



30 SEP 2015 Waterfront Meeting

	Speaker	Topic	Time
Lecture Pretests			10
CNSP FORCE Medical	CAPT Padden	Opening Remarks	10
NMCSD Orthopedics	LCDR Bernhardson	Orthopedic Emergencies	45
NMCSD Cardiology	LT Oakley	EKG Interpretation	30
CNSP FORCE Dental	CAPT Paddock	Dental Updates	10
MRD Well Woman Clinic	LCDR Potswald	Well Woman	5
MRD Optometry	LT Collins	Updates	5
University of SD	CDR Buechel	HPV Study	5
MRD-SD	LT Hightower	Updates	5
Lecture Posttests			5
		Total	130



Pre Test

Please start on the quizzes as soon as you find a seat!
Put your name on the quiz and **pass to the end of the row (left) when you are done.** Thank you!

January

Chest Pain- Dr. Oakley

Triage- LT Feroli

February

Shock- Dr. Mecklenburg

Pulmonary Emergencies- Dr. Powers

March

Acute Pain- Dr. Voogd

Surgical Abdomen- Dr. Ignacio

April

Airway Management- Dr. Hauff

May

Dental- LT Meadows (IDC's)

Ultrasound- Dr. Hurst (MO's)

June

Poisoned Patient – Dr. Carstairs

Allergic Rxn's – Dr. Clapp

July

Trauma – Dr. Wisniewski

Psych Emergencies – Dr. Ong

August

GYN – Dr. Heaton (IDC's)

Radiology - Dr. Lee (MO's)



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COMMANDER NAVAL SURFACE FORCE

CAPT Padden
Force Medical



COMMANDER NAVAL SURFACE FORCE

CAPT Paddock
Force Dental

Operational Orthopaedics: Emergencies and Common Occurrences

LCDR Andrew Bernhardson
PGY4 Orthopaedic Resident
NMCSD



Disclaimer

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- No financial disclosures



NMCS D Bone Phone

● (619) 954-6797

ORTHOPAEDIC EMERGENCIES



ORTHOPAEDIC EMERGENCIES

- Open Fractures
- Compartment Syndrome
- Dislocations
- Septic Joint
- Cauda Equina
- Neurovascular Injuries

Open Fractures

- Irrigate
- Cover
- Splint
- Antibiotics



Open Fractures

○ Irrigate and Debride

- 1-2 liters for small wounds, 3-4 liters for big wounds
- Take a picture

○ Cover

- Sterile Gauze and **KEEP IT COVERED**

○ Splint

- Grossly align limb and splint in comfortable position

○ Antibiotics

- Ancef 1 gm Q8H (2gm if >70kg/155lbs)
- If PCN allergic, Clindamycin 600mg q8h

Open fractures

● REVIEW:

- Irrigate and Debride
- Cover it up
- Splint
- Antibiotics



Compartment Syndrome

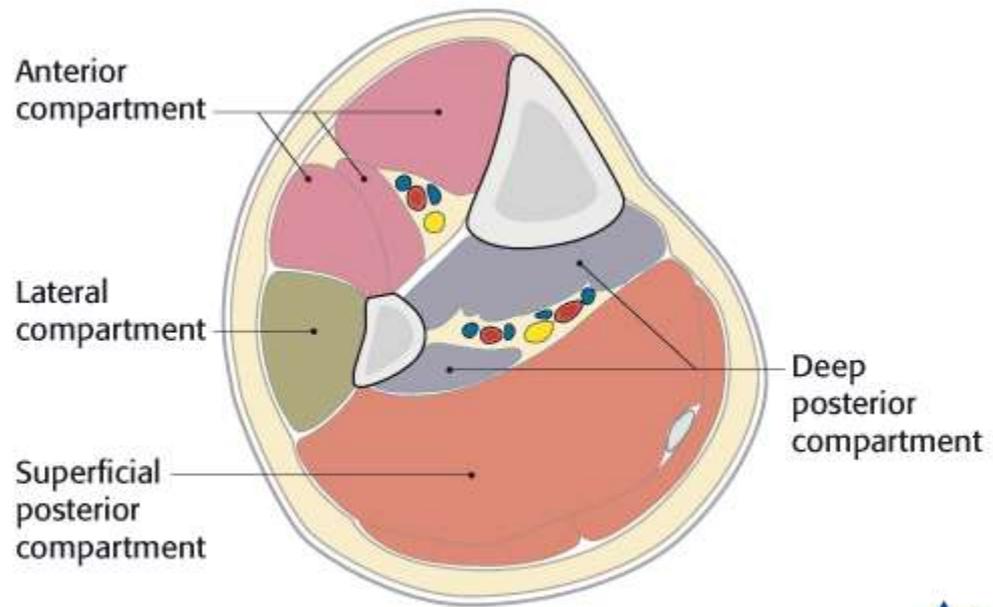
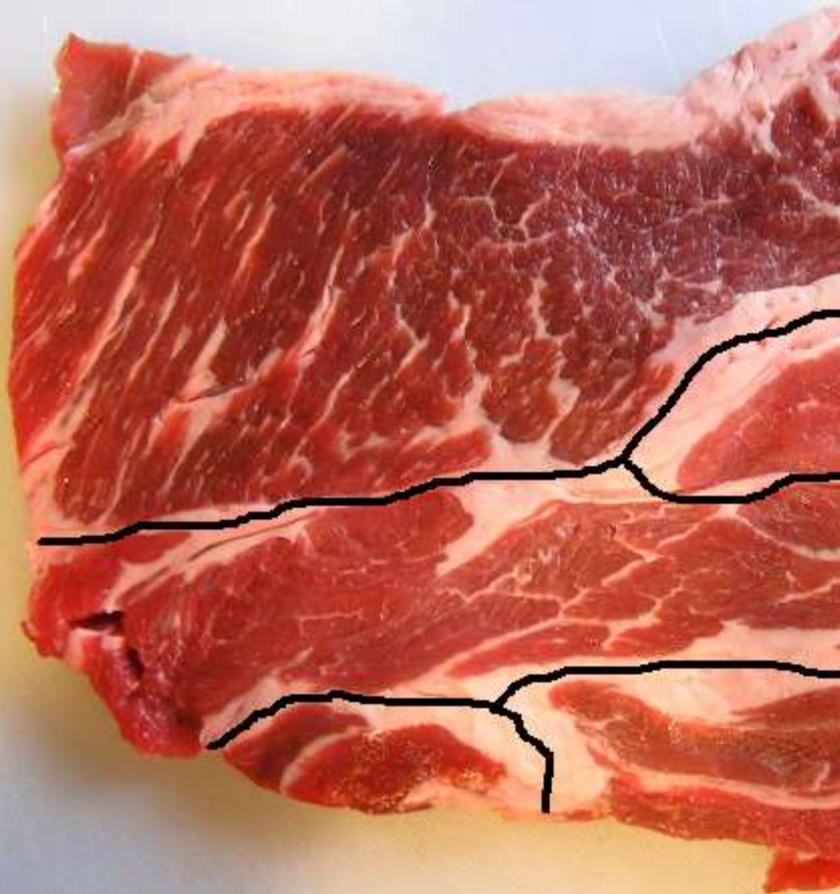
● P's

- Pallor
- Paresthesia
- Poikilothermia
- Pain out of proportion
- Pulselessness
- Paralysis



**TOO MUCH
PRESSURE!**

Compartment Syndrome



Compartment Syndrome

○ Locations

- Upper arm
- Lower arm
- Hand
- Paraspinal
- Glutes
- Thigh
- Lower leg
- Foot

Compartment Syndrome

- ◉ Don't elevate the limb
- ◉ Splint/stabilize
- ◉ Get patient to an orthopaedic surgeon
- ◉ Fasciotomy?

Compartment Syndrome

○ REVIEW:

- Exam: Pain worse with passive stretch
- Open fracture doesn't rule it out
- Send to higher

QUESTIONS???



