The University of North Carolina
Department of Surgery
Intern Handbook

2009-2010
Compiled by Jeff Dehmer, MD
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2008-2009 UNC PGY-1 class

General Surgery: Staci Beamer, Krista Evans, Katharine Mcginigle, Sally Stander, Adam Suchar, Raeshell Sweeting, William Bradford, Tyler Elkins-Williams, Dominic Papandria, Jose Piscoya, Matthew Smith
Orthopaedic Surgery: Reid Draeger, Timothy Murphy, George Edwards, Amanda Robertson, Lucas Wymore
Urology: Eugene Simopoulos, Stephen McKim
Otolaryngology: Jessica Kehren, Kibwei McKinney, Scott Shadfar, Yu-Tung Wong
Neurosurgery: Bruce Geryk
Vascular – Integrated: Marc Camacho

IMPORTANT PEOPLE – see point number 1 on the next page

Senior-in-house
Pager 216-4363, phone 445-7301
The boss at night. Oversees all traumas, general and pediatric surgical consults, and is in charge of keeping things copacetic in the hospital at night. This is who to page when things are really going south and you can’t get the chief of the service to call you back. Not that such a situation would ever occur…

Junior-in-house
Pager 123-7007 (ironically 123-P00P), phone 445-7302
The initial contact person for all traumas, general surgical consults, and management of the cardiac surgery service at night. Also has the joy of managing all the outside phone calls from people who had surgery 19 years ago and suddenly develop abdominal pain in the middle of the night and want to talk to their surgeon.

Bed commander
Pager 123-6650, phone 445-7303
Ruler of the surgical ICUs at night. If your patient is moving to the ICU, this person is going who will become responsible for them so it is expected that you will be giving them a call to discuss the patient.
Words of wisdom:
1. YOU ARE NEVER ALONE. Load the boat.
2. Load the boat.
3. Load the boat. Seriously, we can’t stress this enough. Especially early on, call with anything. Use your head. If you think about calling, you probably should (same for intubating a patient). If you have any doubt about whether you should see the patient, you then you already know the answer to this one…no matter how cozy the call room bunk bed is...get your butt up and make that trek over to 6 Neuroscience or 7 Children’s. You’ll sleep better if you know you’ve done the best you can for your patients. Plus, you’ll get in a lot more trouble for not calling than for calling without really needing to.
4. Follow up on your own studies. Seriously, it is possible for a patient to get to the OR and not have what you think they do. Don’t assume other people are doing it.
5. A sin of omission is usually worse than a sin of commission.
6. Do it right the first time. An extra 30 minutes in the OR is better than lying awake at 3 AM wondering if that stitch in the IVC will hold. This becomes more and more applicable as you travel up the surgical ladder.
7. It's our job to worry.
8. Post first, ask questions later. OR time is at a premium.
9. Play nice…with everyone. One of the hardest things about intern year is learning how to deal with frustration. You will want to destroy your pager. For a creative idea on how, watch the Office Space fax machine scene. Try to return pages promptly, especially if it’s another MD, ASAP page, or 911 page. Remember that usually when someone pages you, they’re just doing their job, even if it is to tell you something you don’t particularly care to know at 3AM (see sample pages at the end). Being rude on the phone is a quick way to ensure you won’t get much sleep on call nights.
10. Be normal outside the hospital. Your life will change, but keep up with friends and family. Exercise. Go places on your golden weekends and vacations. Be social. Life is too short to miss out on the next 5 to 10 years. Plus, your fellow residents will be your allies, your teammates, those you can commiserate with, can help you out in a pinch (when you get called at 1:00 AM to place in a Corpak and you don’t even know what a Corpak is, or where it’s supposed to be placed) and those whom you will be calling in future years for consults.
11. Be enthusiastic. This frequently gets lost as the year drags on. Remember that most of us have wanted to be surgeons for a long time. We all have been where you are now and remember how it can be. Being able to see the big picture (you’re not an intern forever) will help you keep a good attitude and make you stand out.
Really making an effort to get in the OR can help rejuvenate you, even if it’s just to watch for a little bit.
12. Try to read. It will help you look like a superstar in conferences and the OR. Plus, the ABSITE creeps up on you.
13. Don’t freak out! This year is hard, but you can get through it. Even though it doesn’t always seem like it, there are a lot of people who want to help, teach, and support you. Never be afraid to ask for help.

**General info on how to get by:**

**The Daily Grind** – Park out by Southpoint Mall and walk 25 minutes to the hospital for perhaps your only exercise of the day. If you want to gain the Intern 15, take the safety shuttle (only available after 5am). Page the cross-cover for sign-out on overnight events, admissions, and funny irrelevant pages received. Sometimes it seems silly and you don’t feel like it, but be respectful of the kid who was taking care of your peeps all night long. Update the list/rounds report and print copies for everyone and their mother. Expectations of the level of detail with the list vary by service, but it may be the only thing that helps everyone keep the patients straight. Once rounds start, it’s usually up to you to navigate the team through them. It’s generally frowned upon to lead your team on a wild goose chase. On rounds, make your list of check-boxes to cross off later. Now that most services are electronic, notes come later. Remember, we all hate writing notes, but it’s how the hospital makes money. In prior years, profitable times for the hospital have resulted in financial rewards for all! In general, if you’re the only intern, it’s really hard to write notes on rounds, especially in WebCIS. After rounds, run the list with the chief or sit down and put in all CPOE orders. The chiefs vary a lot and you may not feel like you have a concrete plan after rounds. If you don’t know how to get something accomplished, ask! Try to find a quiet place away from the nurses to put orders in. It is very frustrating to be entering all the orders for the day, including advancing Mr. McFunnypants’ diet and being continually approached with questions like “Can we advance Mr. McFunnypants’ diet?” Generally, the flow usually goes like this: put all the orders in CPOE, call all the consults, write notes, follow up on all the studies that are supposed to be done by this time in the day but probably aren’t. If you’re lucky and have five minutes before clinic or the OR, you might want to eat something so you don’t fall over. Consider doing a mini-preround sometime around 3ish. That way you’ll know the answers to the standard “how’s so and so doing?” or “what did the consult team say about Mr. McFunnypants?” on afternoon rounds. Finish notes with any spare time you have in the day. This may not be possible and you’ll be doing notes at home. Sucks, but
true. The attitude about getting to the OR during the day varies from service to service and senior resident to senior resident. In general, you are the only one looking out for the floor/ISCU patients, so if you don’t make things happen, they won’t happen. It won’t take long to be efficient enough that you can accomplish all of the above in a fairly reasonable amount of time. Afterwards, you may be asked to go to clinic. If not, consider poking your head in the OR. It makes a good impression and generally speaking, someone will ask you to scrub in and put your hands on something. Savor that time as the reward for all your hard work. Following afternoon rounds, tidy up orders and the list. Page the cross cover intern to give sign-out. If they happen to be in the middle of rounds, you’ll be able to keep yourself busy until they’re done. Signing out at 4pm and asking the cross cover intern to do post-op checks on patients who got out of the PACU at noon will make you distinctly unpopular with your colleagues. Drive home. Reward yourself for all the hard work with a tasty dinner. Repeat x 365 (minus 4 days off per month and 3 weeks vacation).

