



29 JUN 2016 Waterfront Meeting

	Speaker	Topic	Time
MRD-SD	LT Hightower	Pretest	5
Sports Medicine	Dr. Skanchy	Orthopedic Conditions	45
MRD-SD	LT Chace	Hypertension Afloat	30
MRD-SD	LT Chace	Fluoroquinolones Black Box Warning	5
Fleet Mental Health	CDR King Hollis	Update	5
MRD-SD	LT Hightower	Post Test	5
		Total	95

ORTHOPEDIC EMERGENCIES AND ACUTE PROBLEMS

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I have no relevant financial relationship with any commercial interests to disclose.

RHABDOMYOLYSIS



PREPATELLAR BURSITIS /SEPTIC ARTHRITIS



PATELLAR DISLOCATION



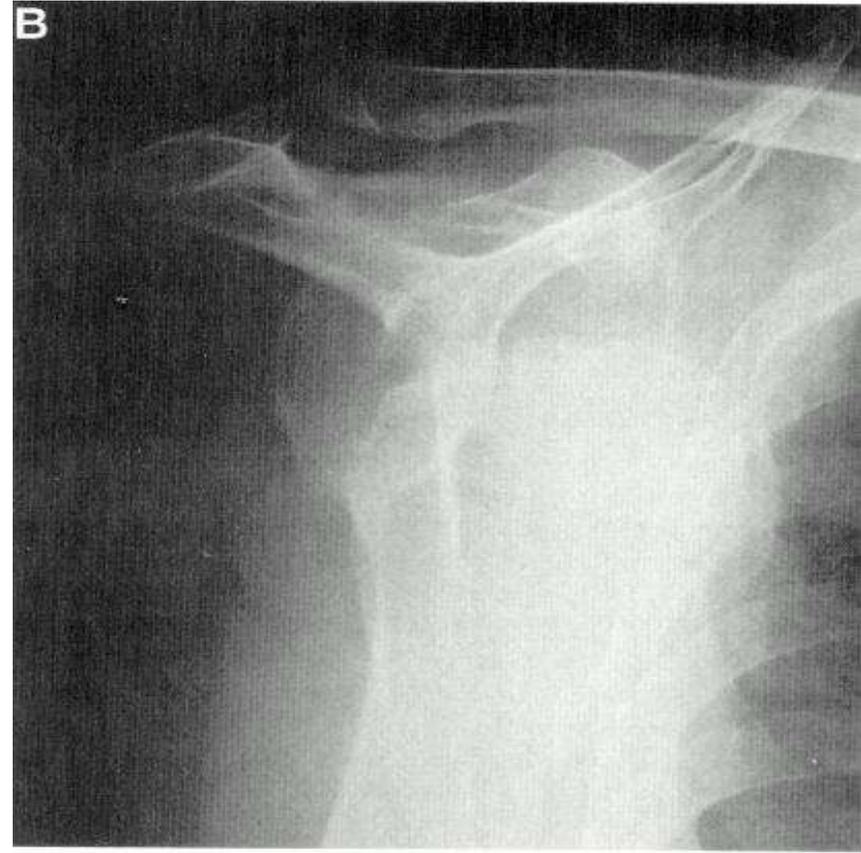
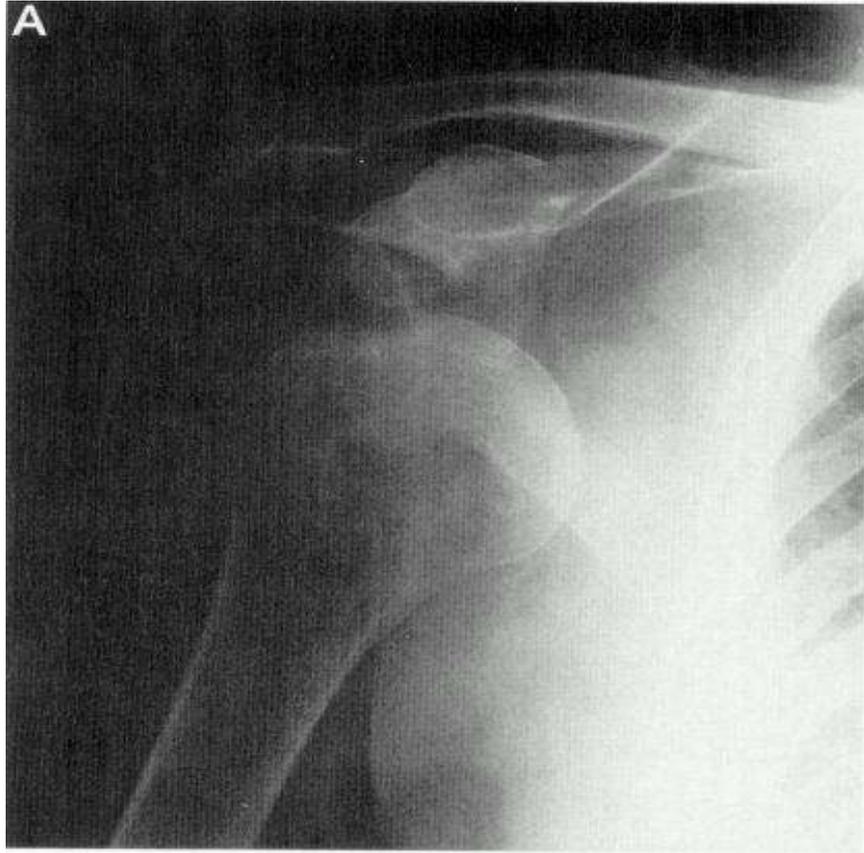
Knee Dislocation/ Patellar Fx



Case 1

- Hx: 56y/o with a fall while skiing on intermediate run at Snow Basin, UT.
- PE:
 - Arm held immobile in slight abduction
 - Unable to touch other shoulder
 - Loss of rounded appearance of shoulder

The AP (A) and scapular Y (B) views of shoulder



EXAMINATION

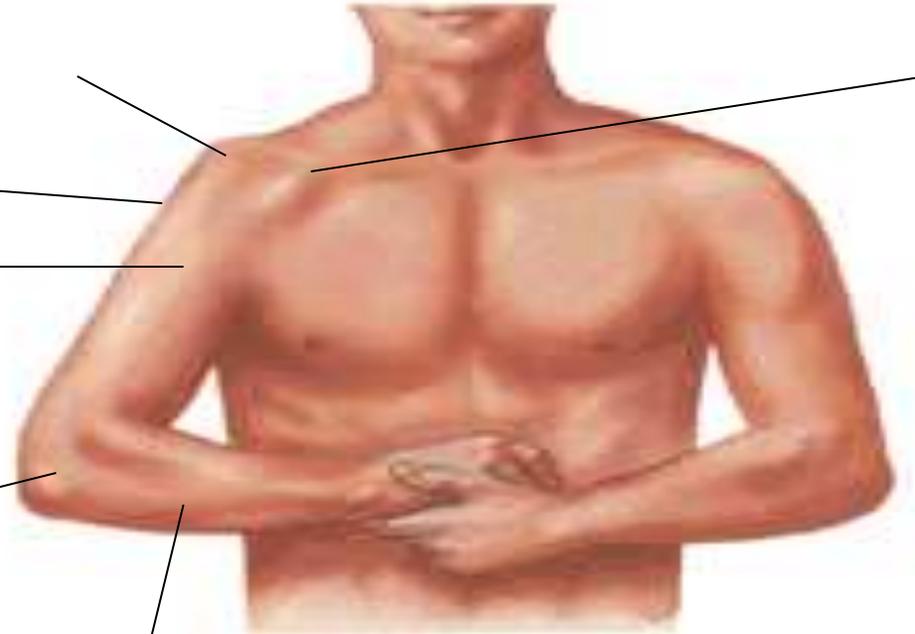
Acromion prominent

Humeral head prominent

Shoulder flexed

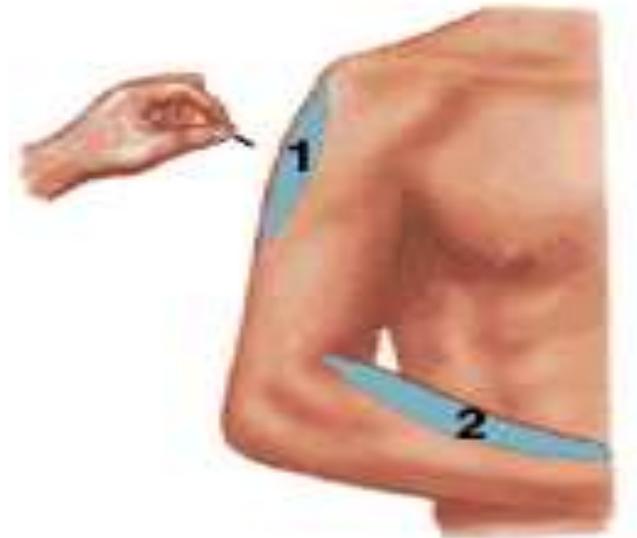
Arm in slight
abduction

Elbow flexed



Forearm internally rotated,
supported by other hand

Testing sensation in
areas of (1) axillary and
(2) musculocutaneous
nerves



Dislocation -Differential Diagnosis

- In acute shoulder injury, should differentiate between
 - *AC separation*
 - *Fractures* - especially of clavicle
 - *Acute subluxation* - full range of motion except for limitations due to pain
 - May have positive apprehension and relocation test
 - *Rotator cuff tears*
 - *Stingers/burners*