Dislocations



Shoulder dislocations

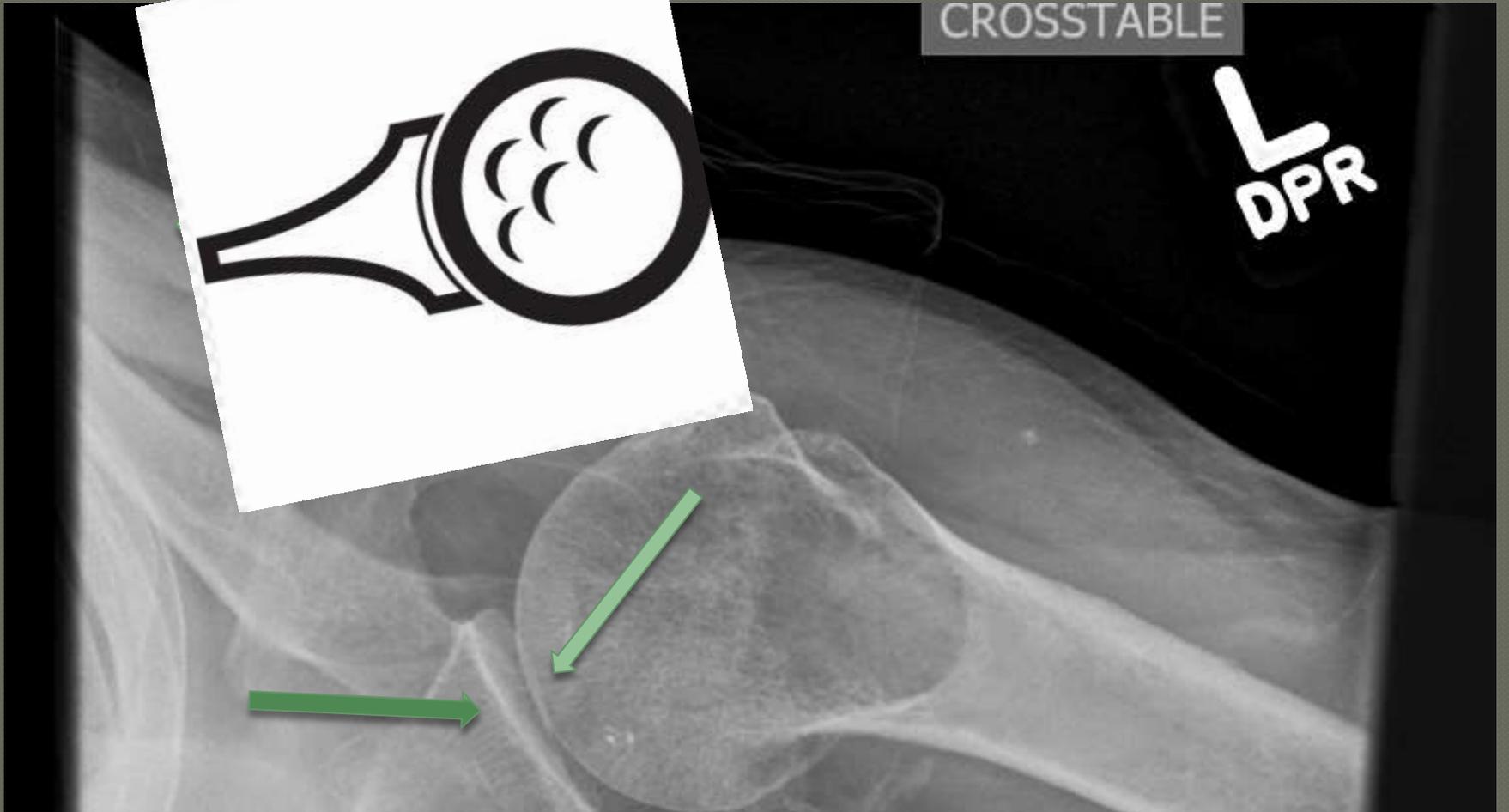
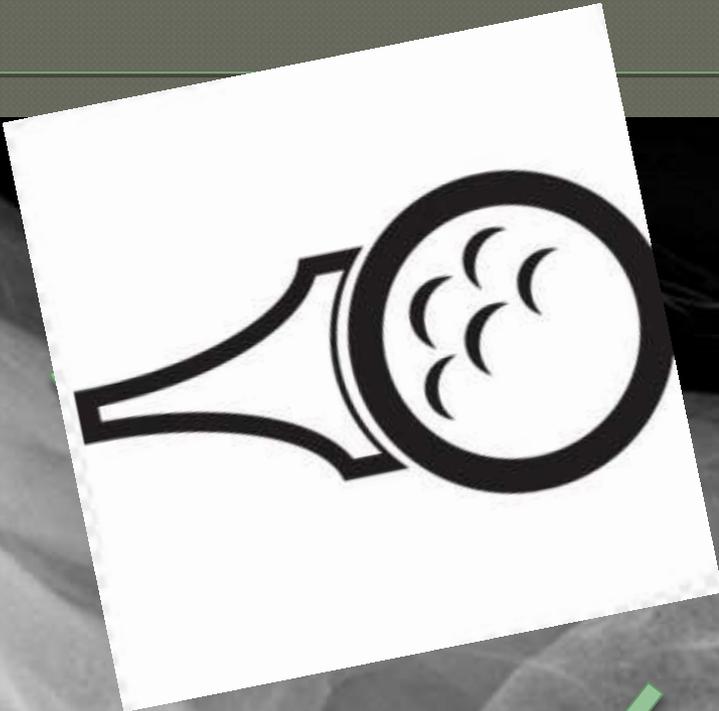
- ◉ Ant-Inferior 95%
- ◉ Posterior 4%
- ◉ Inferior 1%