FOOD – The first and most important thing. There are several options for grub. The staple is the Terrace Café on the 1st floor of the Children’s Hospital Lobby. They always have pizza and grill food. At lunch and dinner there are extra tasty selections. The Corner Café is on the ground floor by the Children’s Heart Center. It’s basically a mini-Terrace Café. In Brinkhous-Bullitt by the Brick Beach there is Grapevine “cafeteria” (being remodeled now). They have Chinese food for lunch most days of the week and Subway every day. All 3 of these places serve Starbucks coffee. Tarheel Takeout (www.tarheeltakeout.com, 919-942-7678) is the greatest invention ever. Call and place your order. They take Freedom Pay (perhaps not for long) and deliver to the main lobby. It takes 45 minutes to an hour and a half depending on how busy they are and can drain your $$ pretty quickly. If you’re in a bind, you can always grab crackers, cheese, and peanut butter from the floors. Boost is surprisingly good on ice, too. As the hospital grows, these options change rapidly.

Pagers – Always text page if you can. Include your phone number and pager number at the end. NEVER page someone to a pager. If it happens to you you’ll understand why. If possible, don’t page your chief to 6-1976. This is the intern call room and you’d think they would forget that number, but they don’t. They know you’re not at the bedside. From outside the hospital, 216 pagers can be dialed like a regular number. For 123 pagers, dial 966-PAGE (966-7243) and enter the pager
number. If your pager is broken, lost, or destroyed after you threw it against the wall, go to communications and get a replacement. The same applies to new batteries. If you’re lazy, usually you can coerce an HUC on the floor to give you a new battery. Having a pager is not cool, like we all thought it was in medical school. The service pager numbers are listed later and should be utilized regularly.

**Calling consults** – Try to call as early in the day as possible. When you send out the page, include the patient’s name, MR #, and reason for consult (as much as will fit in 1 page). In general, serial pages are poor form. Leave a phone number and the pager of whoever they should call with questions or results. Make sure you know why you’re asking for the consult. Often, you won’t and that makes it miserable for you and for the person you’re calling. If you don’t know, ask your upper level (or try to talk them into calling it for you).

**Moving to the unit** – If a patient goes south and needs to be moved to a higher level of care, lots of things need to happen. Make sure the chief of the service knows what’s going on. Page the house supervisor (347-1922) and inform them of the situation, they’ll let you know what beds are available. If going to the ICU, page the ICU bed commander (123-6650) and let them know as well since they have to start helping to manage the patient. Put the orders in CPOE (transfer to service, review and revised, etc). Lastly, try to call the family. If you showed up in the morning to visit your family member and they weren’t where they were the night before, you’d be upset too.

**Codes** – Usually, the medicine code team responds to these. If it’s on a surgical floor, you should go. If it’s your patient, you should definitely go. When the surgery team arrives, the medicine folks usually retreat. Remember the ABC’s. Don’t reflexively start compressions without stopping to think first (i.e. always check on more than 1 lead that it is actually asystole on the monitor). Don’t forget to call the chief of the service. If you’re feeling bold, elbow your way in and maybe you can put in the groin line. At the end, make sure someone documents what has happened in the chart.

**Cross cover and sign out** – This is one of the true joys of intern year. On call nights, you will be answering questions about patients that you know little to nothing about. Once you get a bad sign-out, you’ll realize why we emphasize doing a good one. Write notes on the check-out sheet and talk in person if possible. Try to leave specifics, such as: if UOP less than xyz, bolus 1L of LR and follow-up, check 10pm lytes and replete as necessary, etc. This makes life easier. Make sure you
clarify if the upper level wants to be called with the result of a test, a lab value, or a consultant’s recommendation. Try to write down the orders you put in and things you do in the middle of the night so when the primary team calls you to find out what happened in the night, you can actually tell them. If you evaluate a patient with something serious, write a note about it in the chart. At night, frequently you’ll have to call around to make sure things like labs and radiology studies get done. Don’t be afraid to wake up your senior resident if you’re worried about a patient. We didn’t go into surgery to sleep 8 uninterrupted hours a night. The Senior in House (SIH, 216-4363) is also a good resource if you need help with a patient sooner rather than later (or your upper level is sleeping through your pages and won’t call you back). Clarify if the chief wants to be paged or called. It’s amazing, but some really can sleep through multiple pages and prefer a phone call.

**Radiology/VIR** – If you have time and can navigate the maze, get in the habit of going to the basement to review radiology studies with the residents. They’ll be happy to teach you something if they’re not too busy. At night, the ED reading room is 6-8850. For VIR in the daytime, put the order in CPOE and call 6-4645. Ask to speak to the radiology resident or the person in charge of the board if the resident is busy. On the weekend and at night, you have to page the senior radiology resident (216-2826).