Dislocation

- Anterior 95 - 97% vs. Posterior 3 - 5%
- Most commonly dislocated major joint
- Definition: complete loss of the humeral articulation with the glenoid fossa
- Mechanism:
 - anterior: posterior force against an abducted, externally rotated arm
 - posterior dislocation: seizure, electric shock

Reduction Techniques

ARRONEN SELF REDUCTION

- Patient sits on ground and firmly interlocks fingers in front of the knee on the same side of dislocated shoulder
- Patient must maintain full elbow extension and relax the shoulder muscles for technique to be successful
 - Steady traction applied by leaning backward and extending the hip

Reduction of anterior shoulder dislocation

- Mod. Kocher technique
 - traction
 - adduction
 - flexion
- The Stimson technique
 - weight applied to shoulder in prone position



Dislocation

- Radiographs
 - Pre? and post reduction
 - AP, axillary lateral or transcapular view
 - confirm dislocation/reduction and r/o fractures
- Complications
 - Musculoskeletal
 - Glenoid lesions
 - Rotator cuff tears
 - Recurrence
 - Humeral lesions
 - Neurologic and vascular

Treatment

- Reduction should be accomplished as soon as possible in patients with acute dislocation
 - Numerous techniques described
 - Consider sedation (Demerol/versed) if readily available, and longer elapsed times from injury.

Post Reduction Treatment

- Immobilization 2 - 6 weeks as needed for comfort.
Immobilization never proven to change outcomes
- Intensive rehabilitation with rotator cuff and scapular strengthening
- Surgical referral
 - recurrent dislocation failed therapy
 - young, 1st time dislocations (due to high recurrence)
 - associated fractures

Case 2

- 27 y/o nurse s/p MVA
- palpable "stepped" deformity between the acromion and the clavicle
- minimal pain at AC joint



AP shoulder

- AC separation measuring greater than 100% (i.e., no residual acromioclavicular articulation).



Acromioclavicular Joint Separation

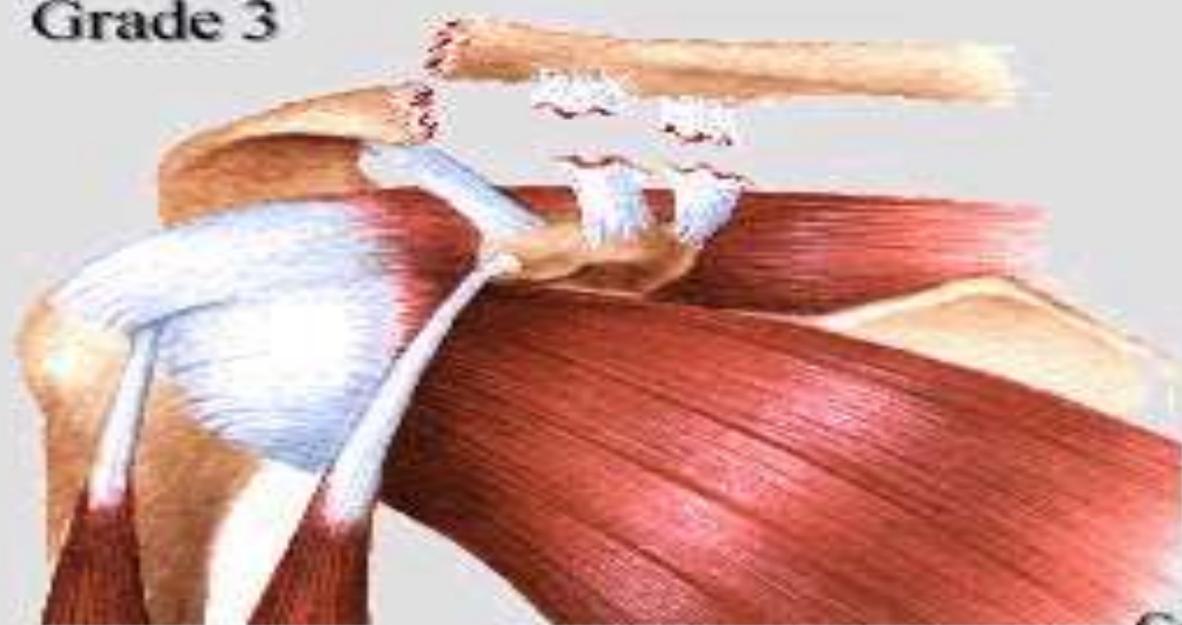
Grade 1



Grade 2



Grade 3



A-C Joint

- Differential Diagnosis
 - Clavicle fracture
 - Shoulder dislocation
 - Contusion - “shoulder pointer”

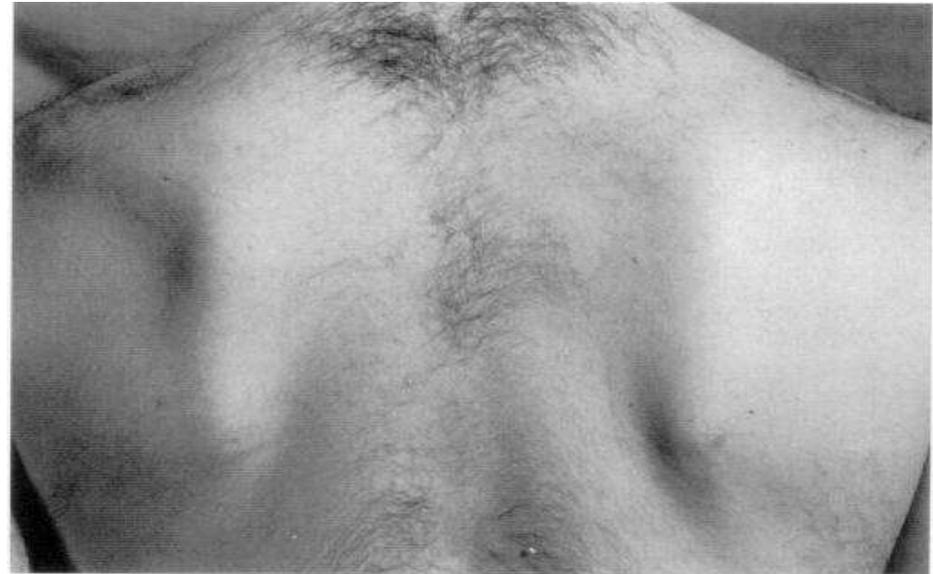


A-C Joint

- Treatment
 - Grade I
 - Ice, NSAIDs, sling (for comfort)
 - Grade II
 - Same as grade I
 - Grade III
 - *Controversial management that depends on degree of pain and deformity*

Case 3: 40 y/o male with shoulder weakness

- Hx: long hx of L shoulder pain and weakness that began with HS tennis
- Painful arc
- Weakness on Abd and ER