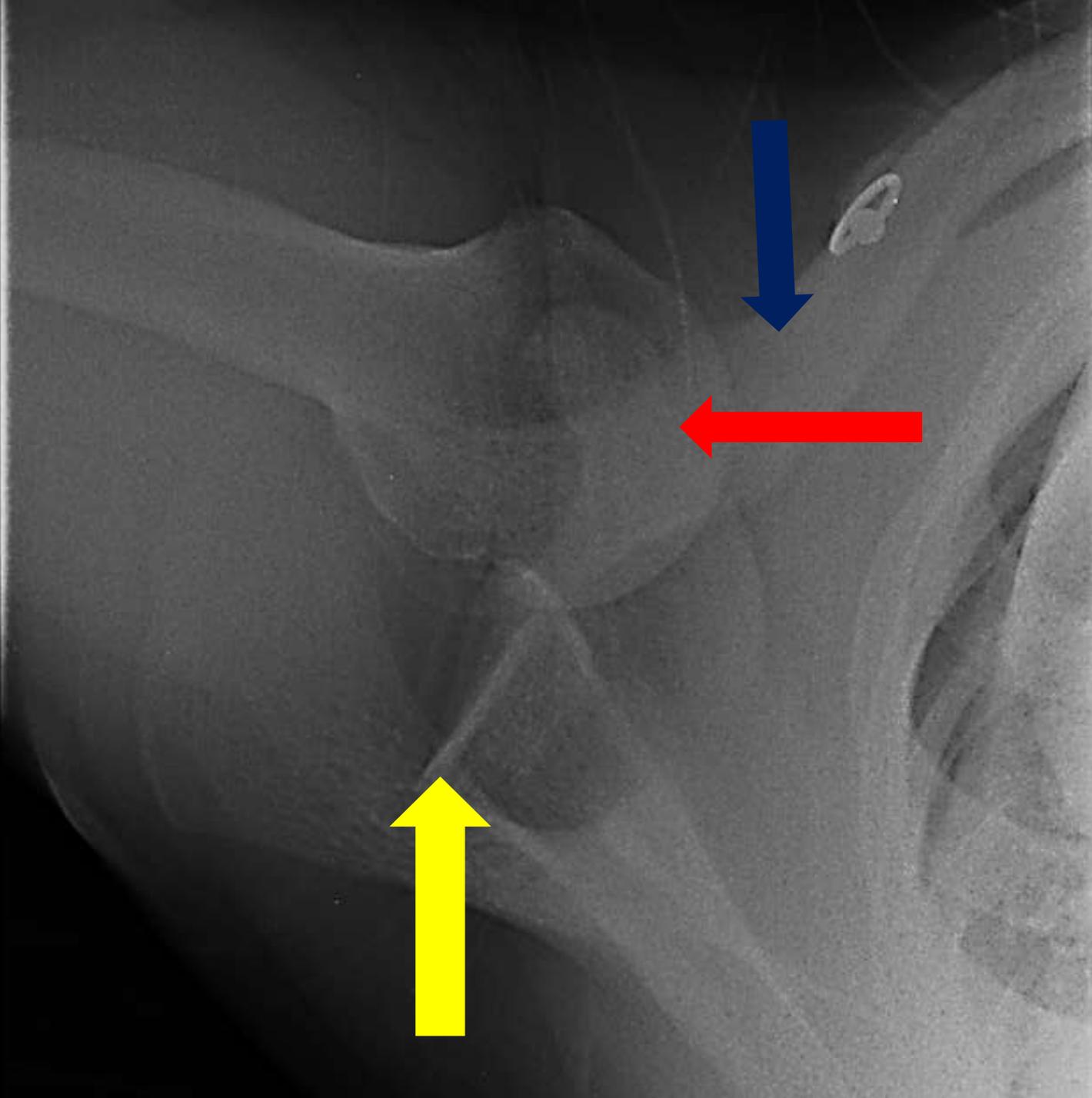
Axillary

CROSSTABLE

L
DPR



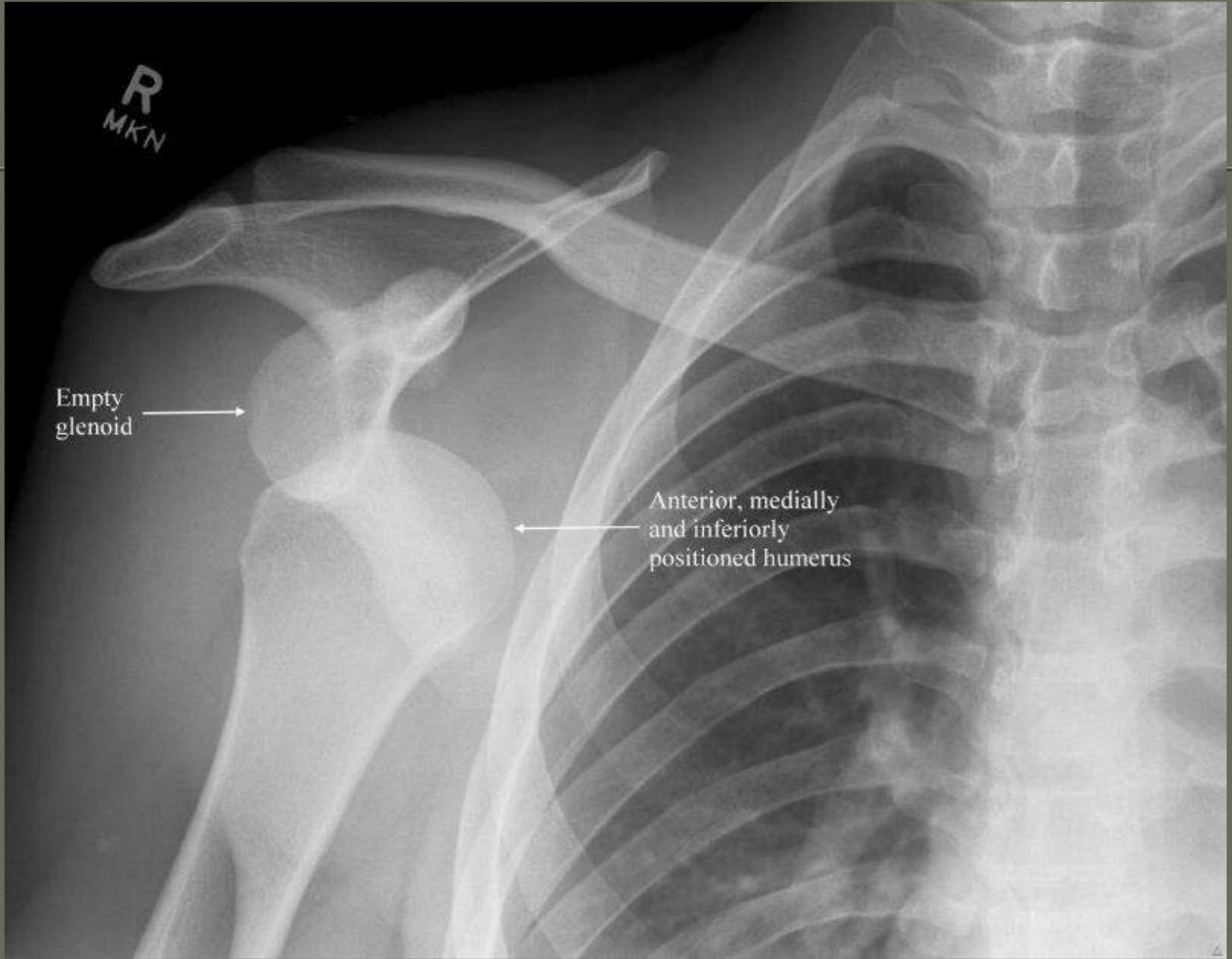
ns



R
MKN

Empty
glenoid

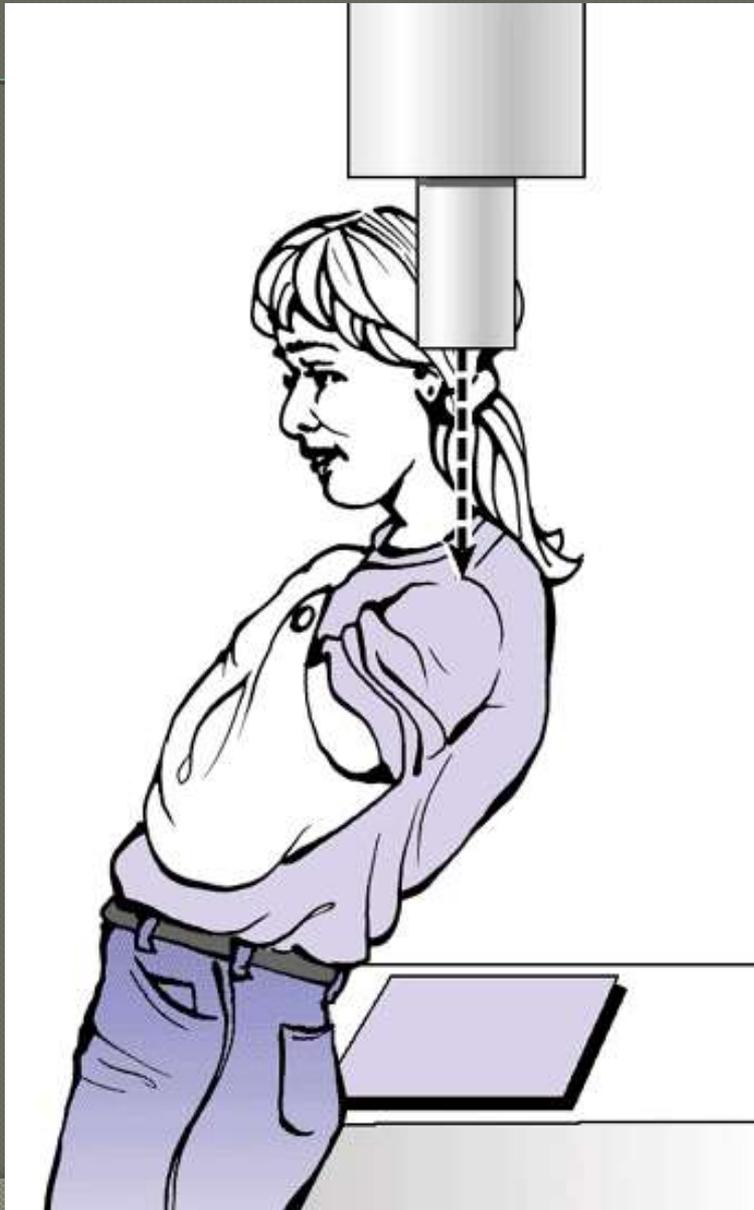
Anterior, medially
and inferiorly
positioned humerus



