

### **Study Skills: Strategies – Index Cards and Summaries**

#### Recommendations for “index cards” (or for notes on the computer or PDA):

- Need to focus on high yield information:
  - What do I need to know to take care of patients? To diagnose? To manage?
  - What do I need to know in order to distinguish between the diseases in the differential.
  - Those things that I do not already know. Usually no need to write down what you already know unless it helps with understanding or unless you feel you will forget this and will need to review it later.
  - Consider writing down the "Heuristic". The heuristic is the “classic” presentation.
- It's vital that you ORGANIZE the information. Organize it in a way that makes sense to you. Make connections; organization follows. Good organization will make it easier to learn. For example, if you were reading an article on abdominal pain:
  - Major headings could be location (epigastric, periumbilical, RLQ, etc.).
  - Under each of these headings put the most common conditions (or other conditions you want to learn, but be judicious. Don't put rare conditions on your card at this point - that's for your fellowship).
  - Under each disease, write down what you REALLY need to know. For example:
    - What are major distinguishing features between the conditions in RLQ? For example, under appendicitis: Comes on gradually over a few hours. Under ovarian torsion: Hyperacute (starts off severe).
  - Consider using charts to compare and contrast
- Less is more - Be picky about what you put down on the card. It's not meant to be complete. It's meant to:
  - Help you organize your thoughts
  - Make connections
  - Help you make a diagnosis. The card really tells you what info you need to gather to distinguish between conditions. It may also help you with differential.
  - Be a QUICK way to review the subject 5 minutes before you see a patient with this condition next week or next month on the wards or in the office.
  - As a general rule, don't write down what you already know. Sometimes exceptions exist if it makes clear important points.

See next page for example:

**Abdominal Pain: Diagnoses**  
**(This is meant to be illustrative; not complete)**

*One way to organize a note on abdominal pain would be by location:*

**Index Card #1**

Epigastric:

PUD/Gastritis:

- Risk factors: H. Pylori (90% of duodenal and 75% of gastric ulcers), NSAID's, ASN, steroids, smoking, ETOH, stress
- Pain: Epigastric, gnawing or burning, 1-3 h after meals. ↓ w food or antacids. May have heart burn, dyspepsia (belching, bloating, fatty food intolerance). If radiates to back think of penetration.
- 25% of pts w sx's of PUD do NOT have PUD.
- Dx: Endoscopy is procedure of choice. UGI has high false pos and false neg rate.
- Rx: H2 blocker. Proton pump inhibitor works faster, better, but more expensive.
  - Diet: Stop ETOH and caffeine.

Gall Bladder: Cholelithiasis (C), Cholecystitis (CC), Ascending Cholangitis (AC)

- Risk factors: Female, Fat, Forty, Fertile
- Biliary pain may start epigastric but usually → RUQ.
- Triggered by fatty food.
- C: Often asymptomatic. If pain, it's colicky and it's intermittent, transient, or recurrent.
- CC: begins colicky then ~ 100% become constant; ↑ WBC (10%)
- AC: Sicker, fever (95%), Jaundice (80%); ↑ WBC (usually)
- Imaging: Ultrasound
- Rx: For CC: NPO, IVF, IV ABT's (Unasyn); if severe: [gent + clinda] OR [CTX + flagyl] Surgery (Lap cholecystectomy) is done during admission but after sx's have subsided if poss.

Pancreatitis: Pain is epigastric and mid-abdominal areas and is sharp, severe, continuous, and radiates to the back

- If secondary to GB disease, amylase is < 3 x normal.
- If primary, amylase is usually >3 x normal.
- Imaging: CT scan (US can miss pancreatitis)
- Rx: IV Fluids, NPO, Meperidine
  - Consult surgeon if: abscess, hemorrhage, failure of medical mgmt

## Index Card #2

### RLQ:

#### Appy:

- Gradually over few hours
- Periumbilical → RLQ
- No or low grade fever (high fever → perforation or wrong dx)
- Classic:
  - Begins periumbilical (as lumen of appendix is plugged → bacterial overgrowth, edema and secretions → distention → visceral pain (SMA distribution thus periumbilical)
  - Patient may have low grade fever, nausea
  - Over ~ 4 hours pain goes to RLQ (inflammation has traversed the mucosal side of the appendix to the serosal side. Now there is inflammation on the outside of the appy which is usually sitting against the peritoneum at McBurney's Point).
- Presentations of appendicitis that vary from the heuristic:
  - Presenting with abdominal pain and “diarrhea”:
    - If appendix is sitting on the distal colon you may get inflammation of the colon (colitis) → frequent, small, mucousy stools (not large/watery).
  - Presenting with abdominal pain and WBC's in the urine:
    - Don't confuse with UTI. If appendix is sitting over ureter, may get pyuria.

#### Ovarian Torsion:

- Any age but usually < 30.
- Hyperacute onset (severe in seconds)
- May radiate to back or thigh.
- Tender mass (50-80%)
- Dx: Ultrasound: usually echogenic mass. Normal doppler does NOT R/O torsion.

**Abdominal Pain: Concepts**  
**(This is meant to be illustrative; not complete)**

**Index Card #3**

Physical Exam Pearls:

Rovsing sign: Push on abdomen away from RLQ and patient c/o pain in RLQ ⇒ appy

Psoas sign: Passively extend Rt thigh → pain in RLQ. This ⇒ inflamed psoas (ie, retrocoecal appy)

Obturator sign: Pain on passive internal rotation of flexed thigh. This ⇒ pelvic appendix against obturator internus muscle.

Murphy's sign: Specific but not sensitive for cholecystitis. When palpating RUQ there is tenderness and an inspiratory pause.

Grey-Turner sign: Bluish discoloration of flank in severe pancreatitis (from hemorrhage)

Cullen sign: Bluish discoloration around umbilicus from severe (hemorrhagic) pancreatitis.

Concepts of visceral pain:

- Usually secondary to distension of viscera. "Cutting" the intestine is not perceived.
- Vague, hard to localize
- Any organ that derives its blood supply from the celiac trunk tends to give pain in the epigastric region
- If blood supply is derived from SMA (small intestine to first half of transverse colon) is referred to periumbilical region.
- If blood supply is derived from IMA (remainder of large intestine) pain is lower quadrants.

Concept of somatic pain:

- Sharp, well localized, specific.
- Responsible for peritoneal signs.