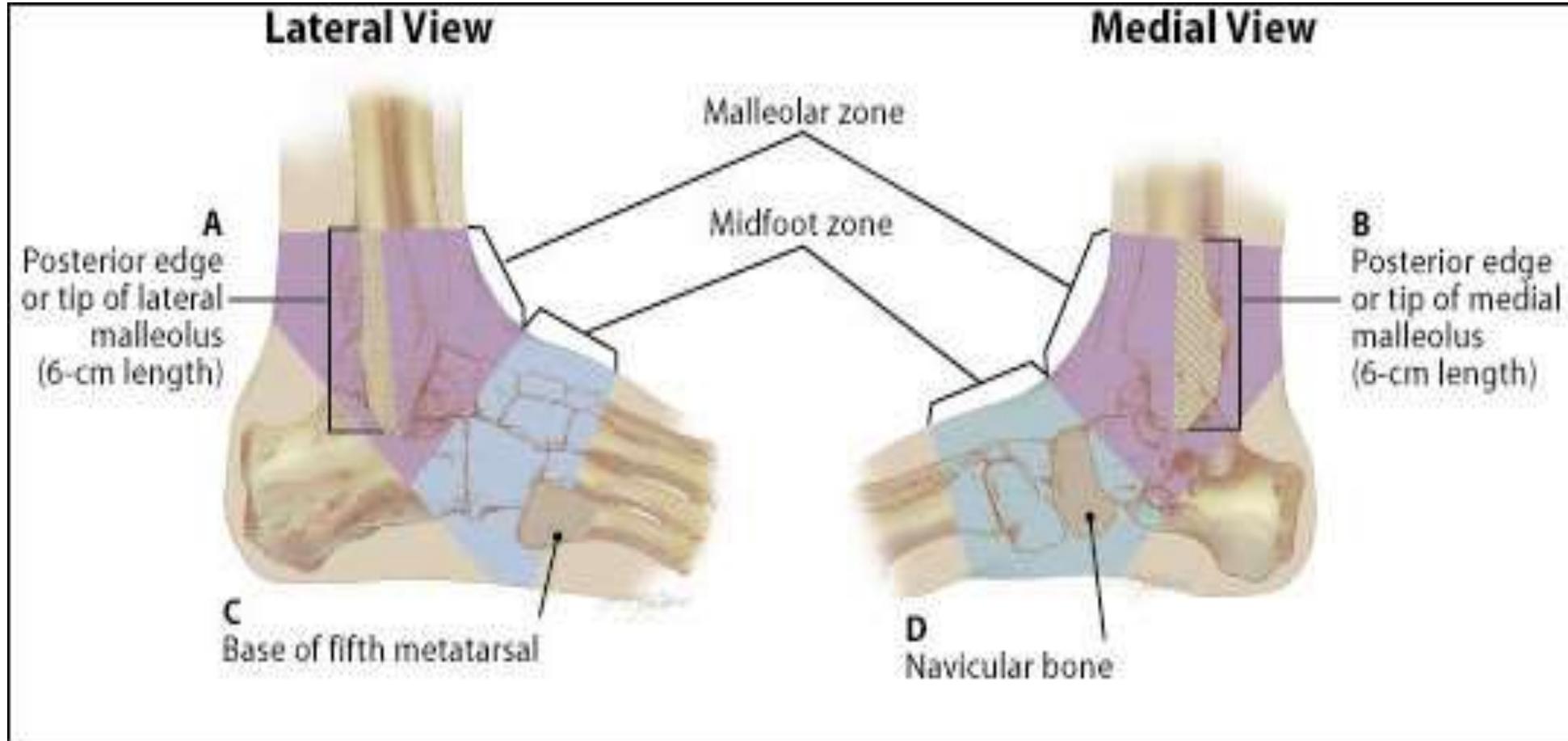


Atrophy Cuff muscles

“Hidden” Ankle Injuries

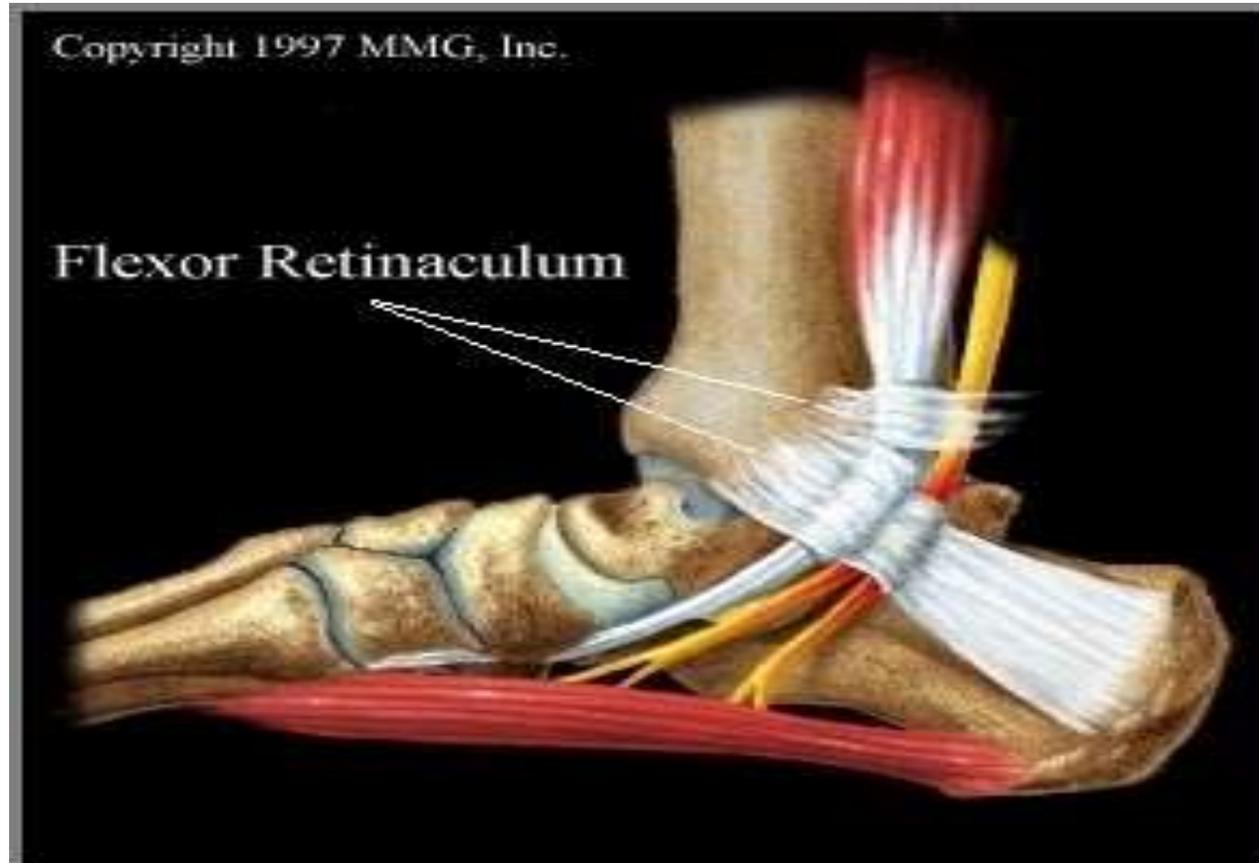
- Injuries that may accompany acute sprains which may fail to heal and cause sx later
- Examine carefully for:
 - Maisonneuve fx – disruption of the deltoid and syndesmotic ligaments with prox fib fx
 - Syndesmosis injury without fx
 - “high” ankle sprain – tear ant tibiofibular lig
 - Fx lateral talar process
 - Fx anterior process os calcis
 - **Achilles Tendon rupture**
 - 5th MT fx
 - Midfoot sprain

OTTOWA Ankle Rules



Conditions Which Mimic Ankle Sprains on the Tibial Side

- Tear of TIBIALIS posterior



Conditions Which Mimic Ankle Sprains On The Tibial Side

- Tear of Tibialis posterior



Conditions Which Mimic Ankle Sprains On The Tibial Side

- Tear of Tibialis posterior



Conditions Which Mimic Ankle Sprains On The Tibial Side

- Syndesmosis sprain

Figures: Courtesy of David B. Thordarson, MD

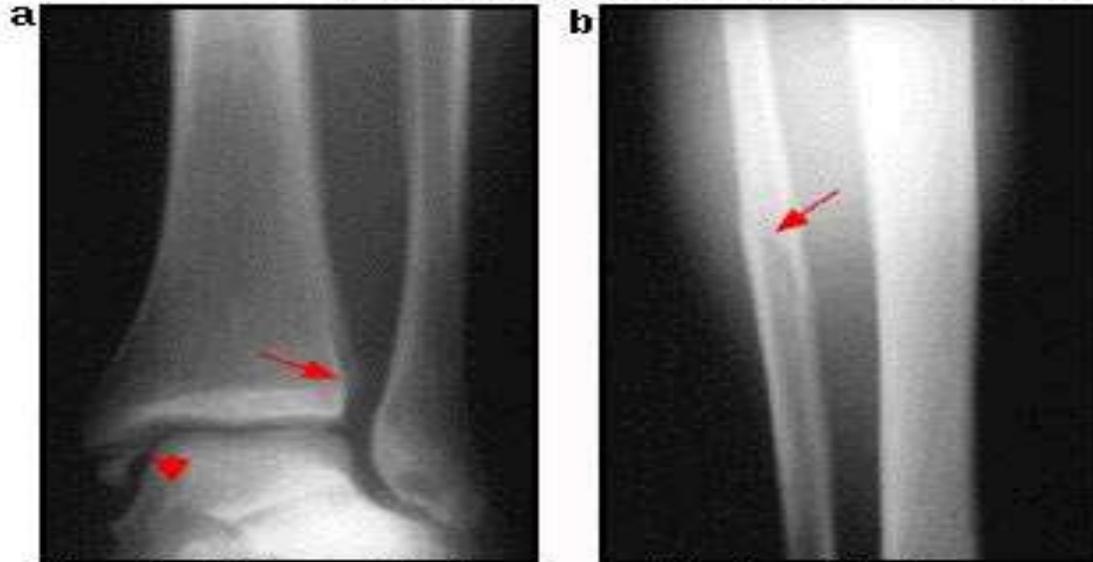


Figure 4. A 20-year-old male college student sustained a Maisonneuve fracture of the ankle while playing intramural basketball. An anteroposterior (AP) radiograph (a) demonstrates an avulsion fracture of the tip of the malleolus (arrow) with widening between the distal tibia and fibula (arrowhead). Note that no fracture of the fibula is evident. An AP radiograph of the midshaft of his tibia and fibula (b), however, reveals a midfibular fracture (arrow). The fracture was secured with screws transfixing the tibia and fibula to allow for proper ligament healing.