R
MN

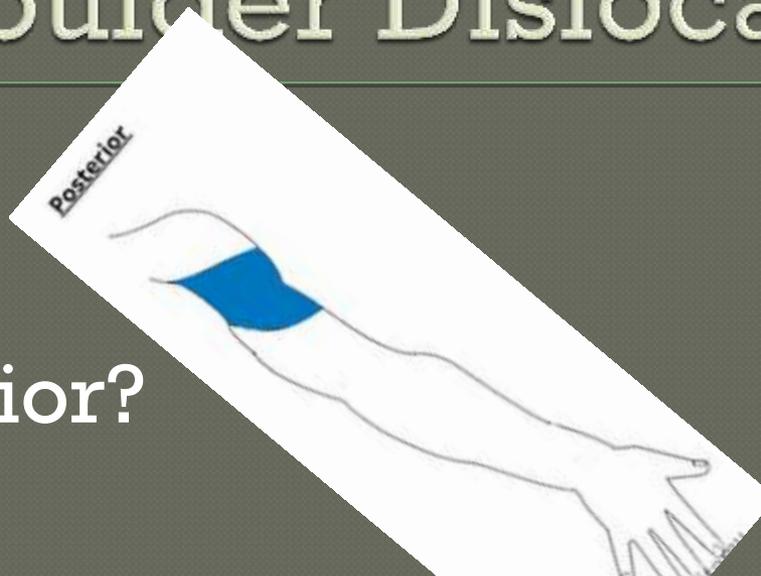


Velpeau View



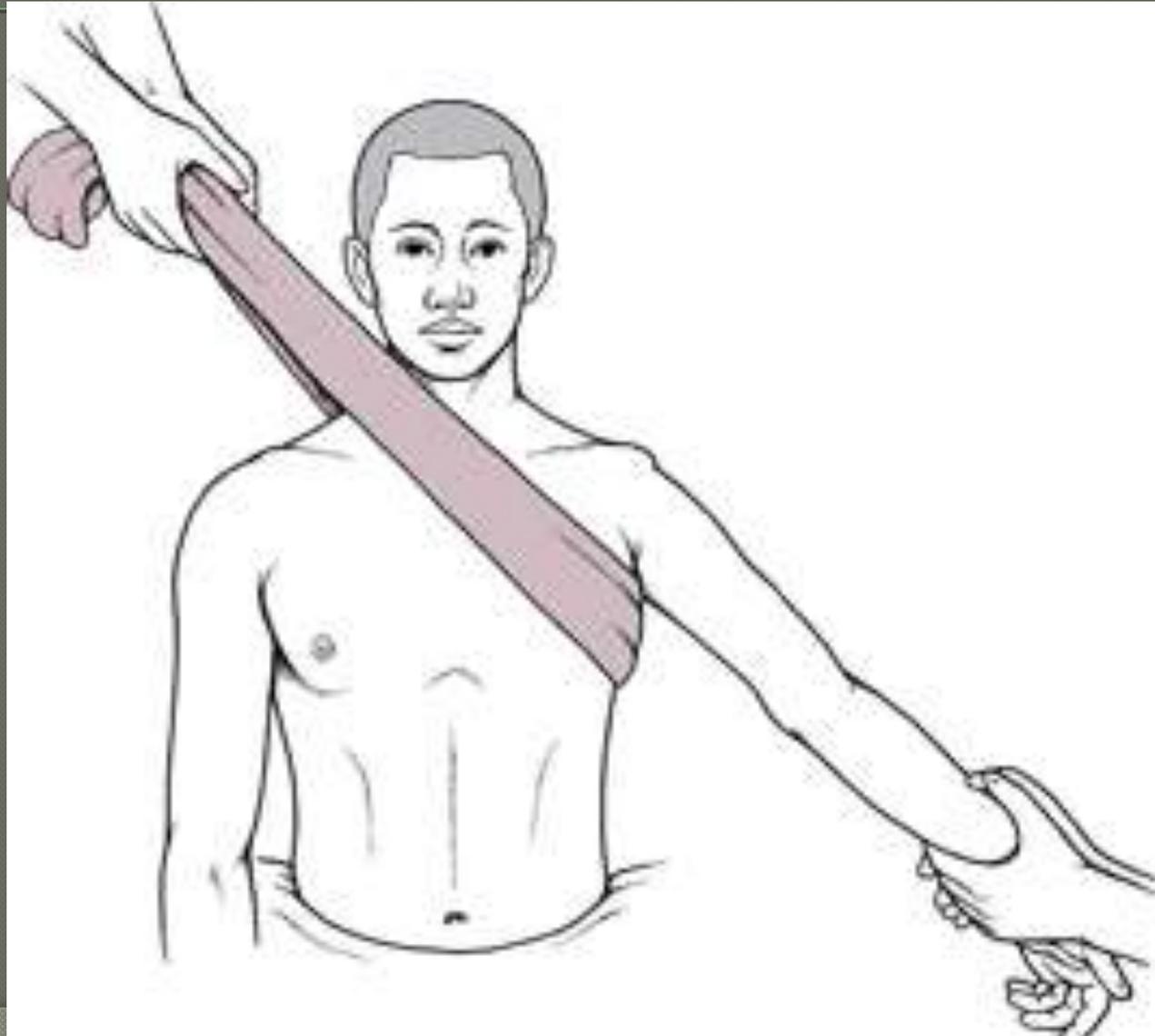
Shoulder Dislocation

- Neuro exam
- Anterior/posterior?
- Analgesia
 - 1-2cm inferior
 - 1cm medial

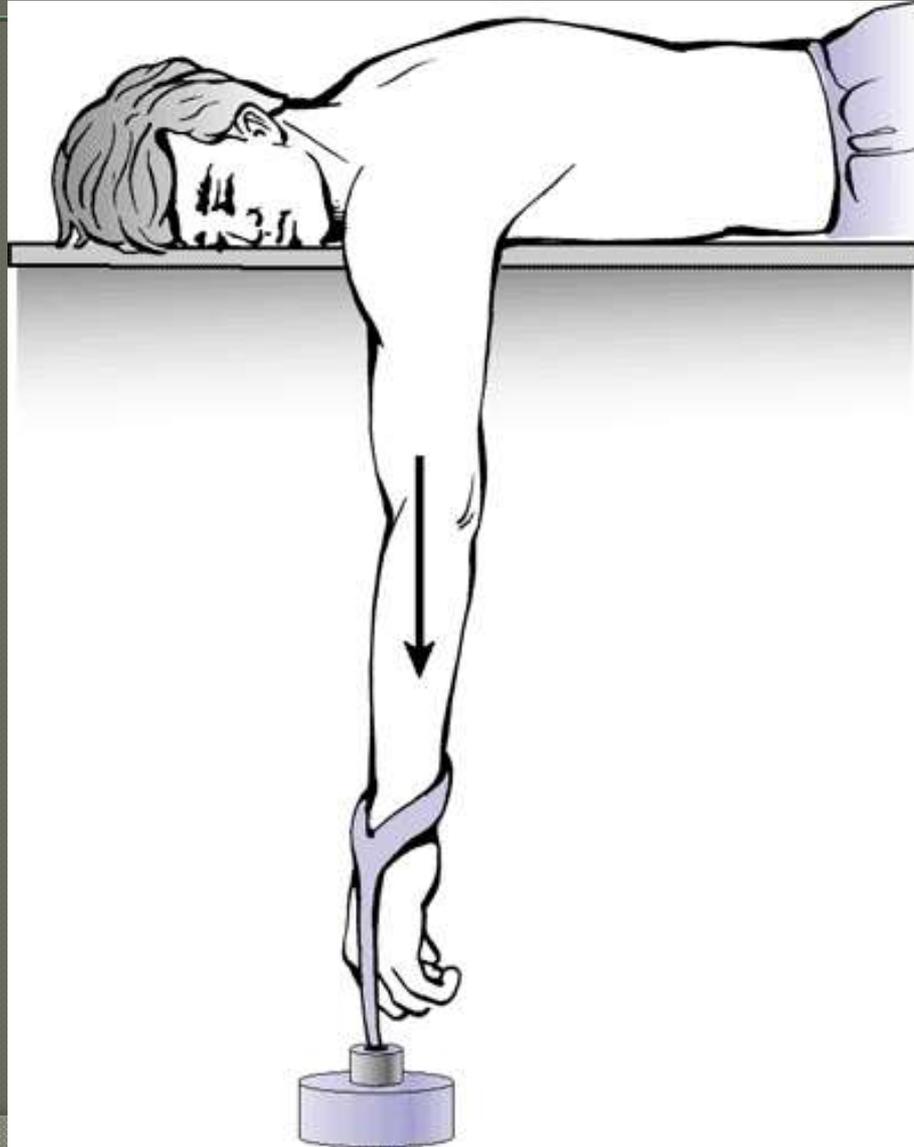


Shoulder Reduction

Traction-counter traction



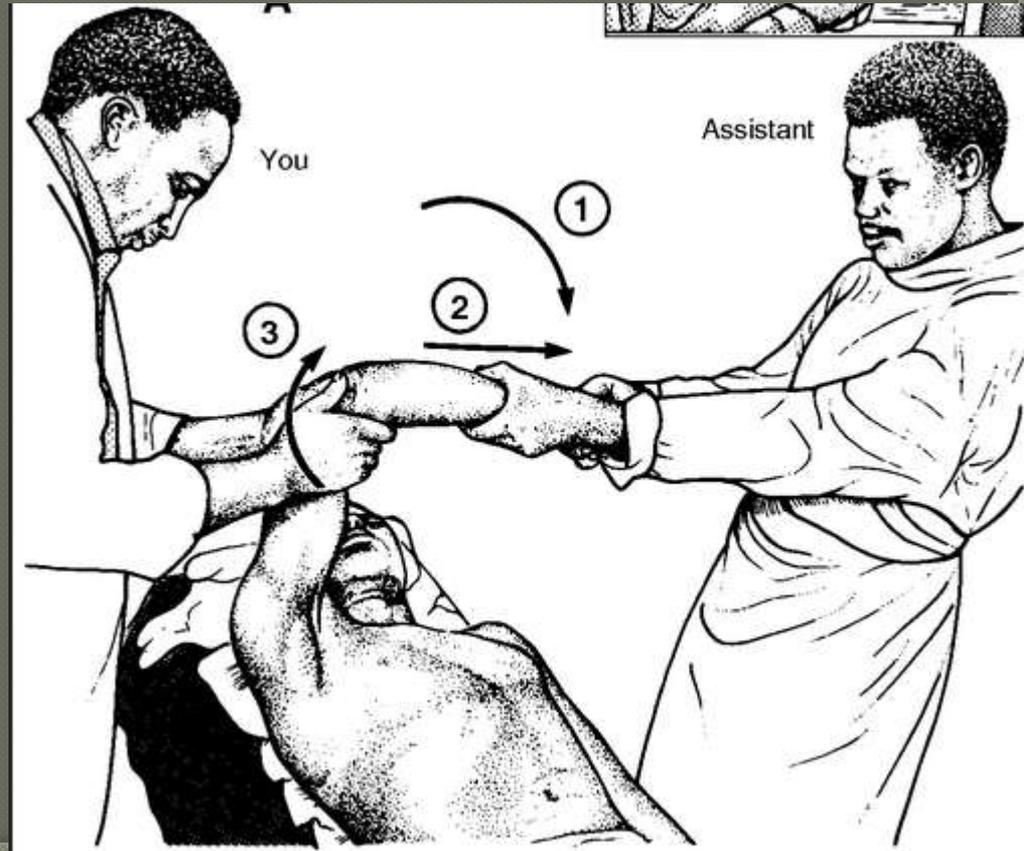
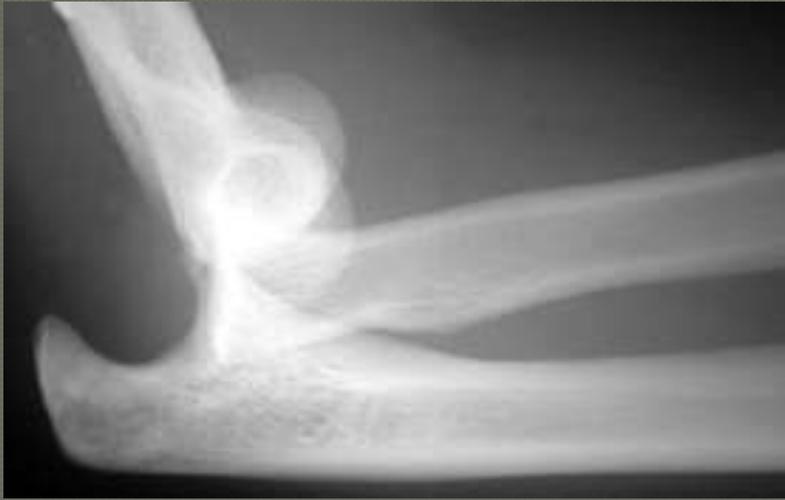
Stimson Technique



