Calgary Zone Department of Emergency Medicine

Grand Rounds Q&A – September 9, 2020

https://www.albertahealthservices.ca/topics/Page17076.aspx

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https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-ncov-2019-staff-faq.pdf

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HI Neil. Thanks. All Cancer patients getting care at TBCC have excellent netcare summaries that review goals, treatments and plans. The patients getting care at RGH (prostate most common) DO NOT have up to date progress notes/plans/treatments accessible to us. Can their division somehow link to Netcare? Is it in process?

> The problem is that our office charts are on Telus wolf and don't go to netcare. As we transition to epic this may become more of a possibility.
>
> We explored the option of having our non-AHS clinic notes uploading to netcare, but the PIA requirements etc. were limiting and the timeline was potentially long. WIth ConnectCare in the works we elected not to pursue this, as we WILL be in scope with ConnectCare and that should then solve the problem.

Do they want us to get a CT CAP if malignant because access is an issue?

> Not necessarily - we usually arrange for that

Just wanted to clarify the preference for simple CT KUB vs contrast-enhanced "hematuria protocol" CT for patients with hematuria where ureteric stone is not strongly suspected

> CT Hematuria protocol in cases stone is not suspected
>
> Technically with gross hematuria a contrast-enhanced CT is preferred over u/s or non-contrast CT KUB.

For a patient that is less than 35 but not sexually active, does your antibiotic regime change?

If patient has already provided a midstream urine (emptied their bladder), are people keeping them in the dept long enough for urine gc/chlamydia or giving abx and OP req

Is the CT hematuria protocol an option in SEC? it's a separate protocol and if you ordered a CT abdo/pelvis or CT KUB without speaking to urology at a non-RGH site it may not get protocoled in time (needs delayed contrast pictures) would it be possible to add to order set?

> "Thanks Patti I will look into that"
>
> *radiology sorry

Technical question: Is it possible to have a desktop link to all of our care pathways? They are difficult to find on the AHS website.

> Thanks Aaron. I will work with Matt Grabove to see if that can happen. I agree it is a little hard to find on the website. Connect Care will fix everything I am pretty sure

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I can imagine it might get tricky in some patients with chronic prostatitis to differentiate from relapsing/abscess. Should we get US in all new pts dx with chronic if not already done? How long could sxs from an abscess last if missed/when are we out of this window

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"I think some clarification is warranted. It would be challenging to reliably diagnose or exclude acute prostatiis without a DRE demonstrating prostate tendernes. My understanding is that the goal is to avoid "vigorous prostatic massage" and the consequently theoretical risk of bacteremia."

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what is the better test for prostatic abscess…US or CT?

Congrats to all on putting together these informative and collaborative multidisciplinary rounds. Well done!

"Thanks for the great work on this Grant. I think there is a real opportunity for improvement here by working with DI to develop a low dose stone CT KUB protocol protocol which provides much more information than XR KUB and an acceptably low radiation exposure. Ultra low dose CT KUB radation doses can range from 0.5-3mSV, as opposed to XR KUB which is typically quoted at 0.5-1 mSv https://pubmed.ncbi.nlm.nih.gov/27810168/"

> Yes - CT KUB is we have is low dose...what we need is ultra low dose CT KUB - keep in mind 1/5 of patients have more radiation exposure with plain film KUB Xray

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Practically speaking Grant, with the strainer do they get sent with a req for stone analysis? Anything done about the strained stone?

Send to lab for analysis - helps us counsel patients later regarding stone prevention

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Thanks Kam, that's exactly what I'm referring to is ultra-low dose. Would be great to develop this protocol

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In setting of cystitis or pyelonephritis (from intercourse, hygiene, whatever…) but the patient happens to have non-osbstructive stones (renal pelvis, other), truly an incidental stone but has infected urine, does the stone require intervention (early? late? not at all?)

"IF single UTI and less than 5mm - no

if recurrent UTIs - we need to distinguish is the upper tract problem (stone, kidney) vs bladder

If stone larger than 5mm usually elective treatment if patient wishes - recommended when recurrent UTIs"

Neil - great to hear IR is so supportive. Is MTU and ICU at sites with ill pateints equally supportive? Can invision senior medicien balking and wanting "sourece control"

As these protocols are finalized, are they being shared with Ryan Chuang (Provincial ED CKCM lead) to ensure Connect Care order set build aligns? Referral/Consut/Admission patterns maybe CZ specific, but imaging recomendations, ABX receommendations, and CDS (clinical decision support) around these should be a provincial standard and built into CC.

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