**Rehab** – Before you even think of calling rehab for a consult, make sure the patient has been seen by PT/OT and that somewhere in their assessment they mention the word acute rehab. Try to have all acute medical issues tied up (i.e. duration of antibiotic therapy, wound dressings, surgery follow-up, etc). Make sure the patient and their family would actually agree to go if accepted. You’d be surprised how common it is that you go through all the steps and then get paged by the rehab docs only to find out that the patient would rather have a barium enema than go to rehab. It helps to type discharge summaries early in the day before because they’ll never be ready by the time the patient is supposed to be transferred if you wait around. You’ll be hunted by social work until it shows up in WebCIS. This applies to discharges to our rehab as well as to outside rehabs/SNFs, or even another acute care hospital.

**TPN** – All the nutritionists are really great and will help you out with this. Feel free to ask them anything. If you think a patient will go home on TPN, let them and social work know ASAP. For pediatric TPN, it has to be done by 1200, adults 1600. The pediatric surgery NPs will help you out with this. You will have the luxury of a new CPOE order set to use. Us old timers had to do paper orders. It’s
fairly self-explanatory and the only thing that will require much thought is rearranging electrolytes.

**Admissions:** For patients who get admitted, the basic requirements are a bed, an H&P, and orders. Bed control is 6-2041 for anyone not coming from the ED. From the ED, the ED admission coordinator is 347-0710. You can start typing the H&P in clinic and put in pre-admit orders in CPOE to cut down on work when the patient shows up on the floor.

**Discharges:** In the era of the electronic record, it is very easy to cut and paste your way through a discharge summary. **DO NOT DO THIS.** Believe it or not, these things really matter, particularly if you are the SIH/JIH at night trying to figure out why someone has bounced back to the ER. Attendings have had issues with poor discharge summaries in the past. Obviously for your uncomplicated appendectomy, a dissertation is not necessary. However, for the patients who end up staying in the hospital for weeks, these are crucial! The easiest thing to do is start one as soon as someone is admitted and try to update it at least once a week. Then when they go home, it’s basically already done.

**PVL** – During the day, just put the order in CPOE. Preliminary results appear in WebCIS pretty quick. If you want it done quickly, give a call to the lab and see if you can get bumped up the list (6-4583). On the weekend, you have to page the tech (216-3954) to diagnose that DVT that you failed to prevent by forgetting to put the patient on chemical prophylaxis and/or SCDs.

**STAT orders** – Basically, whenever you enter in a stat order and the nurse doesn’t already know about it, at least call the floor to tell the HUC if you want it to actually happen before the end of shift. And for radiology studies, put in the order, then call the appropriate department to help fast track your patient. Unfortunately, being the intern sometimes means you have to be a secretary, RN, and transporter all rolled into one.

**Social Work** – On all services, it is strongly suggested that you call you social workers every morning to run the list. You would be glad you did, unless you really like pre-rounding and writing notes on the 35 patients of your continuously growing service. Let them know early what you anticipate – rehab, SNF, wound care, home health, etc. It will make your life a whole lot better (particularly on SRH, SRV, and SRN).
Dressings – Try to order supplies to the bedside for AM dressing changes. A reasonable number of mornings, there will be enough to patch something together. If (a big if) your med students have it together, they will also have extra supplies ready and anticipate your needs. Feel free to encourage them to help out with this (in a very educational and PC way). If you want to have the dressing down in the AM for rounds (hope the burn interns read this), you can put an order in CPOE, but it’s a good idea to make sure the RNs know.

Pre-op: Basically, to go to surgery, everyone needs a signed and witnessed consent, a pre-op note, NPO orders, and possibly antibiotics. Ask about NPO/ABX from an upper level if you’re not sure. Ancef (cefazolin), clindamycin, ertapenem, and Levaquin + Flagyl are popular choices. If doing this in the clinic, there is a H&P sheet with blue stripes that must be filled out. Also there is an order sheet for CXR, EKG, labs, and ABX. Occasionally, you’ll have to post a patient for the OR. Go to the OR front desk and fill out a posting sheet. Find the CPT code in the enormous book. For any details you’re not sure about, ask the chief. You may get asked questions when consenting for a procedure that you don’t know the answer to. Be honest and tell the patient you don’t know but will find out. Don’t make stuff up. If you are having issues and not sure about how to consent someone, bump it up to the senior resident or attending. At this point we don’t expect you to know everything about everything.

Reading: Self explanatory, but can’t be stressed enough. Seems easy, but can get lost in the other things that need to get done as well as having an outside life. Suggested reading materials are listed later in the education section, many of which are available online for free. Also really important to try and read about your patients and cases before the OR so you have some idea what’s going on. The best (and perhaps most unrealistic) policy is to get in the habit of reading some every day. You’ll be surprised how fast you can get through a major textbook and how much it can pay off in conferences and on the ABSITE.

Notes:
Medicolegal issues:
The legal department wanted to include a plug in here on how being a resident fits into the larger picture of medical malpractice. A lot of it is common sense, but a little reminder never hurts.

*Top 10 Ways to Avoid Litigation and Liability* (from their handout):

1. **Foster good patient relationships.** Duh. Patients and families get mad when they feel that we haven’t been honest and when they feel that we don’t care. Put yourself in their shoes and act accordingly.

2. **Be thorough in your clinical assessment and treatment.** This boils down to knowing when to ask for help. As interns, this is all the time, but even chiefs need help occasionally. If our patients had simple problems, odds are they would be somewhere other than UNC. If things are going down, make sure someone above you knows about it.

3. **Be comfortable with the procedures you are performing.** This means having someone available to help if you need it. It’s exciting to put in your first subclavian line or chest tube, but no one expects you to do it solo the first few times.