Shoulder Dislocation

- After the reduction:
 - Sling for 3 days at all times
 - Gently increase range of motion, active only
 - >50% of first time dislocators <20yo wil dislocate again
 - Surgery??

Elbow Dislocation



Finger dislocations

- ◉ Look for open wounds
- ◉ Traction and gentle rotation
- ◉ Most are stable
- ◉ ROM as tolerated



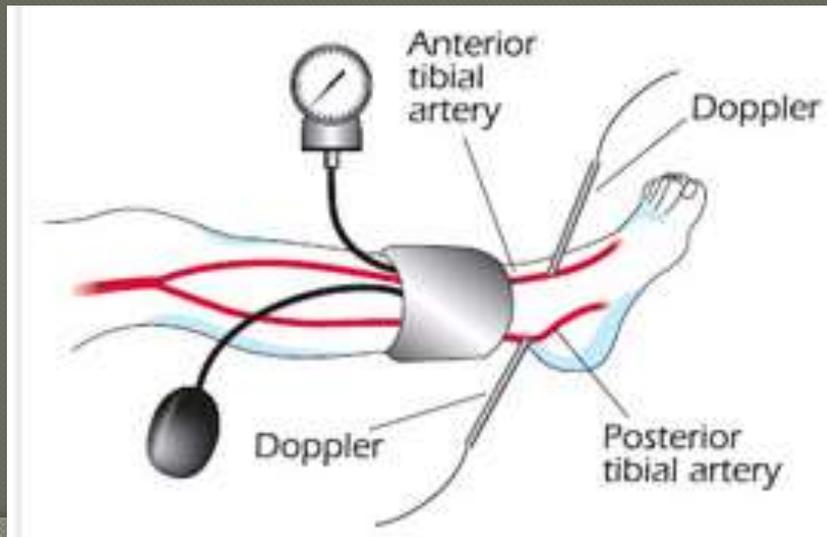
Hip Dislocations

- Rare
- Anterior force + rotation



Knee Dislocation

- Check vascular exam
- ABI: Arm Systolic BP
Ankle Systolic BP
- Normal 0.9-1.1



Ankle Dislocation

- Common, usually with fracture
- Goal is get the foot bone back under the leg bone



Ankle Fracture Dislocation

- Inject just medial to Tibialis Anterior Tendon
- Bend knee
- Traction on heel, foot plantarflexed



Septic Joint

- Intraarticular infection
- WBC's invade
- Kills cartilage
- Can lead to sepsis
- Knee 50%, Hip 25% (kids), Wrist 10%, Shoulder ankle and elbow 15% combined



Septic Joint Diagnosis

- No painfree arc of motion
- Usually history of infection trauma or surgery
- Aspiration to diagnose
 - >50,000 WBC's
 - UA strip



Leukocytes
60 - 120 sec

neg.

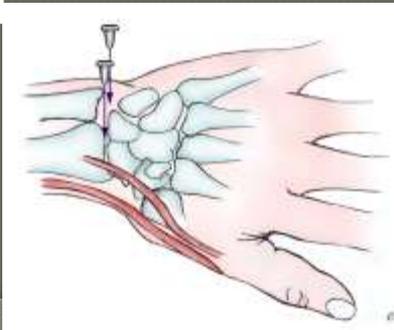
trace

+

++

Joint Aspiration

- **Knee: Superolateral**
 - In line with top of patella
 - Push patella towards you to tent skin
- **Ankle:**
 - Medial to Tibialis Anterior tendon
- **Shoulder:**
 - Posterior from soft spot towards coracoid
- **Wrist:**
 - Feel bump on dorsal radius. 1cm distal is wrist joint

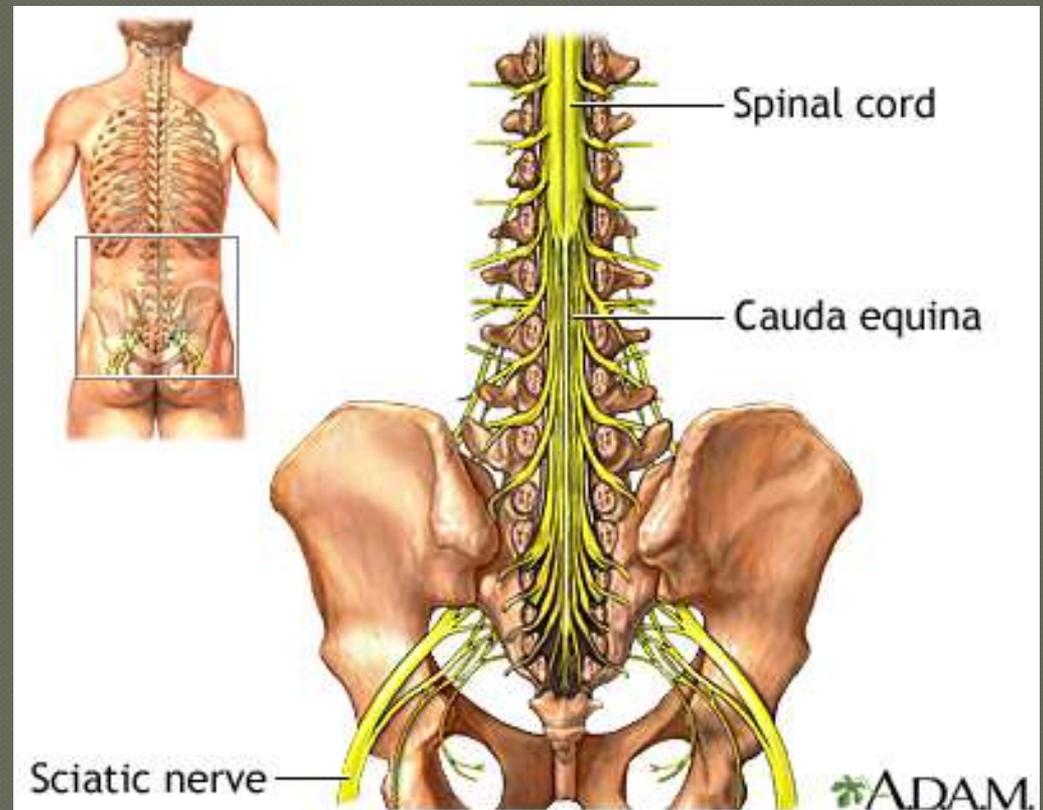


Septic Joint

- Get pt to an orthopaedic surgeon ASAP
- If you can't, ABX: Ancef 1-2gm Q8
- Splint the joint
- Elevate

Cauda Equina Syndrome

- Loss of bowel control
- Urinary RETENTION
- Saddle anesthesia
- Decreased rectal tone
- Bilat Leg pain/weakness



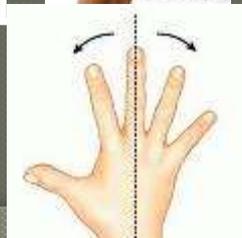
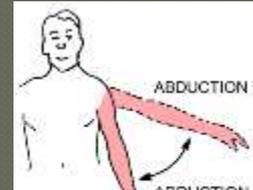
Neurovascular Injuries