Conditions Which Mimic Ankle Sprains On The Tibial Side

- Navicular Sfx & Tuberosity Fx

Figures: Courtesy of David B. Thordarson, MD

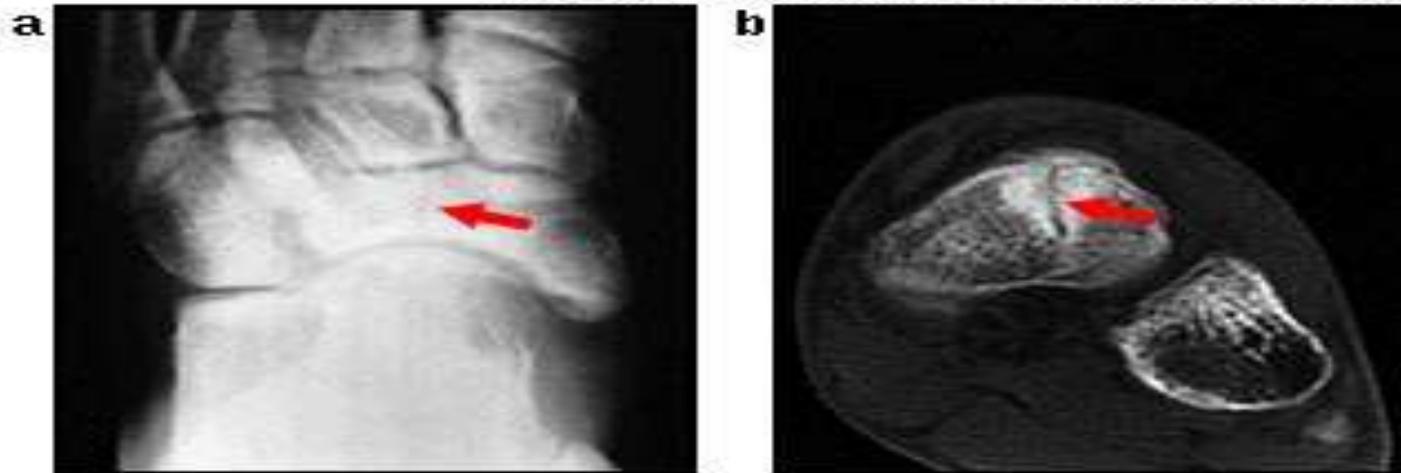


Figure 1. An 18-year-old male high school baseball player experienced gradually increasing medial midfoot pain during the season. Oblique and lateral x-rays revealed no abnormalities, but an anteroposterior radiograph of his foot (a) revealed slight radiolucency at the navicular (arrow). A coronal CT scan (b) demonstrated a nondisplaced stress fracture running through the navicular from dorsal to plantar aspects (arrow). The patient responded to 8 weeks in a non-weight-bearing cast. His immobilization was supplemented with noninvasive electromagnetic bone stimulation.

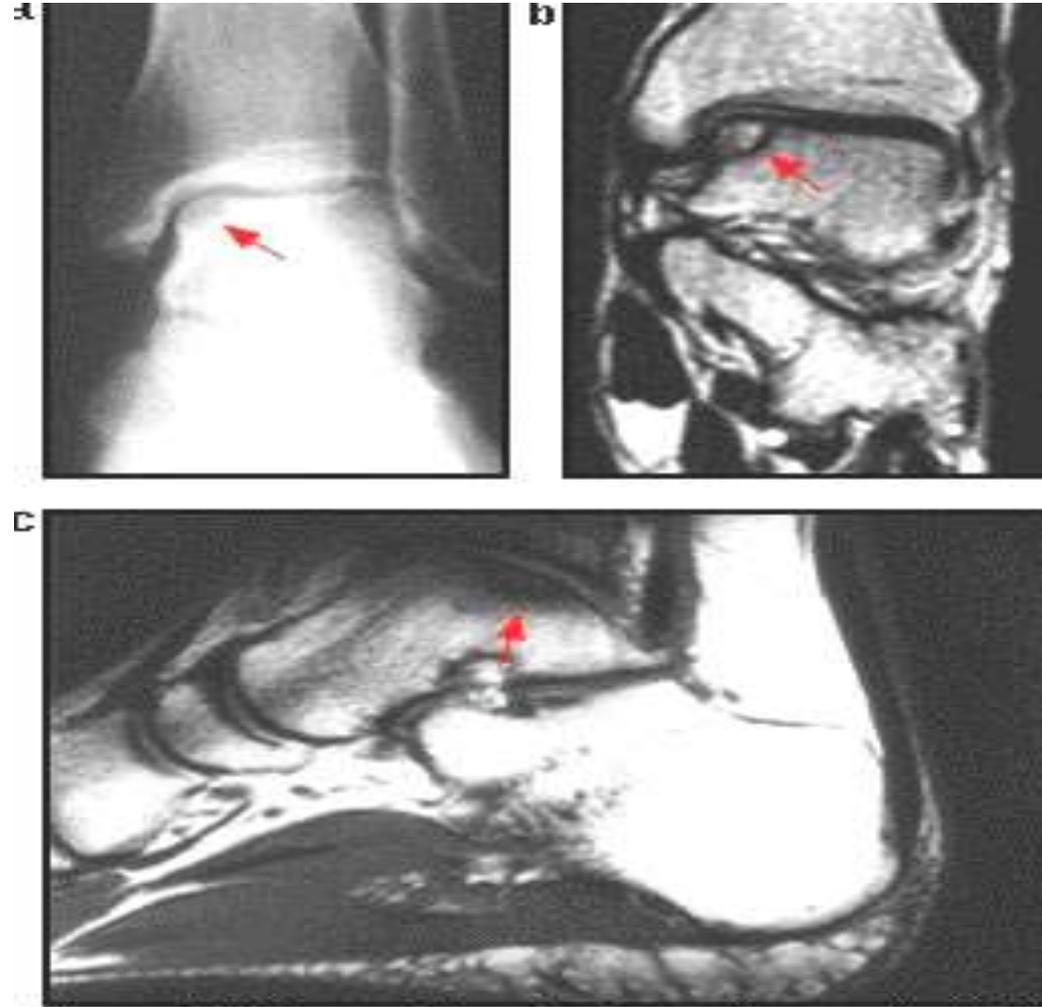
Conditions Which Mimic Ankle Sprains On The Tibial Side

- Talar dome fracture



Conditions Which Mimic Ankle Sprains On The Tibial Side

- Talar dome Fracture



Conditions Which Mimic Ankle Sprains On The Fibular Side

- Base of the 5th metatarsal



Conditions Which Mimic Ankle Sprains On The Fibular Side

- Base of the 5th metatarsal



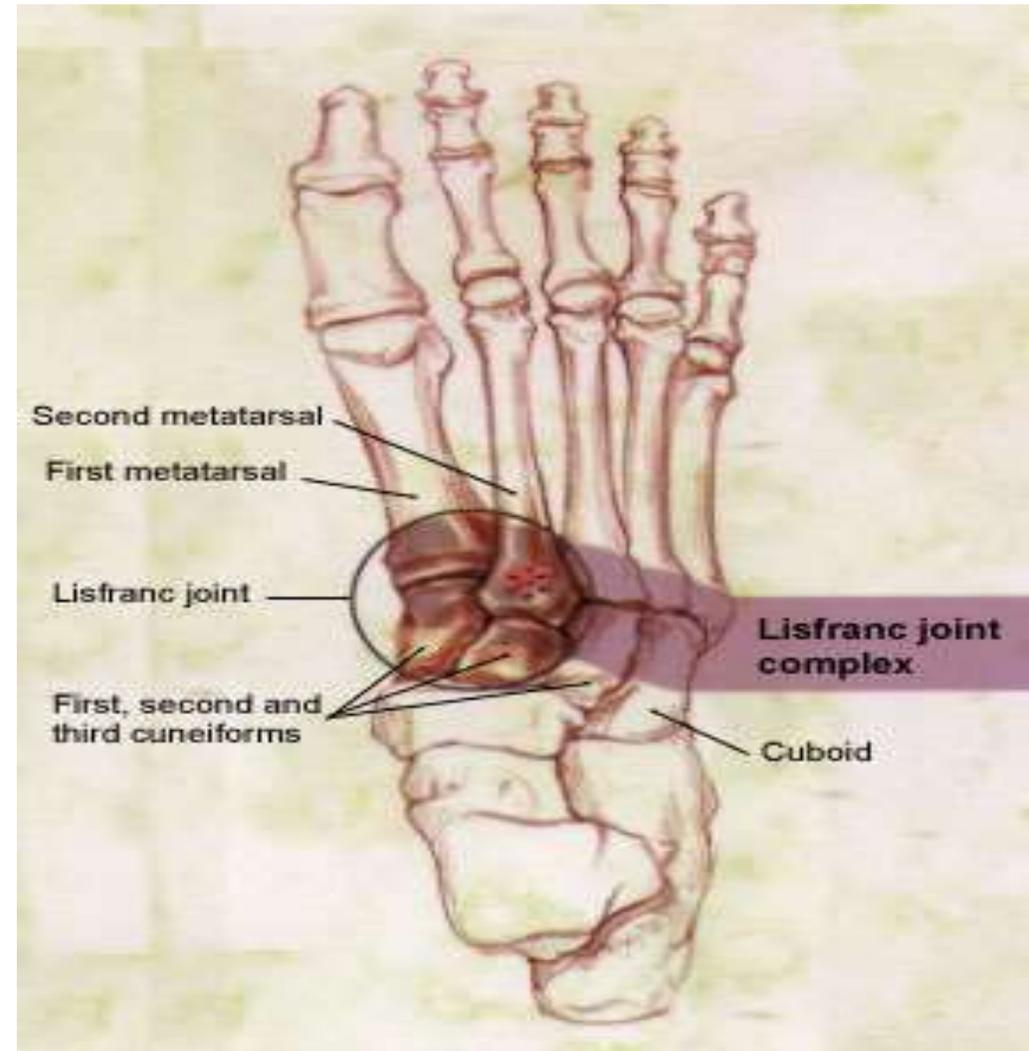
Conditions Which Mimic Ankle Sprains On The Fibular Side