4. **Never guarantee the result of your treatment to a patient.** Don’t fall into the “it’s just a…” trap. There is no such thing as just an appendectomy or just a lap chole. There’s a reason there are mortality statistics for all procedures. We don’t want you to be overly negative, but keep in mind that everything has a risk and benefit.

5. **Be aware of the implications of informed consent.** Make sure that you are consenting the right person. Before you consent someone, try to have an idea of the most common complications and mention them. For example, always include infection and bleeding with any surgical procedure. All laparoscopic procedures have a risk of converting to open. Make sure people know they are consenting for blood too.

6. **Personally confirm the patient’s identity and the location of the procedure.** 100/100 juries conclude that there’s really no excuse for cutting off the wrong leg. Period.

7. **Never criticize another health care professional’s work.** This applies for verbal or written comments. Regardless of the legal implications, finger pointing is just bad practice. And yes, the medicine teams talk as much trash about us as we do about them.

8. **Respect patient confidentiality and privacy.** Duh. Remember all that HIPAA training? Try not to talk about patients in the halls, elevators, cafeteria, etc. This applies for exams too. Patients don’t need to be totally naked just to check out their abdominal incision. Remember to close out all your programs, especially WebCIS.
9. Document all clinically pertinent information in the medical record, objectively and as close to the time care is given as possible. Progress notes are frustrating a lot of the time, but it’s one of the few objective signs of what we do. When cross-covering, if you see a patient for something important (chest pain, SOB, altered mental status, etc) you should document it. Also document if you spoke to the upper level about it. Always date and time your notes. Create phone messages to document outside calls if you take them.
10. Support the quality improvement processes of the hospital. In short, if something fishy is going on, talk to someone senior about it. If you have issues with a particular person and you think that patient care is suffering, bring it up. There’s no harm in trying.
Service by Service:
GI surgery – Koruda/Sadiq (SRG-K) or Farrell/Overby/Bunzendahl/Rupp (SRG-F), 123-7049: Moderately busy, can pick up at a moment’s notice. OR and clinic days are pretty much every day of the week. This is a good rotation for getting into the OR with Koruda, particularly if there’s just a PGY5 on Koruda’s service with no PGY4. Make sure you can throw down a good square knot prior to entering. In CPOE, there is a GI surgery order set that has most of what you need for post-op orders. Treat nausea aggressively (write for Zofran and Phenergan) and pay attention to steroids. Many patients will be on a taper after surgery. Pre-op conference on Tuesday at 9am. You’ll probably get pimped, but it’s a good chance to learn, look at radiology studies, and get face time with the attendings. Dr. Koruda dictates all of his operative and clinic notes (score!). There are discharge instructions for many of the GI surgery patients (Nissen, gastric bypass, etc) on the computer with the list. These are helpful for discharge summaries as well.
Floor: Home base is 4 Anderson North. There is a nook with several computers primarily for our use including the one with our lists. Many patients have chronic pain issues and are on doses of narcotics that could severely impair an elephant. Don’t let this frighten you. Many people are on TPN. See above in general info. There will be a lot of wounds to look at. Try to schedule woundVAC changes around OR cases and clinic so either you or the chief can have a look. Don’t get frustrated if you get paged that your new patient is on the floor and you didn’t know anything about the admission. At any point in time, there may be multiple patients who have been accepted as transfers, but are waiting for an open bed. Just look in WEBCIS and try to figure it out. Do the H&P and then page the chief. If it’s a transfer from an outside hospital there will be some info with the patient.
Notes:
Vascular (SRV, 123-7057) – Steady torrential downpour of work. In general, the only concrete rule is that Friday is resident clinic day. This starts between 8:30-9:00 after weekly conference (in 5 Bedtower conference room). Don’t be late. There are an insane number of patients, usually returns. Lots of wound checks, post-op checks, etc. It’s OK to dictate during clinic only if there are no available patients to see. If you get caught dictating and not seeing available patients, you will get mocked. Frequently people will need studies during their visit. For PVLs, always call prior to sending someone. The RNs are good about helping set up other studies. Other than that, there’s not much structure. At any point, you could be called to clinic to help out or to the OR to do the occasional wound debridement or toe amputation.

Floor: Home base is 5 West. Lots of people will be on heparin drips. Goal PTTs are usually 60-80. This is pretty easy now that attendings have adopted the heparin nomogram. If managing it yourself, q6 aPTTs are the norm. Try to work out dressing changes with the medical students so that you’re not delaying rounds too much. Develop a good relationship with Cardiology and Nephrology because a lot of your patients will need them. Notes are in the computer and can be a time drain. Some days, you’ll be very frustrated on this service. In the case that you need a break, I’d recommend doing the notes at home so at least you can be out of the hospital. The same applies to dictations. You may get the lovely page “Your patient is here. Need orders.” This makes you want to cry. Us too. Look in WEBCIS to try and figure out why. Frequently, it will be a stealth admit from VIR or clinic. Do the H&P and page the chief to discuss the patient. Pre-contrast regimens are in the meds section at the end.

Hypercoaguable Workup:
1. Factor II DNA analysis prothrombin mutation
2. Factor VIII activity
3. Factor IX activity
4. Factor XI activity
5. Factor V Leiden DNA analysis
6. Fibrinogen
7. Anticardiolipin antibody
8. Anti-thrombin III activity assay
9. Homocysteine
10. Lupus inhibitor
11. Protein C activity
12. Protein S panel

Notes:
**Trauma (SRH, 123-7051)** - This service is BUSY. All traumas + general surgery call from Monday AM through Saturday AM. A lot of time will be spent trying to coordinate disposition of patients. Develop a good relationship with social work, rehab, PT/OT, speech, etc. They will be crucial in helping to diurese the census. Also, you’ll be working a lot with ortho and neurosurgery because many patients will have multiple injuries. PT/OT will ask you to clarify weight bearing status prior to touching them. Usually this involves tracking down the ortho resident who is seeing the. Another treat is the flex/ex. This involves going down to radiology to physically remove the collar for the x-ray. That’s it. Not really sure why we have to do this. At WakeMed, it magically happens without our presence. If the patient has pain when you do this, put the collar back on to fight another day. If you’re interested, occasionally there are OR cases (hernia, appy, lap chole, abscess I&D, etc) up for grabs since SRH is on general surgery call most of the week. *In the trauma bay*... The primary job of the intern is to piece together an H&P. This can be difficult in the chaos, but having a catalogue of the patient’s injuries is very important. Most ortho residents aren’t too happy about being called for a femur fracture 6 hours after the x-rays. For the note, try to have some idea of what the plan is (i.e. consult neurosurgery for head bleed, ENT for temporal bone fracture, ortho for pelvic fracture, admit to ICU for serial H/H if liver or spleen laceration, etc). If unsure, odds are either the JIH or SIH will still be around to help clarify.

