CASE STUDY #1 - Wuebker

78yo male presents to ER 11:42pm and seen by ER physician at 12:12am w/ complaints of colicky right upper quadrant abdominal pain, nausea, and diaphoresis. This has occurred on and off for last 3 weeks. Past medical history significant for Type II DM, coronary stent placement, osteoarthritis, exploratory laparotomy for pancreatic mass (benign) 12 years ago, and remote history of peptic ulcer. He takes aspirin, ibuprofen, and metformin. Vital signs -- temp 101.8 degrees F, pulse 100, respiratory rate 20, BP 132/88. Exam reveals RUQ tenderness. Abdominal plain x-rays normal and abdominal ultrasound suspicious for cholecystitis and presence of calculi. Lab normal w/ exception of WBC count of 16,500 and elevated ALT and AST.

Scenario 1: Hospitalist asked to admit patient and performs H&P at 2:45am. Patient given IV narcotics ER w/ resolution of pain, and Impression states "Cholecystitis, acute on chronic, resolving. Will continue conservative therapy with pain control, IV hydration, and begin IV antibiotics. Monitor blood sugars. Looking much better and expect patient will go home tomorrow. Admit inpatient as patient will have 2 midnights of total hospital time".

What is the correct status?

Observation. When do responsive services start – in this case after midnight, so incorrect accounting of midnights already crossed – as well as need for a reasonable 2-MN expectation of need for hospital services)

Scenario 2: Hospitalist H&P has following impression: "Abdominal pain with significant concern for acute cholecystitis. Patient high risk for complications including sepsis due to diabetes and presentation w/ fever and tachycardia. Will require aggressive antibiotic treatment, continued monitoring, blood cultures, and followup scans. Consider acute surgical intervention if pain recurs or patient worsens. Expect greater than 2 midnights of hospital care after today."

What is the correct status?

Inpatient. Well-supported expectation of 2MN stay, capturing the risk of the patient to support this, and documenting the acuity of the patient.