- Base of the 5th metatarsal



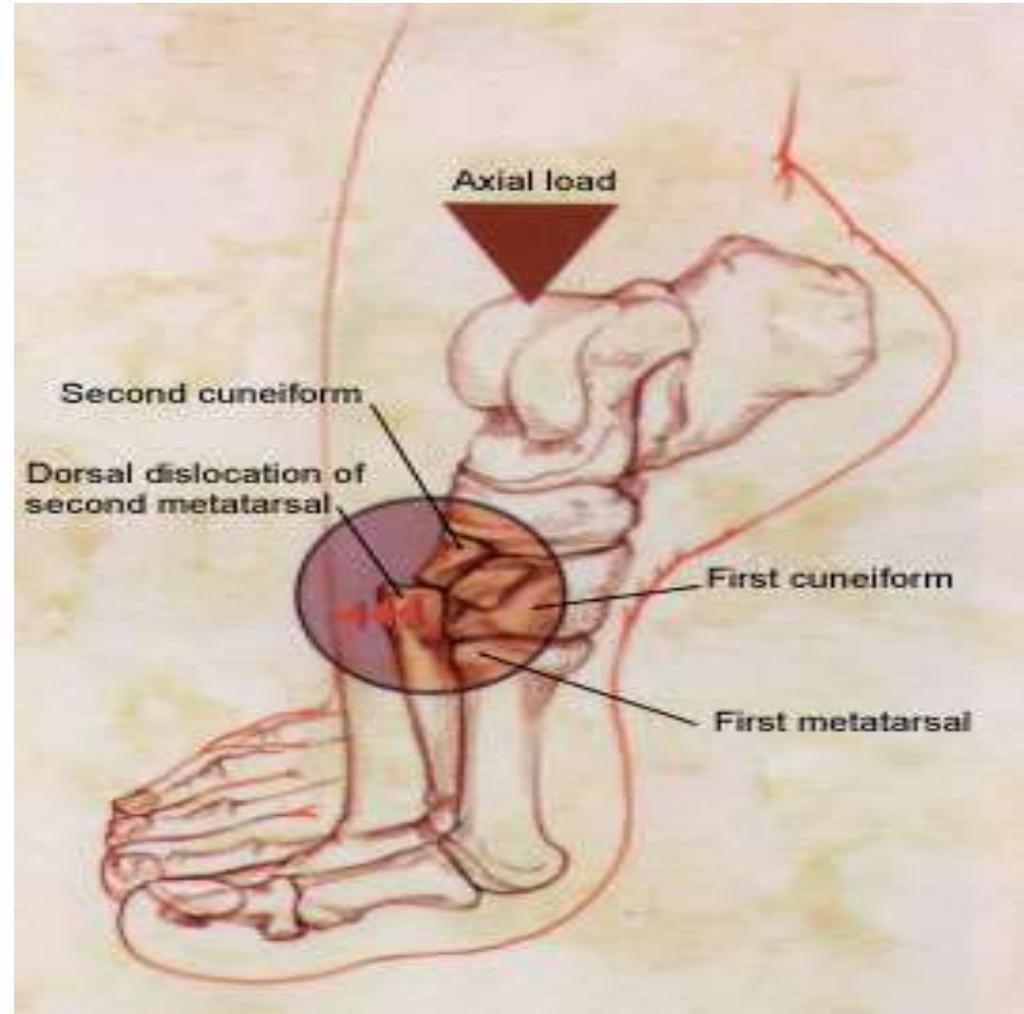
Conditions Which Mimic Ankle Sprains On The Fibular Side

- Midfoot sprain /
Lisfranc Fx



Conditions Which Mimic Ankle Sprains On The Fibular Side

- Midfoot sprain / Lisfranc Fx



Conditions Which Mimic Ankle Sprains On The Fibular Side

- Midfoot sprain / Lisfranc Fx



Conditions Which Mimic Ankle Sprains On The Fibular Side

- Midfoot sprain / Lisfranc Fx



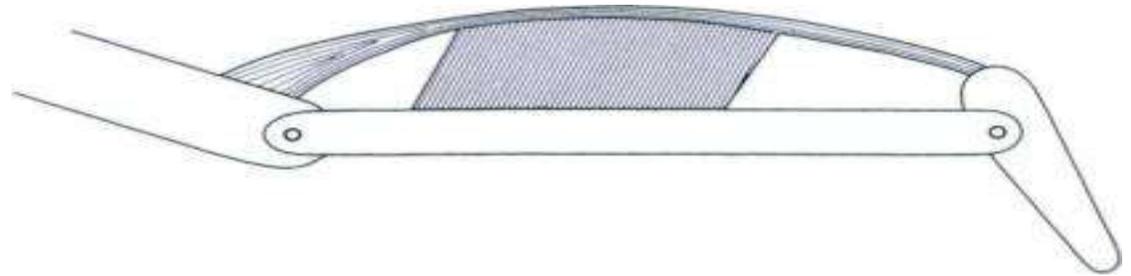
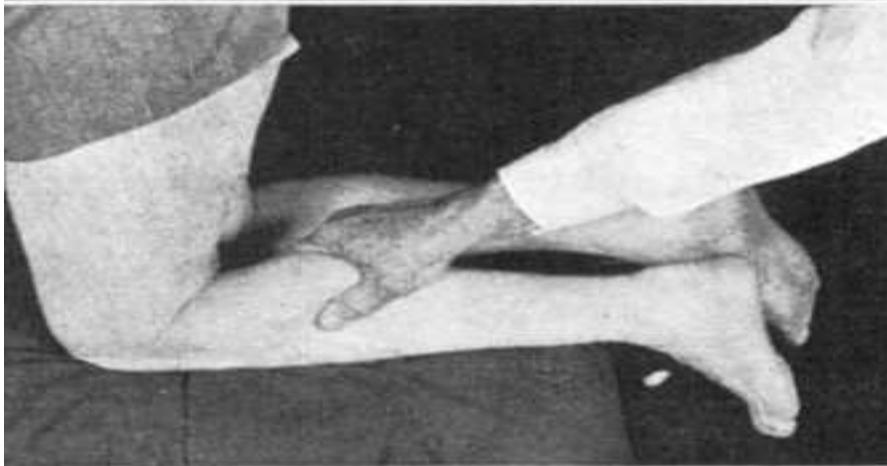
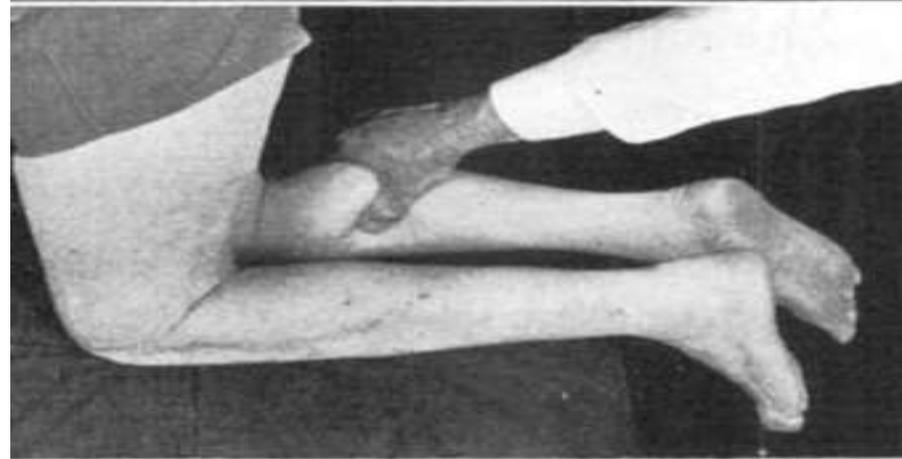
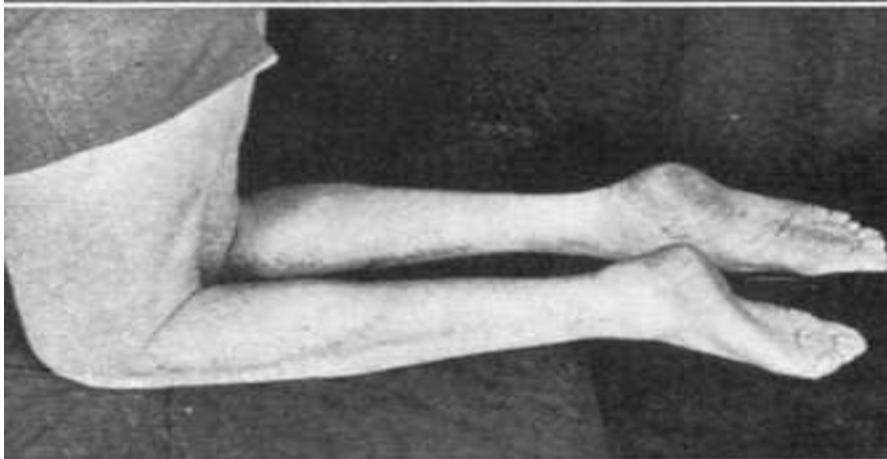
HISTORY/PHYSICAL EXAM

- DOC Someone Hit me in the heel!
- Swollen and Painful Achilles 3-10 cm from calcaneus
- Palpable and Visible defect (early)
- Thompson Test (early)
- O'Brien's Test
- Inability to Heel Raise

Physical Exam



Physical Exam/Thompson Test



BICEPS RUPTURE



BICEPS RUPTURE

- Distal Vs Proximal
- Distal Urgent
- Proximal Bulge = Distal injury
- Distal Bulge = Proximal injury



Hypertension Afloat

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Disclosures

- * I have no relevant financial relationship with any commercial interests to disclose.
- * Presentation reviewed by Internal Medicine Staff, NMCSD

Purpose

- * To ensure all operational providers on sea-going platforms know how to screen, identify and treat hypertension to include urgency and emergency.