**Conferences**

- **Monday – Noon in 4050 Burnett-Womack – SICU/Critical Care**
- **Tuesday – 8AM in 4050 BW – Multidisciplinary Dispo AND 1PM in 4050 BW – M&M (alternating)**
- **Thursday – 8AM in 4050 BW – Pre-operative conference (expect to present a case or 2)**

**Floor:** Home base is 5 Bedtower. Usually, most of the work involves getting people up and out of bed and then to a suitable place, whether home, rehab, SNF, etc.

**TRAUMA ATTENDINGS ARE TERRIFIED** of being sued for missed injuries and incidental findings that didn’t get followed up. Hence, all patients need a tertiary survey which means a head to toe exam 24-48 hours after admission and a review of all x-rays with documentation of all abnormal findings (the incidental adrenal mass or pulmonary nodule that needs f/u). In the ideal world, the trauma service would have a template note in WEBCIS called “tertiary survey” instead of the multi-tabbed nightmare known as the “inpatient progress note”. They don’t have that. Instead, the wiki has a template for a tertiary survey which you can use. Enter your version of the tertiary survey under “daily course” tab of progress notes.

**TRAUMA ATTENDINGS BELIEVE THAT CUT AND PASTE IS AN INVENTION OF THE DEVIL** but for the tertiary survey you can cut and paste the summary findings from the CT’s into the note. Use the wiki for direction on how to do d/c summary.

**Notes:**
**WakeMed** – The land of milk and honey. This is a great month for interns. Basically you show up and round on “your patients”. Believe it or not, they really are yours. Run big decisions by the upper level following with you or by the attendings. They are definitely OK with you paging them directly and expect you to discuss management with them. Paper notes and orders make if fairly streamlined. The nurse practitioners and PAs are great and will help with discharges, particularly on the trauma patients. Usually, this works like a well oiled machine. You’ll be assigned cases by the PGY4. Definitely read up the night before and try to meet the patient in pre-op holding, some attendings won’t let you scrub in unless you do. Call nights consist of seeing consults and traumas. Expect to put in chest tubes and groin lines. If you are needed to run a trauma solo, just remember your ABCs and don’t freak out. The ER people are there to help. Drive home safely post call. It’s quite a trek when you haven’t slept. A nice secret for getting good OR cases is to keep tabs on the pediatric surgery attendings. Their cases can go uncovered and are a nice treat for the nosy intern that takes the time to find out. Make sure you know your ONYEN because the didactic conference on Wednesday AM goes through the online Sabiston from the UNC library page.

Notes:
Transplant (SRF, 123-7050) – Hit or miss in terms of workload. This service is very particular – follow the Scut Monkey (http://viper.med.unc.edu/surgery/AbdominalTransplant/) for everything. Don’t be afraid to bump even minor questions up the food chain. Simple things like giving electrolytes are important (i.e. tacrolimus + low magnesium = seizure = bad). Order tacrolimus or cyclosporine levels daily, and most patients merit daily labs. Fortunately, they keep their central lines for a while. You’ll have very little clinic responsibility this month. Obviously, a biliary anastamosis for a liver transplant is not part of the intern skill set. Still, make an effort to get to the OR and you can probably scrub in. These are amazing cases. Time off this month is at a premium. You may be asked to round on the weekend and have a random day off during the week. Take advantage and do normal people things like go to the bank, sleep, play golf, etc.

Floor: Home base is 5 East. You’ll work closely with the transplant coordinators. They help immensely with discharges, medication regimens, follow up-coordination, etc. You’ll be ordering crazy studies like transplant ultrasounds with lots of numbers that you don’t understand. Just do it and report the data. Try to read about what they mean so you have some idea what’s going on.

Notes:
Urology (SRU, 123-7053) – Pretty chill. For the non-urology PGY1s, this month consists of pre-op workups, admissions, and discharges. Usually there is no pre-rounding and you can leave at a reasonable hour. There’s lots of down time during the day to read. Take advantage and study for the ABSITE. This is also a very particular service so don’t be afraid to bump things up the food chain if you’re not sure.

Floor: Home base is 5 West. Follow outputs closely – JP drains, nephrostomy or SP tubes, and Foley catheters. There’s a lot of turnover so be prepared to do lots of green sheets and discharge summaries.

Notes:
Burn Unit (SRX, PDX, 123-7056) – Crazy ridiculous busy. For many, this will be the first month where you are the first call for ICU patients. NEVER feel afraid to bump it up the food chain. In fact, usually, you are expected to do this prior to making any management decision, ESPECIALLY on ICU patients. These are some of the sickest in the hospital (i.e. q1 hour ABGs, on CVVHD, with 5 chest tubes, 10 pressors, and an albumin drip). It can be intimidating, but you’ll learn a lot if you have a good work ethic. You’ll get to do a ton of procedures – central lines, change over wires, and bronchoscopy, primarily. Try to go to the OR for skin grafts and tracheostomies, especially if Dr. Meyer is around. It’s a good chance to get face time with the main man. Always listen to the nurses, because they’ve been doing this a lot longer than you and can help you out. Wound care is extremely important, so don’t dismiss it if someone wants you to look at a wound, even if you’re busy. If you’re not sure what to do about it, ask up. Make sure to do a burn map for every admission.

