DIG DEEPER WHEN ASSESSING PAIN IN THE ELDERLY

Internists have various tools at their disposal for assessing pain, but in elderly patients, unfortunately, a lot of them don’t work. Research has shown that scales of zero to 10, as well as pictorial representations aren’t always accurate in the elderly and can lead to distorted readings of distress. But there are ways around this, experts say, including using larger scales, such as zero to 100, and asking specific questions with yes/no answers. In our cover story on page 1, Stacey Butterfield details what works in the elderly, what doesn’t, and how to ensure that elderly patients’ pain is dealt with appropriately.

In our May issue, we discussed the risks and benefits of joining a large health system. This month, our second cover story, also on page 1, covers the basics of accountable care organizations (ACOs), which have been growing in popularity in recent years. ACOs can be an attractive option because they allow physicians to join together to improve quality of care, but they also have their own pitfalls. Our story dissects the types of ACOs available and what physicians need to consider before jumping in, namely the ACO’s culture and priorities, the level of autonomy physicians can retain, and the resources and technology that will be offered. And turn to page 11 to learn more about the nitty-gritty of negotiating contracts with an ACO, including how to dissolve a partnership in the future if it doesn’t work out.

Beginning Aug. 1, the Physician Payments Sunshine Act, part of the Patient Protection and Affordable Care Act, will go into effect. This means that drug and device manufacturers and group purchasing organizations are required by law to begin collecting data on gifts or transfers of value to physicians. CMS will start publicly reporting the data on the Web on Sept. 30, 2014, and will perform annual updates thereafter each June 30. Although physicians don’t have to do the reporting themselves, they should still be aware of what’s being reported and how. Our story on page 15 tells you what you need to know.

On page 7, Joshua M. Liao, MD, an ACP Resident/Fellow Member, reflects on his just-concluded intern year at Boston’s Brigham and Women’s Hospital. And turn to page 17 to learn about the College’s annual Leadership Day, when ACP members visit Capitol Hill to talk to senators and representatives about pressing priorities in health care.

We hope you enjoy this issue. Let us know what you think at acpinternist@acponline.org.

Sincerely,
Jennifer Kearney-Strouse

Test Yourself

MKSAP Quiz: Abrupt onset of chest pain

A 67-year-old woman is evaluated for the abrupt onset of right-sided pleuritic chest pain and moderate dyspnea. She recently had symptoms typical of an upper respiratory infection (rhinorrhea, headache, sore throat and nonproductive cough), and her chest pain and dyspnea seemed to be triggered by an episode of vigorous coughing. She has not had fever, chills, purulent sputum, or risk factors for thromboembolic disease. She smokes, and her medical history is significant for COPD without additional complications. Her medications are daily salmeterol and as-needed albuterol.

On physical examination, she appears uncomfortable but is not in respiratory distress. She is speaking in full sentences. Temperature is 37.0°C (98.6°F), blood pressure is 129/58 mm Hg, pulse rate is 78/min and regular, and respiration rate is 22/min. Oxygen saturation is 98% on 2 L of oxygen via nasal cannula. Pulmonary examination is significant for a prolonged expiratory phase but no wheeze; breath sounds are symmetric bilaterally. The trachea is midline. There is no accessory muscle use. Cardiac examination is normal with no murmurs. No edema is noted. Electrocardiogram shows normal sinus rhythm without ischemic changes. Chest radiograph is shown.

In addition to hospital admission, which of the following is the most appropriate next step in management?

A: Evaluation for pleurodesis
B: Needle aspiration
C: Serial chest radiography
D: Tube thoracostomy

See Test Yourself, page 22, for answer.

Cartoon Caption Contest

Put words in our mouth

ACP InternistWeekly has compiled the results from its latest cartoon contest, where readers are invited to match wits against their peers to provide the most original and amusing caption.

This issue’s winning cartoon caption was submitted by James Baumgartner, MD, ACP Member. Thanks to all who voted! The winning entry captured 65.5% of the votes.

Captions and voting are conducted through ACP InternistWeekly. If you’re not already receiving ACP InternistWeekly, visit www.acpinternist.org/subscribe; contact Customer Service at 800-523-1546, ext. 2600, or direct at 215-351-2600 (M-F, 9 a.m. to 5 p.m. EST); or send an e-mail to custserv@acponline.org.

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Crossed Words

Bottoms up

By Justin Vader, MD, ACP Resident/Fellow Member

Answers to clues are placed horizontally in rows to reveal an answer written vertically. Unlike the familiar acrostic puzzle format, the final answer can be in any column.

Horizontal clues
1) Scaffolding protein
2) Filament spread by deer fly or mango fly
3) Cardiac anomaly with tricuspid valve displaced toward apex of right ventricle
4) Negri bodies 100% diagnostic
5) X-linked collagen disorder
6) Plural synonym for hordeola

Find in the vertical column: Classic contributor to Québécois cardiomyopathy.

See Crossed Words, page 22, for answer.