Content

- * Definitions
- * Primary Essential Hypertension
- * Risk factors
- * Screening
- * Diagnosis
- * Evaluation
- * Physical Exam
- * Testing
- * Treatment
- * Urgency/Emergency
- * AMAL
- * Lifestyle Modifications
- * Complications

Definitions

- * Normal blood pressure: systolic <120 mmHg and diastolic <80 mmHg
- * Prehypertension: systolic 120 to 139 mmHg or diastolic 80 to 89 mmHg
- * Hypertension (HTN):
 - * Stage 1: systolic 140 to 159 mmHg or diastolic 90 to 99 mmHg
 - * Stage 2: systolic ≥ 160 mmHg or diastolic ≥ 100 mmHg

Definitions

- * White Coat HTN: Blood pressure consistently elevated by office readings, but does not meet diagnostic criteria for HTN based upon out-of-office readings.
- * Moderate to severe hypertensive retinopathy (formerly called "malignant hypertension"): Moderate to severe hypertensive retinopathy, including retinal hemorrhages, exudates, or papilledema.
- * Hypertensive Urgency: Severe hypertension (DBP > 120 mmHg) in asymptomatic patients.
 - * There is no proven benefit from rapid reduction in blood pressure in asymptomatic patients who have no evidence of acute end-organ damage and are at little short-term risk.
- * Hypertensive Emergency: Severe hypertension (DBP > 120 mmHg) with evidence of acute end-organ damage. Can be life threatening and requires immediate treatment, usually with parenteral medications in a monitored setting.

Primary Essential Hypertension

- * Blood pressure reacts to changes in the environment to maintain organ perfusion over a wide variety of conditions. Primary factors determining the blood pressure are the sympathetic nervous system, the renin-angiotensin-aldosterone system, and the plasma volume (largely mediated by the kidneys).
- * Pathogenesis — Maintenance of arterial blood pressure is necessary for organ perfusion.
- * Blood Pressure (BP) = Cardiac Output (CO) x Systemic Vascular Resistance (SVR)

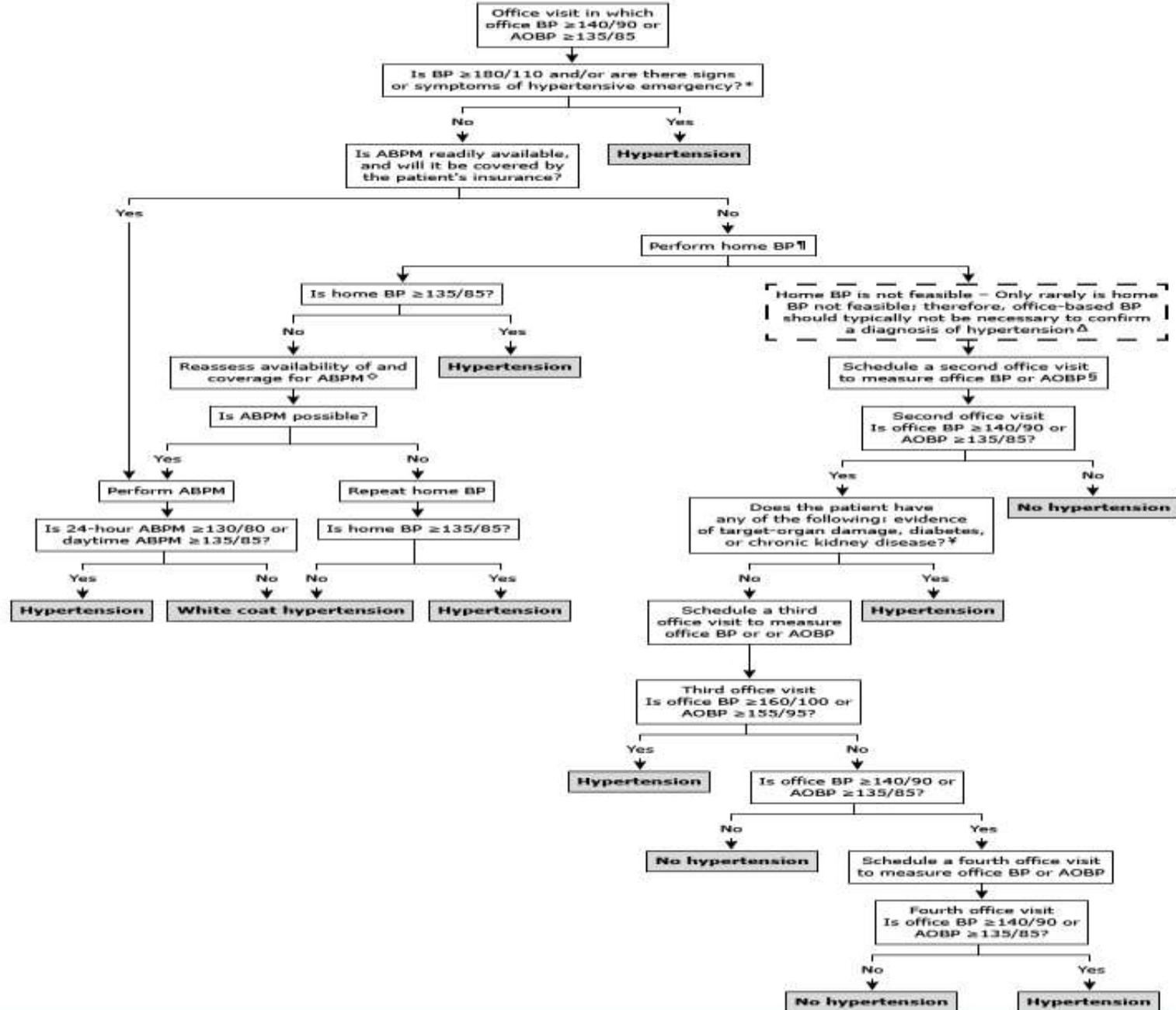
Risk Factors for Primary Essential Hypertension

- * Age
- * Obesity and weight gain
- * Family history – Twice as common in subjects who have one or two hypertensive parents
- * Race – More common, be more severe, occur earlier in life, and be associated with greater target-organ damage in blacks.
- * Reduced nephron number – Reduced adult nephron mass may predispose to hypertension, which may be related to genetic factors, intrauterine developmental disturbance, premature birth, and postnatal environment.
- * High-sodium diet – Excess sodium intake (eg, >3000 mg/day), sodium restriction lowers blood pressure.
- * Excessive alcohol consumption
- * Physical inactivity – Exercise is an effective means of lowering blood pressure.
- * Diabetes and dyslipidemia – Appear to be associated with an increased risk of HTN
- * Personality traits and depression – Hypertension may be more common among those with certain personality traits, such as hostile attitudes and time urgency/impatience, as well as among those with depression.

Who Should Get Screened?

- * Screening — 2015 United States Preventive Services Task Force (USPSTF) guidelines that all individuals 18 years or older should be screened for elevated blood pressure.
- * An elevated screening blood pressure, which is typically obtained in the clinician's office, should be confirmed using out-of-office measurements, if possible.
- * However, **at a minimum**, the frequency of screening should be as follows:
 - * Adults 40 years or older should have their blood pressure measured at least annually
 - * Adults between 18 and 39 years should also be screened at least annually if they have risk factors for hypertension (eg, obesity) or if their previously measured blood pressure was 130-139/85-89 mmHg
 - * Adults between 18 and 39 years whose latest blood pressure was <130/80 mmHg and have no risk factors for hypertension should be screened at least every three years.

Approach to the diagnosis of hypertension in adults



Diagnosis

- * Two or more office visits after initial screening of 140/90.
- * In the uncommon patient who has an initial screening blood pressure $\geq 180/110$ mmHg or who presents with hypertensive emergency, a diagnosis of hypertension can be made without further confirmation.

Evaluation

- * To determine the extent of target-organ damage and/or established cardiovascular disease.
- * To assess other cardiovascular risk factors
 - * Serum LDL > 159
 - * Serum HDL < 40
 - * Diabetes mellitus or glucose intolerance
 - * Smoking
- * To identify lifestyle factors that could potentially contribute to hypertension.
- * To identify interfering substances (eg, chronic use of nonsteroidal anti-inflammatory drugs, oral contraceptives) and potentially curable causes of secondary hypertension.
- * Most patients with presumed primary hypertension (formerly called "essential" hypertension) should undergo a relatively **limited** work-up for secondary causes utilizing information gained from the history, physical examination, and routine laboratory tests.

