eConsult Primary Care Newsletter

May 2018 Issue 3

Dear Primary Care Colleagues,

Our thanks to those of you who have provided feedback on the UW Medicine eConsult program! We appreciate your support and want to share our current data and best practice tips for eConsults.

Since the program began in 2016, over **280 unique PCPs** have participated, resulting in over **4,000 eConsults completed across 13 specialties**. In the last few months, we have also extended service to NWH primary care and the Island Clinics.

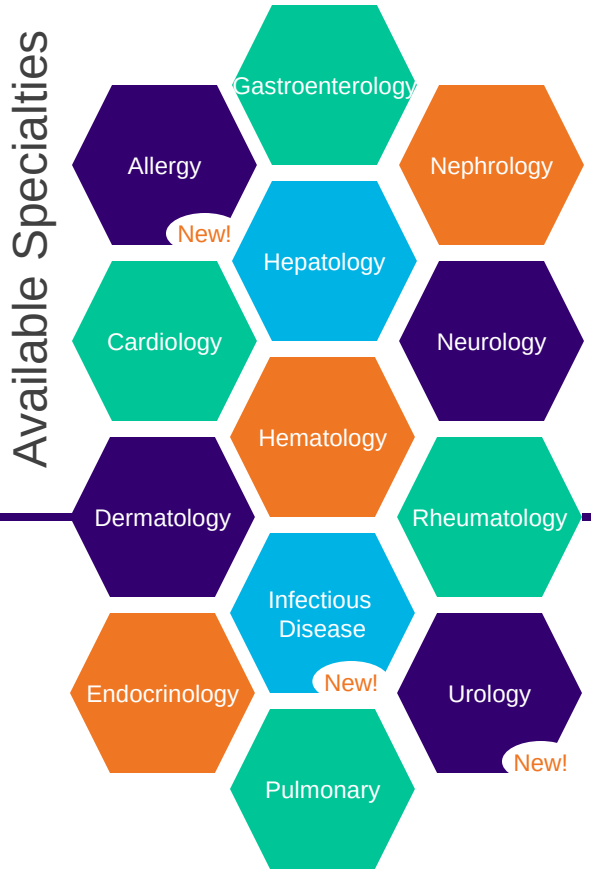
If you have any questions, are looking for materials, or just need support, please reach out to us at econsult@uw.edu.

- eConsult Team

In This Issue:

Top Tips:

- Tell the specialist your *specific* clinical question
- Order the recommended labs and/or imaging listed in the eConsult template before placing a referral
- Please do not eConsult if you intend to have the patient seen in person. eConsults are not for questions about existing referrals



Good eConsult questions ARE:

- ✓ Focused questions that a specialist can reasonably answer without knowledge of the patient's entire medical history
- ✓ Answerable using only the information available in the EMR
- ✓ Answerable within 3 business days, without an in-person visit
- ✓ Not for patients actively receiving care in that specialty (either within UW Medicine or outside the system)

eConsults are NOT:

- Logistical questions about a specialty
- For querying about work-up prior to a face to face visit
- For patients established with the specialty (i.e. patients seen by that practice in the past two years for the same or related issue)
- Easily answered by consulting a textbook or clinical guidelines

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Exemplary eConsult Exchange: Infectious Disease

PCP Clinical question: 25 yo man with positive PPD (BCG in the past), positive Quantiferon, and negative CXR on INH/B6 for 4 months. He had normal LFTs prior to starting INH and then in Mar 2018 began experiencing ab pain/heartburn and nausea, symptoms quickly resolved with stopping INH. He restarted INH later that same month but had recurrence of abd pain/nausea. I am checking LFTs and switching him to Rifampin 600mg PO daily today.

My question is how long does he need Rifampin for? The recommendations show that Rifampin is administered for total of 4 months for LTBI but I am wondering if he requires a full 4 months given that he has already been treated for 3-4 months with INH.

Specialist eConsult Response: I have reviewed the chart and discussed his case with a colleague at the TB clinic who agrees that "credit" can be given for the time on INH. We can give him credit for 25% completion and therefore deduct 1 month from rifampin regimen making a total of 3-month course of rifamipin. I did not see an HIV test in the system and would recommend that one is checked. If he was HIV positive recommendations would be for a 6-month course of treatment instead of 4 months.

Hematology eConsult Guidance

- eConsults about the **cause** of iron deficiency anemia should be sent to Gastroenterology
- Questions about management of iron replacement (oral versus iron) are best directed to Hematology
- Obtain labs +/- imaging recommended in the disease-specific template before placing the eConsult

David Garcia, MD

Evaluation of Mild Thrombocytopenia

When considering isolated mild thrombocytopenia we consider a variety of etiologies including medication side effect, immune mediated destruction, decreased platelet production (from infection, bone marrow conditions, vitamin deficiencies, or alcohol use) or platelet clumping or sequestration in the spleen. Nearly all patients need:

- CBC with differential, review of the peripheral blood smear by pathologist (or hematologist), and screening for hepatitis C & HIV

Depending on the rest of the clinical picture, an ANA reflexive panel, and/or an ultrasound of the liver and spleen may be advised.

Leslie Padrnos, MD

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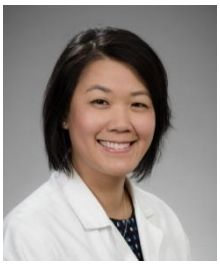

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