- ◉ Neuropraxia: Nerve bruise, temporary. Resolves over days to months.
- ◉ Neuro exam on every pt
- ◉ You won't find what you don't look for

Upper extremity

Motor:

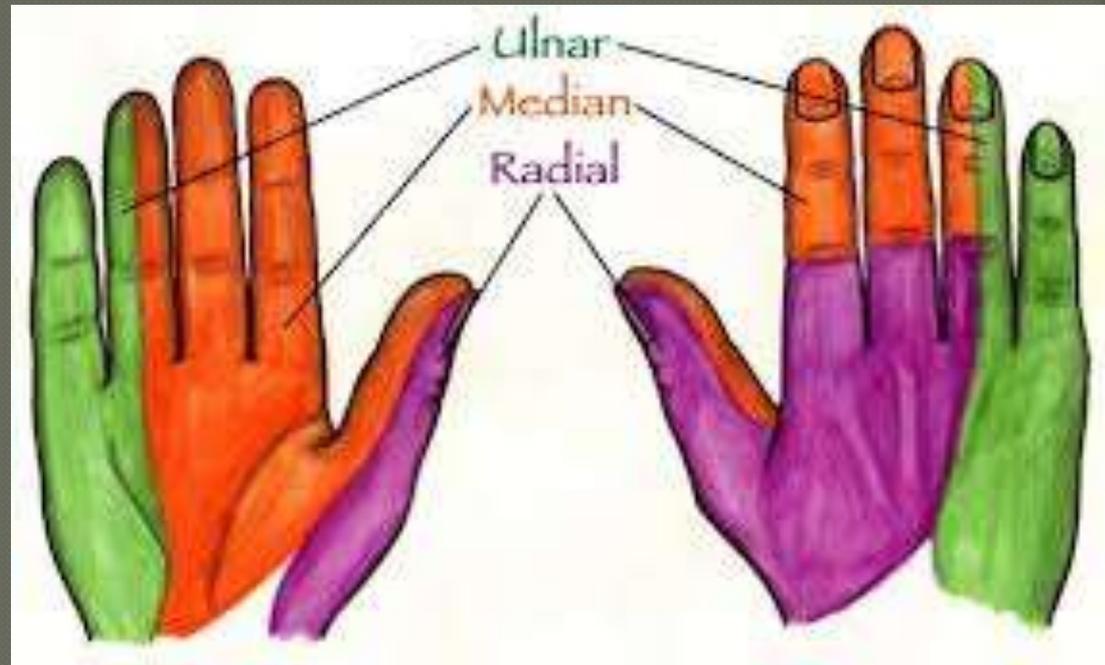
- Axillary: Abduct arm- Deltoid
- Musculocutaneous: Flex elbow- Biceps/Brachialis
- Radial (PIN): Thumb's up- EPL
- Median (AIN): OK sign- FPL/FDC
- Ulnar: Fan fingers- Interossei



Upper Extremity

○ Sensory

- Axillary
 - Lateral shoulder
- Radial
 - Dorsum of thumb
- Median
 - Palm of hand on thumb side
- Ulnar
 - Ulnar 1.5 fingers



Lower Extremity

Motor

- Femoral: Straighten knee- Quads
- Deep peroneal: Dorsiflex foot- Tibialis Anterior
- Superficial peroneal: Evert foot- Peroneus longus
- Tibial: Plantarflex foot- Gastrocnemius



Dorsiflexion



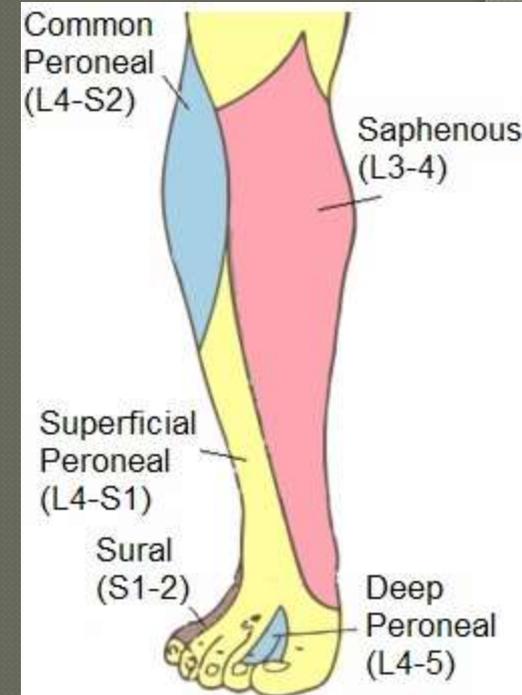
Foot eversion



Lower Extremity

○ Sensory:

- Saphenous: Medial lower leg and foot
- Superficial peroneal: Dorsum of foot
- Deep Peroneal: Between big toe and second toe
- Sural: Lateral foot
- Tibial: Plantar foot



Common Orthopaedic Injuries

- Ankle sprains
- Metacarpal fractures
- Hatch Hand
- Knee sprains
- Back pain
- Others?

Ankle Sprains

- RICE
- Ice water soak alphabet
- Lace-up ankle brace
- Early ROM and strengthening once tolerating weightbearing with full ROM

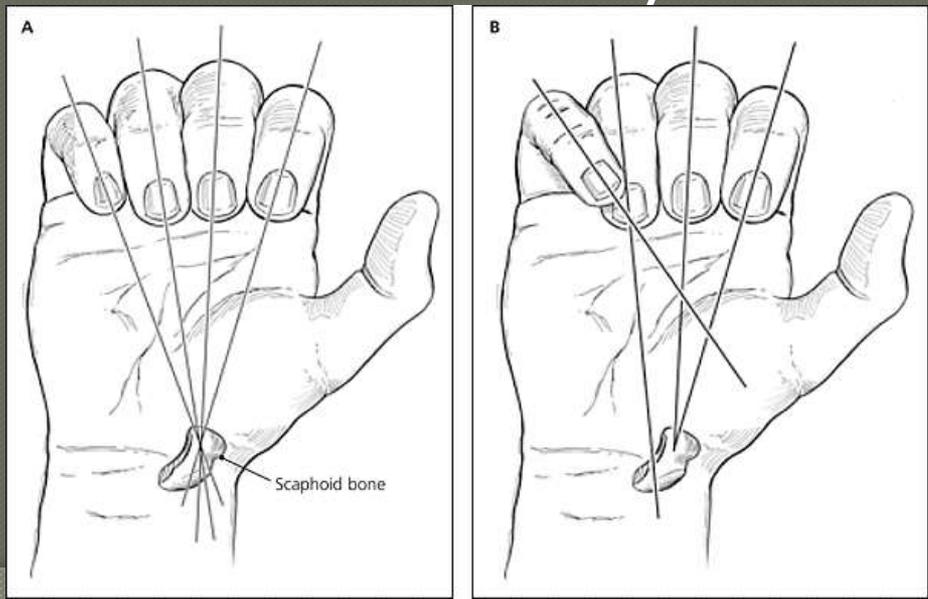


Metacarpal Fractures

○ “Boxer’s” Fracture

○ Look for:

- Open wounds dorsally
- Rotational deformity



Hatch Hand

- Complex injuries to skin, tendons, ligaments, bones, nerves, vessels and muscles
- Irrigate
- Cover
- Splint
- Antibiotics



Knee Sprains

- ◉ RICE early
- ◉ Brace as needed
- ◉ Ligament exam once swelling goes down



Back Pain

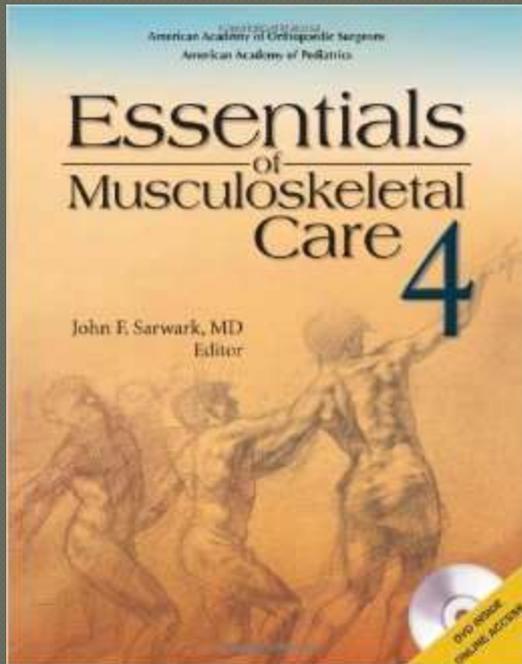
- 80% of people have annually
- Rule out Cauda Equina/Red Flags
- Radicular symptoms?
 - Pain/tingling in a strip down the leg
 - Unilateral weakness in specific muscle group/groups
- THERAPY!