Floor: Home base is the burn unit. There are 2 parts, the BICU and the burn floor (BURN in CPOE), but both are contained in the geographic burn unit. Yes, we were confused at first as well. There are great order sets in CPOE for AM labs on ICU patients, wound care, etc. Try to keep the list updated. Med students can help with this. For some patients it’s the only way you’ll come up with a coherent discharge summary (i.e. patient who has been in the hospital for 6 months, most of which you’ve never known them). Anthony (the PA) will round on the floor patients, so you are responsible for those in the burn unit.

OR plans: You will be asked to pre-op a lot of patients. Consents are usually for "excision & grafting <insert burned places here>, possible auto/allo/xeno graft ". Autograft = person’s own skin, allograft = somebody else’s skin, xenograft= pig skin. The main risks include bleeding (that’s why we type & cross everybody for 2 units for STSG), infection, and possibility of graft not taking. Make sure and ask someone about holding heparin, tube feeds, and increasing IV fluids to compensate.

Lines: Patients need either a new line or change over wire every three days and this is a great chance to get comfortable doing central lines.

Notes:
Plastics (SRC, 123-7055) – Pretty chill. This is a fellow-run service with no general surgery residents. As such, you’re pretty much on your own for doing floor stuff, even if solo and post-call. You can get to the OR a bunch, particularly if the census is light and there are 2 interns. The attendings are great and will let you do a fair amount. It’s a great chance to practice suturing and get good at it. Pre-op clinic is Wednesday in the ACC. It is painful, particularly if you’re the only intern and post call. Just keep your nose to the grindstone and muddle through. Do dictations at home if you want, although the patients all start sounding the same when you’re tired. If you have gotten fast at dictating, it’s OK to do them between patients if you’re not backed up.

Floor: Home base is 5 East. The list is on a computer in the nursing education room. This is a nice nook to get orders done, do green sheets, and take a quick snooze. The most important thing is wound care. Try to have wounds down for rounds in the AM. This is a good task for the med students. There is a bag with supplies that should be kept stocked and taken on rounds by one of the students.

Notes:
Thoracic (SRT, 123-7054) – Pretty chill to moderately crazy. This service varies a lot depending on the level of assistance you have. It can go from being the only intern with only a PGY-3 and no fellow to having 2 interns, a PGY-3, and a fellow. Regardless, it is a good rotation to get some ICU experience and get in the OR a bit here and there. You will be the consult resident for this rotation, which can be frustrating, but you’ll get to be comfortable placing and managing chest tubes, which is a key skill for us. Multidisciplinary Thoracic Oncology Program (MTOP) clinic is complicated, but a good chance to see the team approach to cancer that is highly touted in the press. Also, there is usually a good free lunch that day. Try not to fall asleep during the conference, it will be noticed.

Floor: Home base is 4 Anderson South. This floor is for cardiac and thoracic surgery patients, with the occasional off service patient. Half of it is considered stepdown (CTSU) so don’t let that confuse you. Pretty much everyone with a chest tube gets an AM CXR (0400). Frequently, all patients on the service have AM CXRs. Don’t get frustrated when they are not done by rounds. This is a common occurrence. The portable x-ray room is 6-1924. Be nice and they’ll try to start doing yours earlier.

Notes:
Pediatric surgery (PDA, 123-7052) – This service can either be steady/chill or crazy busy if you’re the only intern. There are 2 nurse practitioners who can help with floor work as well as line issues, G-tube issues, and TPN (which must be in by 1200). They are fantastic and will help you out immensely. You will not have any clinic responsibilities (finally). You’ll get a chance to do some operating, particularly if there are two interns and you show some interest. Common intern cases include placing central lines (Cook catheters, Port-A-Caths, and Brovias), I&Ds of abscesses, and the occasional hernia or appendectomy. There are usually med students on the service, so pre-rounding (usually vitals only) isn’t too stressful. Needless to say, this service can be frightening as most of us haven’t done pediatrics since 3rd year of medical school. If unsure of anything, send it up the ladder. If asked to see a consult because everyone else is in the OR: Is it a midgut volvulus? Do they need a Broviac? After that you can take your time figuring it out. Make sure to pick up a set of cards from the pediatric pharmacy by the PICU. They’ll have common meds with doses and info on pediatric TPN. Keep in mind that the main goal for the intern is to become more comfortable taking care of children.

Floor: Home base is 7 Children’s and the “bunker” in the W&C PACU, but you’ll have patients all over the building. The list is in WebCIS. Rounds usually start in the PICU even if you don’t have patients there. Try to pull up all films for your patients before rounds start. Be nice to the pediatric nurses. Odds are that they know a lot more about kids than you do.

** Check in at the pediatric pharmacy next to the PICU early on. They have little cards that are a great reference for pediatric medications, electrolyte management, and TPN.

Notes:
Neurosurgery (SRN, the bomb is not the intern pager 123-2642) – Remember the Nike slogan: Just do it. You are expected to pre-round on all floor patients to gather vitals, labs if they are back, and to examine the patient. You may be the only person to see the patient that day. You will be expected to put in all orders and call all consults (even on the unit patients) but you really only have to follow floor patients. Social work will be your friend, as always. Be familiar on how to order a stat head CT and q6h sodiums. There is always a Neurosurgery resident in house and they are usually on top of their game. The “bomb” (123-2642) will be your friend 24/7 for any questions. You will memorize this number quickly. They also encourage you to scrub cases. You will be called randomly during the day to come to clinic to do pre-op.

Floor: Home base is 6 Neurosciences. The Pons in the NSICU is also a popular meeting place. Only the interns use the list, so if there is one, it’s on the high side of the floor in the workroom behind the nurses’ station.