Important aspects of the history in the patient with hypertension

Duration of hypertension	Presence of other risk factors
Last known normal blood pressure	Smoking
Course of the blood pressure	Diabetes
Prior treatment of hypertension	Dyslipidemia
Drugs: types, doses, side effects	Physical inactivity
Intake of agents that may cause hypertension	Dietary history
Nonsteroidal anti-inflammatory drugs	Sodium
Estrogens	Alcohol
Adrenal steroids	Saturated fats
Cocaine	Psychosocial factors
Sympathomimetics	Family structure
Excessive sodium	Work status
Family history	Educational level
Hypertension	Sexual function
Premature cardiovascular disease or death	Features of sleep apnea
Familial diseases: pheochromocytoma, renal disease, diabetes, gout	Early morning headaches
Symptoms of secondary causes	Daytime somnolence
Muscle weakness	Loud snoring
Spells of tachycardia, sweating, tremor	Erratic sleep
Thinning of the skin	
Flank pain	
Symptoms of target-organ damage	
Headaches	
Transient weakness or blindness	
Loss of visual acuity	
Chest pain	
Dyspnea	
Claudication	

Physical Exam

Important aspects of the physical examination in the hypertensive patient

Accurate measurement of blood pressure
General appearance
Distribution of body fat
Skin lesions
Muscle strength
Alertness
Fundoscopy
Hemorrhage
Papilledema
Cotton wool spots
Neck
Palpation and auscultation of carotids
Thyroid
Heart
Size
Rhythm
Sounds
Lungs
Rhonchi
Rales
Abdomen
Renal masses
Bruits over aorta or renal arteries
Femoral pulses
Extremities
Peripheral pulses
Edema
Neurologic assessment
Visual disturbance
Focal weakness
Confusion

Testing

- * Electrolytes and serum creatinine
- * Fasting glucose
- * Urinalysis
- * Lipid profile (total and HDL-cholesterol, triglycerides)
- * Electrocardiogram

Stage I Treatment

- * In uncomplicated Stage I Hypertension:
 - * Thiazide diuretics (HCTZ)
 - * Long-acting calcium channel blockers
 - * Amlodipine
 - * Angiotensin-converting enzyme (ACE) inhibitors
 - * Lisinopril
 - * Angiotensin II receptor blockers (ARBs)
 - * Losartan

Treatment

- * Black patients: Thiazide diuretic or long-acting calcium channel blocker
- * Diabetic nephropathy or non-diabetic chronic kidney disease with proteinuria: ACE inhibitor or ARB
- * Beta-blockers: No longer recommended as first line therapy

Stage II Treatment

- * Start with combination two-drug therapy
 - * Long-acting calcium channel blocker + long-acting ACE inhibitor
 - * If patient is already on ACEi and thiazide, can replace ACEi with CCB

Hypertensive Urgency

- * Definition: Relatively asymptomatic patient with a blood pressure in the "severe" range (ie, $\geq 180/\geq 120$ mmHg), often a mild headache, but **no** signs or symptoms of acute end-organ damage.
- * How quickly should the blood pressure be reduced?
 - * The blood pressure should be reduced over a period of hours to days,
- * What is the blood pressure target during this period of time?
 - * $<160/<100$ mmHg. However, the mean arterial pressure should not be lowered by more than 25 to 30 percent over this relatively short period of time.
 - * Short-term blood pressure target may need to be above 160/100 mmHg in patients who present with very high pressures. In the long-term, the blood pressure should usually be reduced further (eg, $<140/<90$ mmHg).

Hypertensive Urgency

- * How should this goal be achieved?
 - * Depends on whether blood pressure should be lowered more quickly (period of hours) or less quickly (period of days).
 - * In addition, moving patients to a quiet room in which to rest can lead to a fall in systolic pressure of 10 to 20 mmHg or more.
- * If the blood pressure needs to be lowered over a period of hours, use oral furosemide, oral clonidine, or oral captopril.
- * If the blood pressure needs to be lowered over a period of days:
 - * Resumption of antihypertensive therapy (in nonadherent patients)
 - * Initiation of antihypertensive therapy (if patients are treatment naïve)
 - * Addition of another antihypertensive drug (in patients who are currently treated).

Hypertensive Emergencies

- * Definition: Severe hypertension in adults (often defined as systolic blood pressure ≥ 180 mmHg and/or diastolic blood pressure ≥ 120 mmHg) associated with a variety of acute, life-threatening complications, including hypertensive encephalopathy, retinal hemorrhages, papilledema, or acute and subacute kidney injury.
- * Labetalol can be given as a series of intravenous bolus injections or as a constant-dose infusion. The bolus dose is 20 mg initially, followed by 20 to 80 mg every 10 minutes to a total dose of 300 mg. The infusion rate is 0.5 to 2 mg/min.
- * Nitrates
- * Calcium channel blocker (Clevidipine, Nicardipine)
- * Dopamine-1-Agonists (Fenoldopam)
- * Adrenergic-blocking agents (Labetalol, Esmolol)
- * Hydralazine
- * Enalaprilat

****ICU LEVEL OF CARE****

What do I have in my AMAL?

* CG/DDG/LCS:

- * HCTZ 25mg tab
- * Lisinopril 10mg tab
- * Clonidine 0.2mg tab
- * Metoprolol 50mg tab

Starting Dosages:

- HCTZ 25mg po daily
- Lisinopril 10mg daily
 - Check K+ after 1st week
 - May increase to 40mg po daily (MAX dose)
- Clonidine: 0.1 mg po BID to 0.2mg po BID
- Metoprolol 50mg po BID
 - May increase to 200mg po BID (MAX dose)

What do I have in my AMAL?

- * LSD, LPD, LHA, LHD:
 - * HCTZ 25mg tab
 - * Lisinopril 10mg tab
 - * Metoprolol 50mg tab
 - * Amlodipine 5mg tab
 - * Max 10mg daily
 - * Verapamil 240mg tab
 - * Clonidine 0.2mg tab

Lifestyle Modifications



Lifestyle modifications in the management of hypertension

Modification	Recommendation	Approximate systolic BP reduction, range*
Weight reduction	Maintain normal body weight (BMI, 18.5 to 24.9 kg/m ²)	5 to 20 mmHg per 10 kg weight loss
Adopt DASH eating plan	Consume a diet rich in fruits, vegetables, and low-fat dairy products with a reduced content of saturated and total fat	8 to 14 mmHg
Dietary sodium reduction	Reduce dietary sodium intake to no more than 100 meq/day (2.4 g sodium or 6 g sodium chloride)	2 to 8 mmHg
Physical activity	Engage in regular aerobic physical activity such as brisk walking (at least 30 minutes per day, most days of the week)	4 to 9 mmHg
Moderation of alcohol consumption	Limit consumption to no more than 2 drinks per day in most men and no more than 1 drink per day in women and lighter-weight persons	2 to 4 mmHg

For overall cardiovascular risk reduction, stop smoking. The effects of implementing these modifications are dose and time dependent and could be higher for some individuals; they are not all additive.

BMI: body mass index; BP: blood pressure; DASH: Dietary Approaches to Stop Hypertension.

Reproduced from: *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.* Available at <http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf>.

Complications of Hypertension

- * Premature Heart Disease
- * Heart Failure
- * Heart Attacks
- * Sudden Death
- * Stroke
- * Intracerebral Hemorrhage
- * Chronic Kidney Disease → Dialysis

Checklist at Sea

- * When going underway and on deployment ensure patients have enough medications!
- * When they do present with hypertension ensure they are hemodynamically stable.
- * Know your limitations and what resources you have!
- * Know your MEDEVAC protocol!
- * Call for help or email consult
- * IDCs: Physician Supervisor
- * Cardiology Duty: 619-804-2229



"I'm going to take your blood pressure, so try to relax and not think about what a high reading might mean for your chances of living a long, healthy life."

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FLUOROQUINOLONES

FDA Black Box Warning for Use in Certain Uncomplicated Infections

LT Hillary Chace, D.O.
PA&I Coordinator
MRD CNSP



FDA Drug Safety Communication

FDA advises restricting fluoroquinolone antibiotic use for certain uncomplicated infections; warns about disabling side effects that can occur together

Safety Announcement

[05-12-2016] The U.S. Food and Drug Administration is advising that the serious side effects associated with fluoroquinolone antibacterial drugs generally outweigh the benefits for patients with acute sinusitis, acute bronchitis, and uncomplicated urinary tract infections who have other treatment options. For patients with these conditions, fluoroquinolones should be reserved for those who do not have alternative treatment options.

An FDA safety review has shown that fluoroquinolones when used systemically (i.e. tablets, capsules, and injectable) are associated with disabling and potentially permanent serious side effects that can occur together. These side effects can involve the tendons, muscles, joints, nerves, and central nervous system.

As a result, we are requiring the drug labels and Medication Guides for all fluoroquinolone antibacterial drugs to be updated to reflect this new safety information. We are continuing to investigate safety issues with fluoroquinolones and will update the public with additional information if it becomes available.

Patients should contact your health care professional immediately if you experience any serious side effects while taking your fluoroquinolone medicine. Some signs and symptoms of serious side effects include tendon, joint and muscle pain, a "pins and needles" tingling or pricking sensation, confusion, and hallucinations. Patients should talk with your health care professional if you have any questions or concerns.

Health care professionals should stop systemic fluoroquinolone treatment immediately if a patient reports serious side effects, and switch to a non-fluoroquinolone antibacterial drug to complete the patient's treatment course.

Fluoroquinolone drugs work by killing or stopping the growth of bacteria that can cause illness (see List of Currently Available FDA-approved Fluoroquinolones for Systemic Use).