Summary

- ◉ If it's dislocated, try to reduce it
- ◉ If it's open, clean it, cover it and give antibiotics
- ◉ If you don't know what to do about it, call for help
- ◉ If you think its bad or could get bad, send it

When in doubt...

- Call the Bone Phone! **(619) 954-6797**



-
- ① 1. What is the most sensitive initial finding to diagnose compartment syndrome?
 - ① A. Tight compartments
 - ① B. Pain with passive motion
 - ① C. Temperature difference in extremity
 - ① D. Pulseless extremity

2. What direction is the most common for a shoulder dislocation?

- A. Inferior
- B. Anteroinferior
- C. Superior
- D. Posterior

-
- 3. When immobilizing a wrist fracture, how high should the splint go?
 - A. From the hand to the forearm
 - B. From the hand to the Shoulder
 - C. Just the wrist
 - D. From the hand to above the elbow

-
- ④ 4. What X-ray view do you need to ensure a shoulder is not dislocated?
 - ④ A. AP
 - ④ B. Scapular Y
 - ④ C. Axillary
 - ④ D. Lateral

○ 5. A boxer's fracture is a fracture of the:

- A. 5th Metacarpal head
- B. 5th Metacarpal shaft
- C. 5th Metacarpal neck
- D. 5th Metacarpal base

Thank you very much!

- ◉ Andrew.s.bernhardson.mil@mail.mil

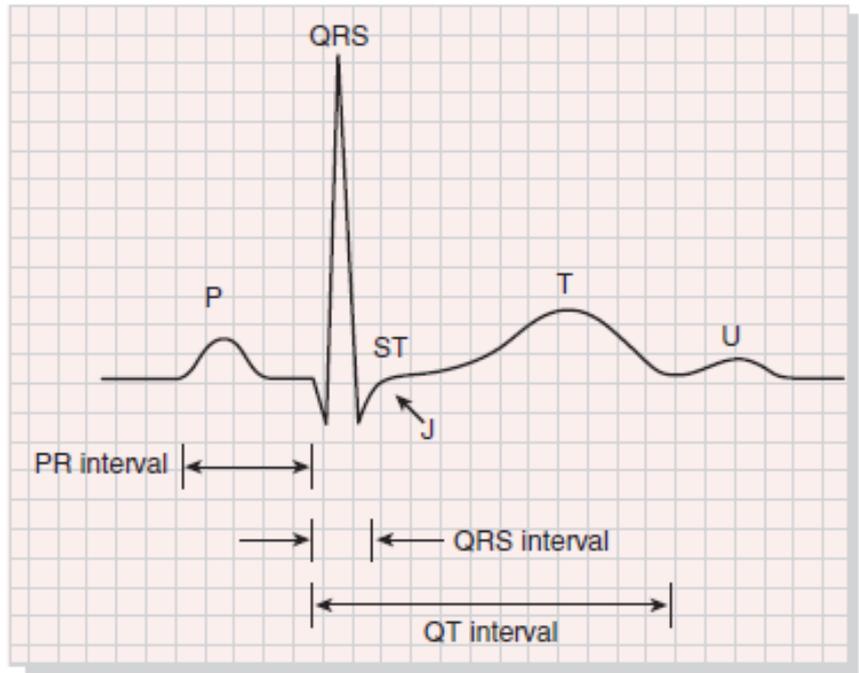
- ◉ Bone Phone:

- ◉ (619) 954-6797

- ◉ Be safe out there!

ECG Basics

Luke Oakley, MD
NMCSO Cardiology Fellow
NBSD Waterfront Mtng
September 2015



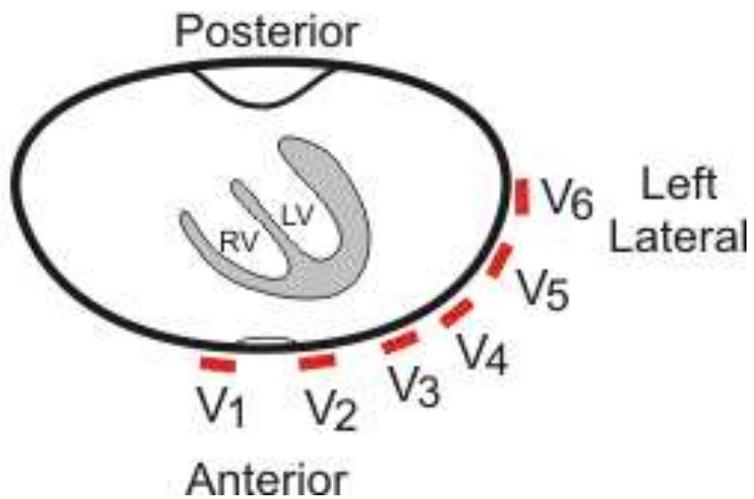
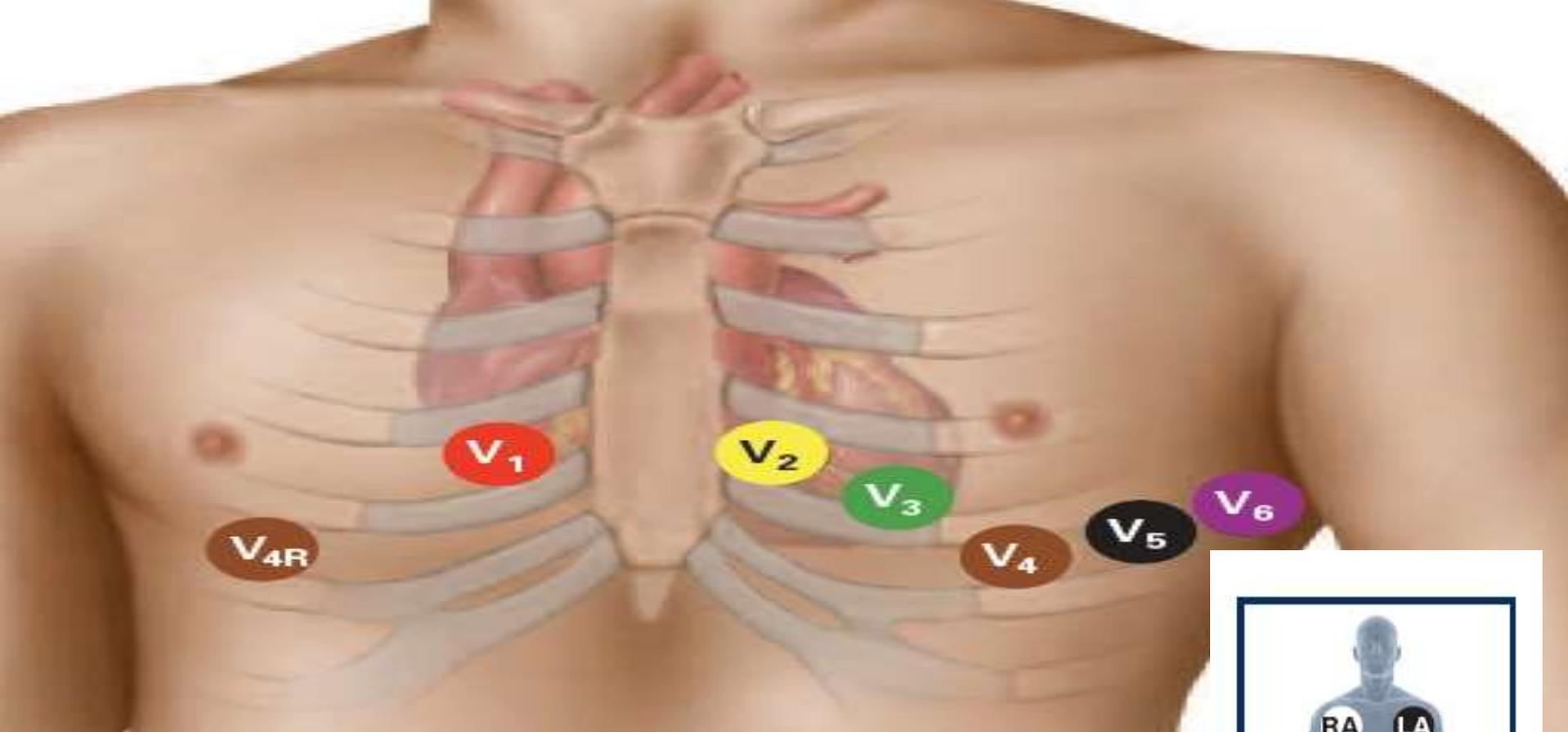
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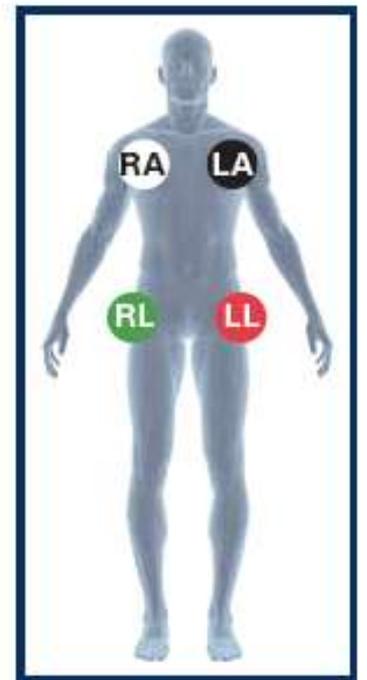