Notes:
Surgical Oncology (SRA, 123-7048) - Interns spend a lot of time in MOR on this service with Dr. Ollila. Know about the patient before you do the case. GET THERE BEFORE HE DOES. You can call 6-0886 to find out what time you should show up. Kathy is the RN over there and she’ll help you out. Read about breast, melanoma, thyroid, and parathyroid before you even start this service. There is a Friday conference where you present upcoming OR cases and you will get pimped on these topics. It’s educational pimping, but it can be intense. When going through your cases, always try to think: “Why are we doing this and what margins do we need?” Those are common questions. SRA is divided into three services by attending: Calvo/Yeh, Meyers/Kim, and Ollila/Demore/Amos. There are lots of opportunities to operate on this service. I’d definitely recommend buying the MD Anderson Surgical Oncology Handbook, especially if you’re a categorical resident. It will help out a lot for pre-op conference.

Floor: Home base is 4 Anderson North. Nothing out of the ordinary. See the GI notes. The list is on the standard 4ANDN computer.

Notes:
Call pools (these may be different by the time you start…):

**SRT/SRH/PDA/SRE:** Even though you will never rotate through ENT, unless you’re one of their residents, you will be expected to cover their patients at night. This can either be ridiculously painful or you may not hear a peep. It depends upon how 6NSH is feeling that night. Bottom line, if you have to see one of their patients, write a note about it. The residents are nice, just particular. Call with anything. For thoracic, you’ll be covering the ICU as well. Obviously, don’t get too big for your britches dealing with those patients and call liberally. In general, one of the better call pools. Peds is usually a crap shoot as well, the most painful things involving talking to family about plans you have no idea about. For Trauma, you are required to go to all Red traumas and help out, do H/P, and sometimes orders. Though Yellows are not required at night, it is always nice to help out the upper levels if you have time. Lots of calls for pain meds.

**SRF/SRA/SRG:** Oh, what to say. This is in a toss up with Vascular/Burn as most difficult call pool. Frequent issues are transplant admissions, rectal tubes falling out, patients in a coma from narcotics who need more pain medicine, etc. It’s a personal decision, but some of us chose to do mini rounds on 4ADN to try and extinguish any potential fires before lying down in the call room. This does not guarantee you won’t be paged 15 times in 30 minutes from the same number. Sadly, this is not far from the truth. Transplant coordinators will page you with details on incoming transplant patients. There are CPOE order sets for pre-op transplants with all of the labs you need. You’ll usually have to post the case. Make sure and ask about which immunosuppression protocol to use. Keep in mind that you are doing all the prep work for a huge operation that is going to change someone’s life. Details are important.

**SRV/SRX/SRC/SRN:** This can be very stressful. Fun events include q1 hour ABGs on BICU patients, admitting the random vascular bomb (Page – your 15cm AAA patient is on the floor and needs orders), trying to talk patients on heparin drips with necrotic limbs out of going to smoke, etc. Definitely keep the burn chief up to date on anything. The sign out should be very clear on what they want to know about. Vascular patients are usually on heparin drips but usually on the nomogram. Unfortunately, these patients have a lot of potential to go down quickly. There’s a tiny call room in the burn unit if you have time. SRN is just covering the floor pt’s and there is an upper level in house for issues, and the do their own admissions (HUGE). SRC is usually pretty light with wound checks and pain control.

**At night:** If you’re having a hard time with a patient, you have several options. Always keep your chief informed. They should be your first contact. The JIH/SIH are always around and can help if you need someone to look at the patient. If you’re really worried and can’t get anyone, call a rapid response or a code. No one will fault you later.
### Streamlined Phone Book – not comprehensive, highlight the ones you actually call, hopefully not the morgue

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Common medications:

**Analgesics** (always be careful with respiratory status and mental status, these are starting doses):

- Tylenol 325-650mg PO/PR q6 (be cautious in liver patients)
- Tylenol #3 (codeine/APAP 30/300) 1-2 tabs PO q4-6
- Percocet (oxycodeone/APAP 5/325) 1-2 tabs PO q4-6
- Oxycodone 5mg PO q4-6 (good for breakthrough when Percocet not enough)
- Darvocet (propoxyphene/APAP N-50 or N-100) 1-2 tab PO q4
- Vicodin (hydrocodone/APAP 5/500) 1-2 PO q4-6
- Ketorolac 15-30mg IV q6-8 (be very careful with this one, must watch kidneys, ask before using)
- Morphine 1mg IV q2 (dose can be increased if needed)
- Fentanyl 25mcg IV q2 (dose can be increased if needed)
- Dilaudid 1mg IV q4 (dose can be increased if needed)
- Fentanyl patch 25-100mcg transdermal q3 days

**PCAs** (starting doses):

- Morphine 1mg q8 minutes, 32mg lockout
- Fentanyl 10mcg q10 minutes, 240mcg lockout
- Dilaudid 0.1mg q8, 3.2mg lockout

*In general – don’t get in the habit of randomly prescribing narcotics – always check with the chief or attending*

**Anti-emetics:**

- Zofran 4mg IV q6
- Phenergan 12.5-25mg IV/PO PR q6 (be cautious in the elderly)

**Antibiotics (many require renal dosing):**

- Ampicillin/sulbactam 3g IV q6
- Cefazolin 1g IV q8
- Clindamycin 600mg IV/PO q8
- Fluconazole 200-400mg IV/PO q24
- Imipenem 500mg IV q6
- Levaquin 500mg IV/PO q24
- Linezolid 600mg IV/PO q12 (usually needs ID approval)
- Metronidazole 500mg IV/PO q8 Pipercillin/tazobactam 3.375mg IV q6
- Vancomycin 1g IV q12

**Prophylaxis:**

- Heparin 5000 units SQ q8
- Enoxaparin 30mg SQ BID
- Famotidine 20mg IV/PO q12
- Esomeprazole 40mg IV/PO q24

