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Hypertensive Emergency **465**

Manish Suneja and M. Lee Sanders

A rapid and severe increase in blood pressure resulting in new or progressive end-organ damage is defined as hypertensive emergency. Clinicians should effectively use the patient interview, physical examination, and additional testing to differentiate hypertensive emergency from nonemergent hypertension. Patients with evidence or high suspicion for end-organ damage should be expediently referred from the outpatient setting to a higher level of care. Knowledge of appropriate hypertensive emergency management and the ability to initiate this care in the clinic could help reduce patient morbidity in certain situations. Patients presenting with nonemergent hypertension can continue to be safely managed in the clinic.

Acute Stroke and Transient Ischemic Attack in the Outpatient Clinic **479**

Salvador Cruz-Flores

Ischemic stroke is cause of substantial death and disability in the United States. Transient ischemic attack, a precursor to ischemic stroke, conveys a high risk of recurrent stroke within 90 days from event. These conditions are highly preventable and treatable. The cause is heterogenous and includes atherothrombosis, cardioembolism, lacunar disease, or cryptogenic, and some uncommon causes, such as arterial dissection and prothrombotic states. The emergent evaluation includes establishing time of onset, vital signs, glucose level, and severity of the deficit.

Tachyarrhythmias and Bradyarrhythmias: Differential Diagnosis and Initial Management in the Primary Care Office **495**

Timothy Joseph Byrnes and Otto Costantini

Tachyarrhythmias and bradyarrhythmias are often seen in the outpatient setting. Patients can present minimally symptomatic or in extremis. Accurate diagnosis of the rhythm, plus a detailed clinical history, are critical for best management and optimal outcome. A 12-lead electrocardiogram is the cornerstone for diagnosis. Practitioners must identify patients who need immediate transport to an emergency department versus those who can safely wait for an outpatient specialty referral. This article reviews how to accurately diagnose and differentiate the most common tachyarrhythmias and bradyarrhythmias, the associated symptoms, and important concepts for the initial steps in the office management of such arrhythmias.

- Outpatient Emergencies: Acute Heart Failure** 507
Malgorzata Mysliwiec and Raphael E. Bonita
- Heart failure is an epidemic in the United States and a major health problem worldwide. The syndrome of acute heart failure is marked by a recent onset of symptoms usually in terms of days to a few weeks of worsening fatigue, shortness of breath, orthopnea, swelling, and sudden onset of weight gain. Physicians caring for patients with heart failure must know the risk factors for this disease, pathophysiology, symptomatology, important examination findings, key diagnostic tests, and management approach so as to improve symptoms and reduce mortality.
- Outpatient Emergencies: Anaphylaxis** 521
Scott P. Commins
- Anaphylactic fatalities are rare; however, mild reactions can rapidly progress to cardiovascular and respiratory arrest. The clinical course of anaphylaxis can be unpredictable. Prompt and early use of epinephrine should be considered. Most anaphylaxis episodes have an immunologic mechanism involving immunoglobulin E (IgE). Foods are the most common cause in children; medications and insect stings are more common in adults. When the cause is not completely avoidable or cannot be determined, a patient should be supplied with autoinjectable epinephrine and be instructed its use. They should keep the device with them at all times and taught the signs and symptoms of anaphylaxis.
- Outpatient Management for Acute Exacerbations of Obstructive Lung Diseases** 537
Brenda Marsh and Matthew G. Drake
- Primary care providers tasked with treating acute exacerbations of asthma and chronic obstructive pulmonary disease must be able to recognize exacerbation of symptoms and triage patients based on exacerbation severity to the appropriate level of care. Early treatment with bronchodilators and corticosteroids should be followed by repeated assessments of treatment efficacy. Primary care providers should also provide symptom-guided action plans to empower patients to manage their disease.
- Psychiatric Emergencies: Assessing and Managing Suicidal Ideation** 553
Andrea N. Weber, Maria Michail, Alex Thompson, and Jess G. Fiedorowicz
- The assessment of suicide risk is a daunting, but increasingly frequent task for outpatient practitioners. Guidelines for depression screening identify more individuals at risk for treatment and mental health resources are not always easily accessible. For those patients identified as in need of a formal suicide risk assessment, this article reviews established risk and protective factors for suicide and provides a framework for the assessment and management of individuals at risk of suicide. The assessment should be explicitly documented with a summary of the most relevant risk/protective factors for that individual with a focus on interventions that may mitigate risk.

