Memorandum

To: Mary K. Greene, M.D.
Anne L. Calkins, M.D.
Dawn Light, M.D.
Mark Warren, D.O.
Frank Pianki, D.O.

From: Elizabeth H. Ey, M.D.

Date: January 18, 2016

- **Appendicitis CPG –** It seems like we should incorporate one of the Pediatric Appendicitis Scoring systems in the CPG. I will forward the two that I have found for your opinions. Also, after talking with Dr. Pence and other surgeons, our Appendicitis CPG should move directly to CT (rather than preliminary US) when patients present with abdominal pain of more than 24 hours duration. Females over 10 years of age should be screened for sexual activity and possible PID. Also, a normal CRP seems to exclude appendicitis in our patient population. Frank has suggested that we triage after 11 pm something like:
    - Low risk...send home or admit for observation
    - Intermediate...admit, +\- immediate CT scan or get ultrasound at 630
    - High risk....get CT scan

  I think we can incorporate these practices into a guideline which most providers can abide. Other thoughts or suggestions?

- **CystoConray shortage –** A nationwide shortage of CystoConray is still being experienced. We may be able to return to using CystoConray in mid-February. In the meantime, the CT use of CystoConray for rectal contrast has been changed to Omnipaque 240 diluted with water in a similar dilution as that used for oral contrast. That seems to be easy for the CT techs to achieve and seems to work. The water soluble contrast for fluoroscopic enemas will be a non-sterile dilution of Conray 43 with warm tap water created by the technologists. For an infant, the tech mixes one 50cc bottle of Conray 43 with 3 bottles of water, creating 200 cc of dilute contrast. For half an enema bag, 5 bottles of Conray 43 and warm water to make about a half of a bag of dilute contrast. For a full bag, 10 bottles of Conray 43 and warm water to fill the bag. For cystography, the pharmacy will create a sterile solution of diluted Conray 30 on an individual patient basis. The radiologist places the usual order for VCUG per protocol in Epic. The order prints in pharmacy, the pharmacy makes the sterile solution for the patient and it is picked up by the radiology tech.

- **CT Chest without IV contrast for esophageal foreign body –** You can try this option when you believe it is appropriate. For concern of a fish bone, try no oral contrast. For a plastic foreign body, you will probably be able to see it. The use of oral contrast would in theory prove whether there is esophageal obstruction, if that is important. For concern of impacted meat or food, the patient can be asked to swallow 10 cc of diluted Omnipaque at the dilution rate for enteric contrast. This is a work in progress. Changes will be made with more experience. Dr. Warren is the champion of this project. Send him your suggestions or experiences.

- **Next radiologist meeting –**will be at the main campus in the conference room on Monday, Jan 24 at 12:30 pm. Please attend and share your thoughts, ideas, and concerns with everyone.