**Cardiovascular:**

- Metoprolol 5mg IV q6 converts to 12.5mg PO BID, 5mg IV x1 is a good start for AF with RVR, SVT
- Diltiazem 10mg IV x1 for AF with RVR, SVT, also used as a drip in the ICU
- Hydralazine 10mg IV q20min (only to bring down hypertension acutely)
- Furosemide 10-80mg IV/PO (the dose of Lasix varies widely based on service and the patient, usually ask before giving), PO dose = 2x IV dose

**Electrolyte replacement:**

- Potassium 10mEq for every 0.1 below 4.0. Ex. K=3.6, give 40mEq (PO better than IV b/c it burns and can ruin peripheral access)
- Magnesium 1g for every 0.1 below 2.0. Ex. Mg=1.8, give 2g IV. Mg oxide PO can cause diarrhea, but is 400-800mg.
- Phosphate is given either as K-Phos or Na-Phos. Dose is usually in the range of 15-21 mMol IV

**Others:**

- Diphenhydramine 12.5-25mg IV/PO q6 (be cautious in the elderly)
- Hydroxyzine 25-100mg PO q6-8
- Zolpidem 5-10mg PO qHS
- Colace 100mg PO BID
- Dulcolax 10mg PR
- Lovenox 1mg/kg SQ BID (treatment dose for DVT)

For renal protection in patients getting IV contrast: Mucomyst (N-acetylcysteine) 600mg PO BID and NaHCO3 – 150mEq (3 amps) in 1L D5W. Run at 3cc/kg/hr for 1 hour prior to study and 1cc/kg/hr for 6 hours after the study. Ask which patients need this before writing for it. Contrast allergy premedication: prednisone 50mg 13hr, 7hr, and 1hr before contrast load, Benadryl 50mg PO/IV 1hr before, Pepcid/Zantac 40-50mg 1hr before
Education:
- There are many resources available online without having to spend a dime. You can access most of them through the UNC Health Sciences Library webpage.
1. Go to www.hsl.unc.edu
2. On the right side of the screen, click on the Clinical Reference Tab.
3. Under Online Textbooks, most are located either with Books @ Ovid, MD Consult Reference Books, or Stat!Ref Online Medical Database.
4. For either of those links, you will be prompted to enter your ONYEN.
5. Also, further down where it says “find more” you can search the entire electronic book catalog and you will be surprised what you can find. Just type in surgery (or be more specific) and the following is a sample of what you’ll get…

There are 13 pages worth of links to electronic books that you can access from home. Most have .PDF links so you can even print specific sections if you want, and most are big textbooks that cost $100 or more.

Here’s a list of what we have found the most useful (and where to find them):
1. **General texts** – Sabiston’s Textbook of Surgery (MD Consult Reference Books), ACS Surgery online (www.acssurgery.com), Mastery of Surgery (Books @ Ovid), Schwartz’s Principles of Surgery (Stat!Ref Online Medical Database).

For a small book to keep in your locker, think about the Washington Manual of Surgery.

2. Other recommended resources are broken down for junior vs. senior residents (keep track of what you use so we can improve upon this list):

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<tr>
<td>MD Anderson Surgical Oncology Handbook – Feig, et al (print)</td>
<td>Current Surgical Therapy – Cameron (print)</td>
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<td>The ICU Book – Marino (Books @ Ovid online)</td>
<td>Mastery of Surgery – Fischer, ed. (Books @ Ovid online)</td>
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Robin Robinson (robinsr@med.unc.edu, 966-0270) is the IT manager in Surgery. She’ll nag you periodically about completing patient notes, but that’ll keep you from getting demerits on your GME record. She’s a good resource for getting noting problems straightened out. Surgery representatives on the WebCIS committee are Robin, Drs. Mark Koruda, Dick Sutherland, and Matt Ewend. Courtney Sommer is the resident representative. Share suggestions and complaints with these people. We all want things to get better. In fact, the creation of the Rounds Report in WebCIS was the brainchild of none other than our own Megan Fuller.
The most important page in the book!
A place to store your 1,001 log-ins and passwords (write in pencil – you have to change them frequently):

WebCIS:

CPOE:

eChart:

PACS:

WebPACS:

Call room/OR locker:

Education resources:
www.acssurgery.com:

www.trauma.org:

www.efacs.org:

www.sccm.org:

UNC ONYEN:

**NEW** - we should have a resident wiki page on the internet by the time the year starts. The address will be: rezwiki.pbworks.com and it should be fairly comprehensive, with many of the items found in this book
Actual pages from the year:
- Patient asks if he can shower, he feels dry.
- Patient with blood pressure 105/115. Please advise.
- Temperature 37.5 – feeling OK (at 2:30AM)
- A/C broken in room. Can you fix it?
- Patient woke up, placed feet on floor, sitting on side of bed. Neuro status stable.
- Patient feels “her nerves are shot”! Please help me (12:07AM)
- FYI: Mr. X wants you to know his penis is gradually enlarging.
- Patient X has a new hard area. Hematoma? (12:38AM)
- Patient wants you to know temperature is 37.8.
- Do you have the patient’s flowsheet? (2:00AM)
- Patient requesting gum or hard candy. Is this OK?
- Patient reports diarrhea off and on for a few years. Can you assess? (5:00AM, patient admitted for 1 night after perirectal abscess I&D).
- Can you renew Ms. X’s Dilaudid order? It’s 12mg PO q3 hours. (2:30AM, obviously a Koruda patient)
- Patient X doesn’t have IV access, but has IV antibiotics ordered. Please advise. (On a patient with a functioning PICC line)
- Can you write for Tylenol for Mrs. X? She has a headache. (1:30AM on a patient with a documented Tylenol allergy and an existing prn order for ibuprofen specifically for headache)

We kept a board in the call room with all the excellent pages we got. I’d recommend doing the same. Humor is a great way to cope with this job.

Please do take time to think about how this book could be better as the year progresses. It really is up to the residents to keep it going. If an online resource is a better way, then that is valuable input too.