List of Currently Available FDA-approved Fluoroquinolone Antibacterial Drugs for Systemic Use

Brand Name	Active Ingredient
Avelox	Moxifloxacin
Cipro	Ciprofloxacin
Cipro extended-release*	Ciprofloxacin extended-release*
Factive	Gemifloxacin [†]
Levaquin	Levofloxacin [†]
Moxifloxacin Injection	Moxifloxacin
Ofloxacina [†]	Oloxacina

[†] available as generic

* available only as generic

We previously communicated safety information associated with systemic fluoroquinolone antibacterial drugs in August 2013 and July 2008. The safety issues described in this Drug Safety Communication were also discussed at an FDA Advisory Committee meeting in November 2015.

We urge patients and health care professionals to report side effects involving fluoroquinolone antibacterial drugs and other drugs to the FDA MedWatch program, using the information in the "Contact FDA" box at the bottom of the page.

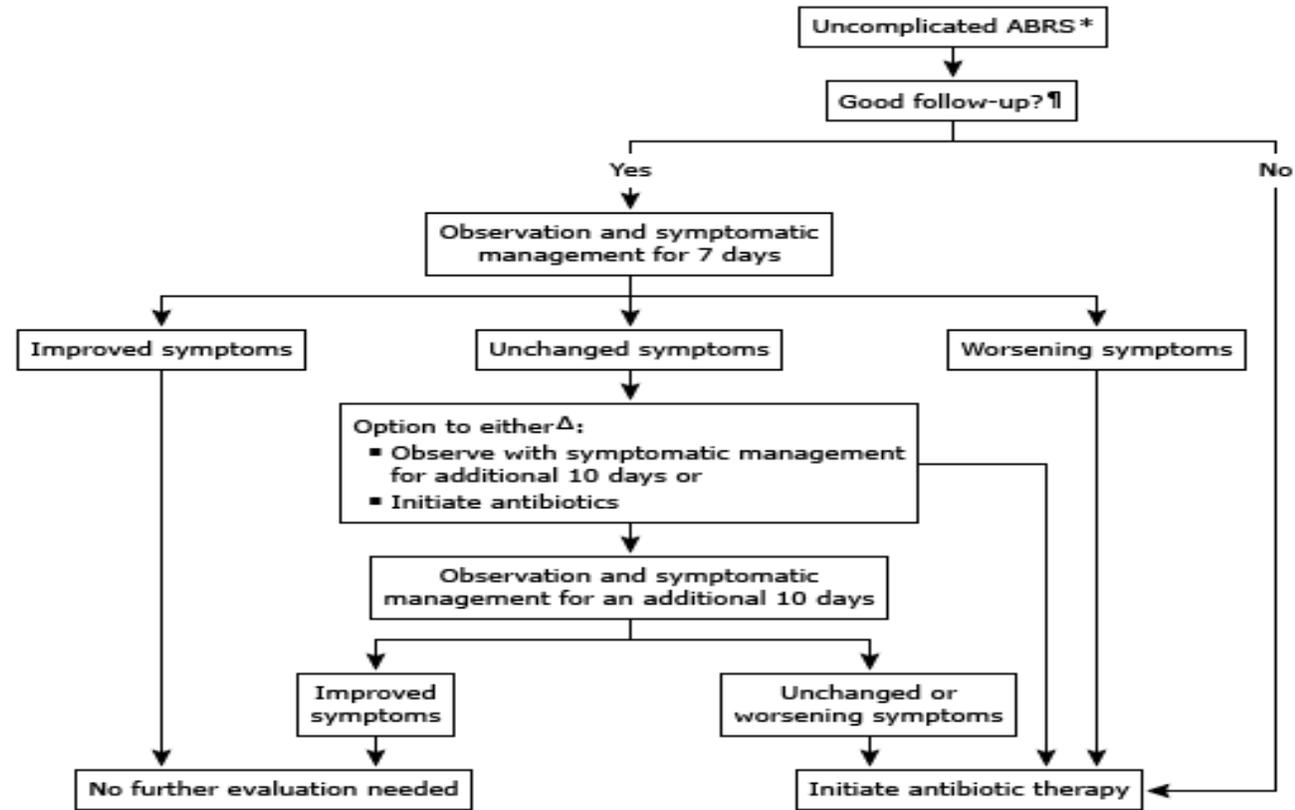
Related Information

The FDA's Drug Review Process: Ensuring Drugs are Safe and Effective
<http://www.fda.gov/Drugs/ResourcesForYou/Consumers/ucm143534.htm>

Thinking it Through: Managing the Benefits and Risks of Medicines
<http://www.fda.gov/Drugs/ResourcesForYou/Consumers/ucm143558.htm>

Advisory Committees: Critical to the FDA's Product Review Process
<http://www.fda.gov/Drugs/ResourcesForYou/Consumers/ucm143538.htm>

Suggested approach to observation versus antimicrobial therapy for outpatient treatment of uncomplicated acute bacterial rhinosinusitis (ABRS) in immunocompetent adults



* Uncomplicated ABRS is ABRS without evidence of extension of infection beyond the paranasal sinuses and nasal cavity into the central nervous system, orbit, or surrounding tissues.

† Good follow-up: Assurance that antibiotic therapy can be started if symptoms worsen or if no improvement within 7 days.

Δ Decision will depend on patient presentation, comorbidities, and social factors. Refer to the UpToDate topic on treatment of uncomplicated acute sinusitis and rhinosinusitis in adults for details.

Acute Sinusitis

- * Augmentin (Amoxicillin-Clavulanate) 500mg/125mg po TID or 875/125mg orally po BID
- * PCN Allergy: Doxycycline 100mg po BID or 200mg orally daily

Uncomplicated Urinary Tract Infection

- * Bactrim DS (Trimethoprim-Sulfamethoxazole 160/800 po BID x 3 days)
- * Nitrofurantoin 100mg po BID x 5 days
- * Cephalexin 500mg BID x 5-7 days

Bronchitis

- * If uncomplicated use symptomatic treatment
- * If > than 10 days may warrant antibiotics treatment:
 - * Azithromycin 500mg x 1, then 250mg po daily for Day 2-5
 - * Doxycycline 100mg BID
 - * Can use Levofloxacin 750mg po daily x 5 days or Moxifloxacin 400mg daily x 4 days if acute exacerbation

Bottom Line

- * Weigh benefits versus risks of the medication
- * Look at symptoms, sometimes you DO NOT NEED medications
- * Call physician supervisor or if needed the Infectious Disease Department for complicated cases: 619-532-7475

Fleet Mental Health

CDR S. King Hollis, PMHNP

Mental Health Fleet Liaison

Contact: 619-556-8090

Consult Liaison CL: 619-384-7280



Medical Readiness Division

MRD_SD_GMO@navy.mil

(619) 556-5191

Bldg 116

San Diego, CA 92136



Active Duty Clinic-Gen Surgery

No longer available!



Upcoming Meetings

- **July 27th @ 1000-1200**
 - GERD
 - OSS
 - IBHC
- **August 31st @ 1000-1200**
 - Health and Wellness



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Commander Naval Surface Forces, U.S. Pacific Fleet

Medical Readiness Division San Diego
Clinic: (619) 556-8114 GMO Office: (619) 556-5191 Email Address mrd_sd_gmo@navy.mil
Senior Enlisted Leadership: (619) 556-0662

What's New

- **MRD Clinic has changed locations!**
MRD Clinic is now located in the Patient Treatment Area (PTA)/Acute Care Area (ACA), in the southwest corner of the 32nd st NAVSTA BMC.
Front desk #619-556-8114
- **Dental Clinic 32nd Street**
Contact: (619)556-8240/8239/8233/9545 during the hours of 0645-1515
- **New hernia guidelines - refer to general surgery for workup**
[CAMO General Surgery Matrix - February 2015](#)
- **TMIP Maintenance Guidelines**
- **Infectious Disease: Ebola & MERS information**
[Evaluation and care of patients with possible Ebola](#)
[Ebola Resources/Disinfectant/CDC Guidelines](#)
[MERS Update](#)
NEPMU-5
San Diego, CA
Quarterdeck: (619) 556-7070
CDO: (619) 726-4421
- **STR Tracking Requirements/Separation History & Physicals Instruction**
[SHPE Instruction](#)
[SHPF Guidance](#)

Quick Reference

CME Guidance

- [Athens Access and Up To Date CME Instructions](#)
- **CME Credit Instructions**
- [CME Follow-Up Survey](#)

Contact Information

- [CNSRW Ship locator](#)
- Fleet Liaison Contact Info: Daytime Office Phone #: 619-532-6430, Fax # 619-532-6404, Duty Phone #: 619-302-8944, email: fmlo-list@med.navy.mil
- Phone Directory: [Media:INTRANET_PHONE_DIRECTORY_\(pao_approved\).pdf](#)

Consult Guidance

- [Consult Appointment Management Office \(CAMO\) Powerpoint](#)
- [CAMO CT Surgery Matrix](#)
- [CAMO Endocrinology Matrix - December 2013](#)
- [CAMO General Surgery Matrix \(revised - February 2015\)](#)
- [CAMO GYN Matrix - February 2014](#)
- [CAMO MRI Matrix - 6 June 2014](#)



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 - or
 - Go to NMCS D SEAT SharePoint site (via citrix or NMCS D/BMC computer) and click on MRDSD Waterfront Meeting

<http://nmcsd-as-spfe05/sites/dpe/setd/Lists/cmesturvey/Item/newifs.aspx?List=be0f840e%2D0489%2D4b5a%2Db8de%2D9c4cd1a323e5&Web=0901130e%2Dd444%2D45b8%2D8bc7%2D5b9ec10dca77>