Recognizing and Caring for the Intoxicated Patient in an Outpatient Clinic 573

Joseph H. Donroe and Jeanette M. Tetrault

Recognizing an acute intoxication syndrome in patients presenting to an outpatient clinical practice with behavior or mental status changes requires initial consideration of a broad differential diagnosis. After a thorough evaluation, early management may include triage to a higher level of care, treatment of the presenting concern, and consideration of treatment of potential substance withdrawal. Additionally, there are medico-legal aspects of caring for intoxicated patients related to privacy, informed consent, and risk of harm to self and others after leaving the clinic with which practitioners should become familiar.

Management of Hyperglycemic Crises: Diabetic Ketoacidosis and Hyperglycemic Hyperosmolar State 587

Maya Fayfman, Francisco J. Pasquel, and Guillermo E. Umpierrez

Diabetic ketoacidosis (DKA) and hyperglycemic hyperosmolar state (HHS) are the most serious and life-threatening hyperglycemic emergencies in diabetes. DKA is more common in young people with type 1 diabetes and HHS in adult and elderly patients with type 2 diabetes. Features of the 2 disorders with ketoacidosis and hyperosmolality may coexist. Both are characterized by insulinopenia and severe hyperglycemia. Early diagnosis and management are paramount. Treatment is aggressive rehydration, insulin therapy, electrolyte replacement, and treatment of underlying precipitating events. This article reviews the epidemiology, pathogenesis, diagnosis, and management of hyperglycemic emergencies.

Monoarticular Arthritis 607

Namrata Singh and Scott A. Vogelgesang

Monoarticular arthritis is inflammation characterized by joint pain, swelling, and sometimes periarticular erythema. Although chronic causes are seen, the onset is often acute. An infected joint can quickly lead to permanent damage, making it a medical emergency. However, acute gout presenting as monoarticular arthritis is often so uncomfortable it requires urgent attention. Monoarticular crystalline arthritis is common and a septic joint is a medical emergency so it is no surprise that these diagnoses come to mind with complaint of inflammation in 1 joint. However, there are many causes of monoarticular arthritis that clinicians must consider.

Ocular Emergencies: Red Eye 615

Andreina Tarff and Ashley Behrens

“Red eye” is used as a general term to describe irritated or bloodshot eyes. It is a recognizable sign of an acute/chronic, localized/systemic underlying inflammatory condition. Conjunctival injection is most commonly caused by dryness, allergy, visual fatigue, contact lens overwear, and local infections. In some instances, red eye can represent a true ocular emergency that should be treated by an ophthalmologist. A comprehensive assessment of red eye conditions is required to preserve the patients visual function. Severe ocular pain, significant photophobia, decreased vision, and

history of ocular trauma are warning signs demanding immediate ophthalmological consultation.

Otolaryngologic Emergencies in the Primary Care Setting **641**

Kendall K. Tasche and Kristi E. Chang

Most otolaryngology-related complaints are straightforward and easily recognized and treated. However, given the proximity of the ears, nose, and throat to numerous vital structures in the head and neck, the potential for serious consequences exists if disease processes go unrecognized and untreated. This article serves to familiarize the primary care provider with the clinical presentation of various complications associated with common otolaryngologic complaints. Clinicians who care for patients presenting with otolaryngologic complaints should keep these entities in mind and attempt to rule out any serious complication.

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