority 2. Initial vital signs obtained 18:50. 16g IV placed R antecubital, Initial O2 NRB mask 12/28/2009 Palm Beach County Fire Rescue 72 (Rescue 73 also responded) Motor Vehicle vs Motorcycle "Moped type vehicle vs. vehicle-multi system trauma"
- EMS Narrative: "29 year old male ***supine in the middle of the road next to moped type vehicle that appeared to be crushed***. Patient is alert, oriented to time, place, and date. Note ***speed limit is 55mph***. Approximate patient contact time, note any delays: 1854 delay due to location near county line…Estimated time of injury: 1835…***Mechanism of Injury: Fell off of moped and run over by a vehicle…Patient run over by vehicle estimated speed greater than 45mph.*** Patient was poor historian did not recall what happened, ***was informed after transport that patient's backpack was under a vehicle. Physical Assessment in rescue truck revealed contusion upper and lower left abdominal quadrants with swelling and abrasions, left femur fracture just proximal to mid shaft w/considerable swelling and fracture to left forearm.*** Denies…use of narcotics/etoh or medications prescribed or OTC

Medical Chronology

DATE/TIME	H/H	INTERVENT/ TIME
9/18/06 1400	12.9/38.8	
9/22/06 1330	12.0/35.1	
9/23/06 0430	7.3/21.4	
9/24/06 0300	5.4/15.4	1X PRBC-0500 1X PRBC-0645
9/25/06 0300	6.9/19.5	1X PRBC-0800 1X PRBC-1030
9/26/06 0300	9.9/28.4	
9/27/06 0800	11.0/31.6	
9/28/06 0350	12.0/34.3	

- Normal Hemoglobin for Women is 12-16 and Normal Hematacrit for woman is 36-48

The Smoking Gun is rare.. Was the death attributable to the initial injury or to the care the decedent received..