Helpful Phone #'s

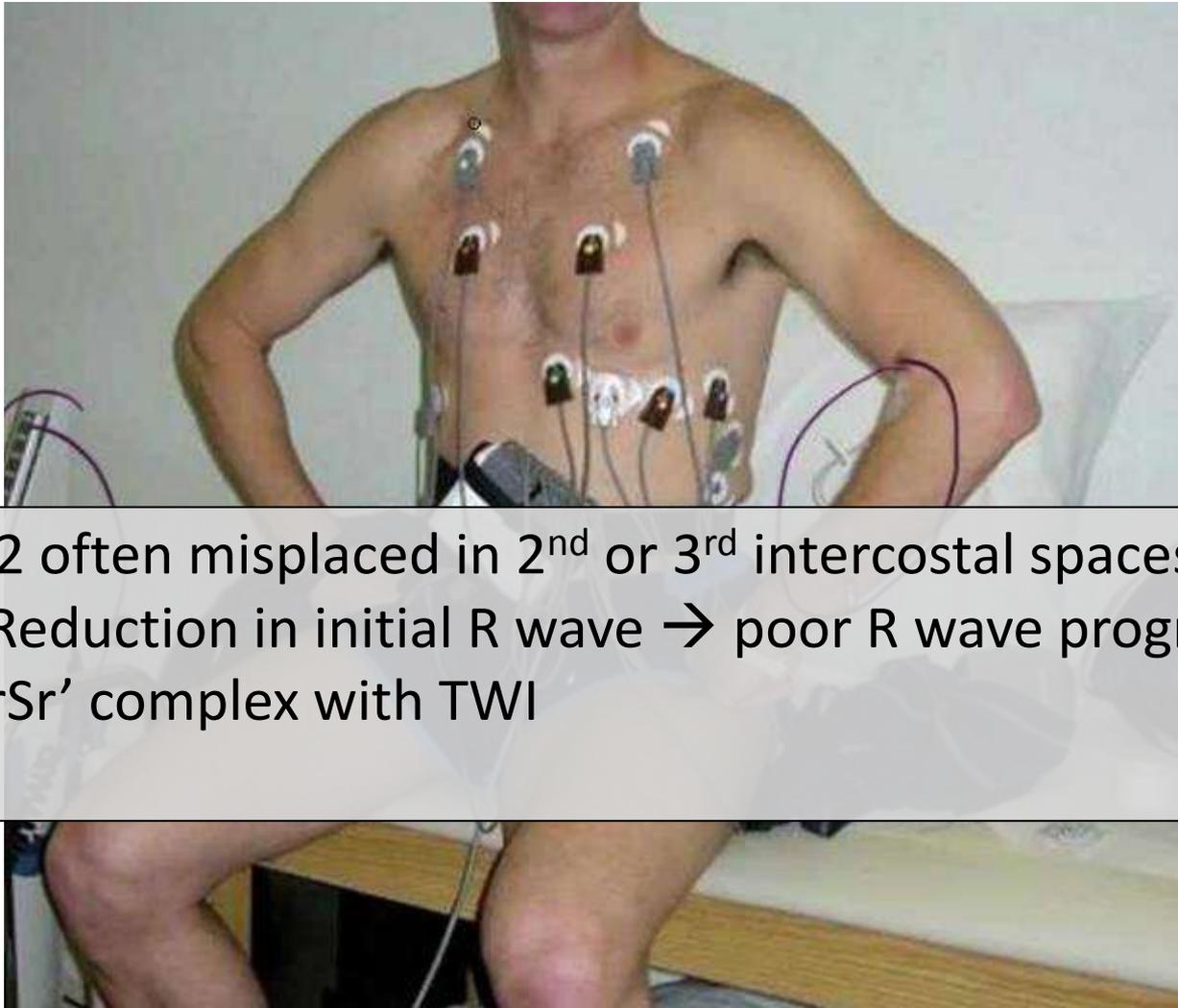
- Cardiology On-Call 24Hr/Day #'s:
 - Resident: 619-804-2316
 - Fellow (STEMI/Higher Level Q's): 619-804-2131
- Outpatient Cardiology Q's / Consults: 619-804-2229
- Tobacco Cessation Clinic: 619-532-9495
 - Bldg 3, 3rd Floor (between Internal Medicine Clinic and the Pulmonary Clinic – in the same space as the Coumadin Clinic)
 - Walk-In Group Clinic on Wednesdays at 1600



- RA** Right Arm
- LA** Left Arm
- LL** Left Leg
- RL** Right Leg

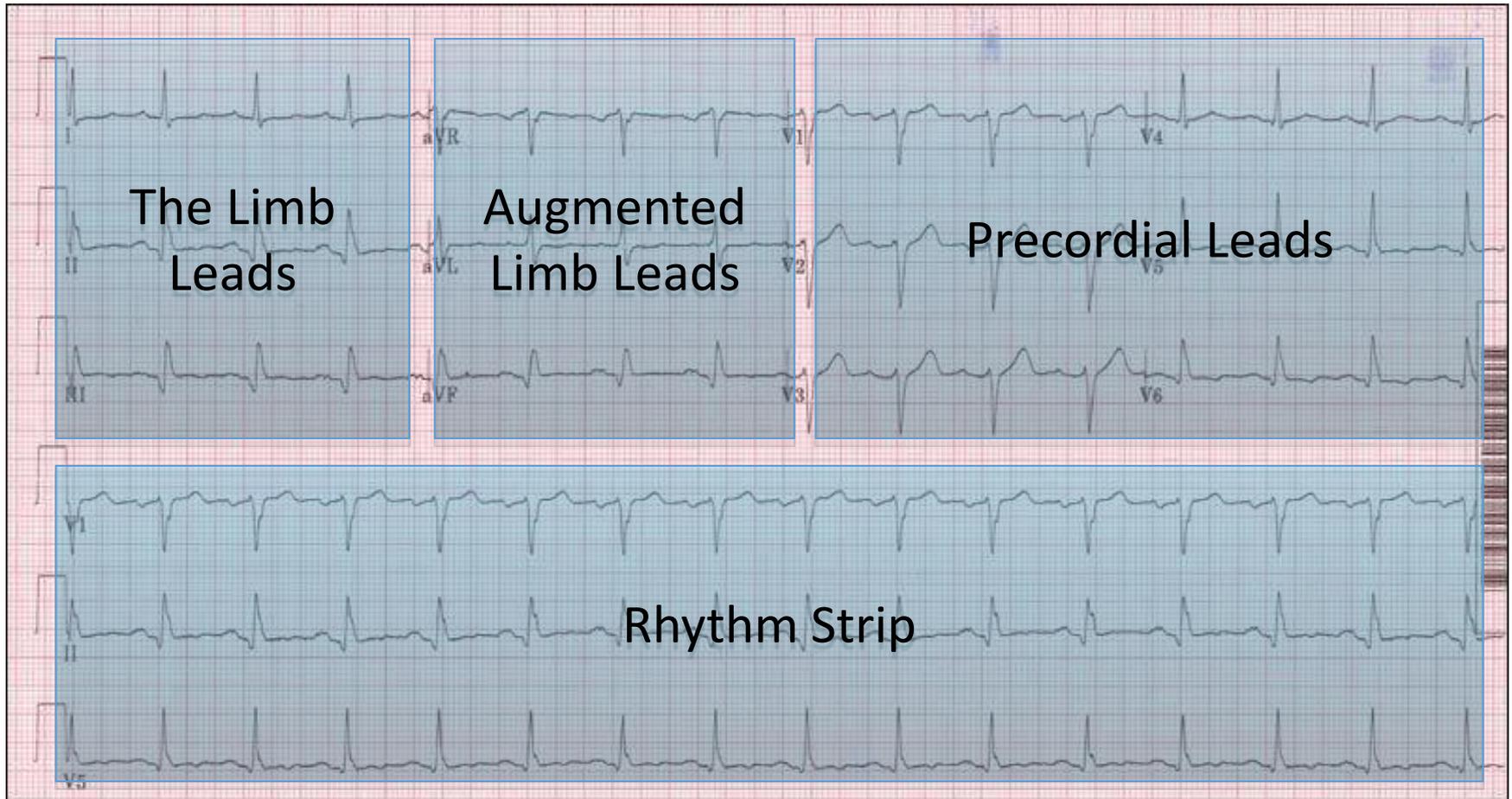


What is wrong with this patient's leads?

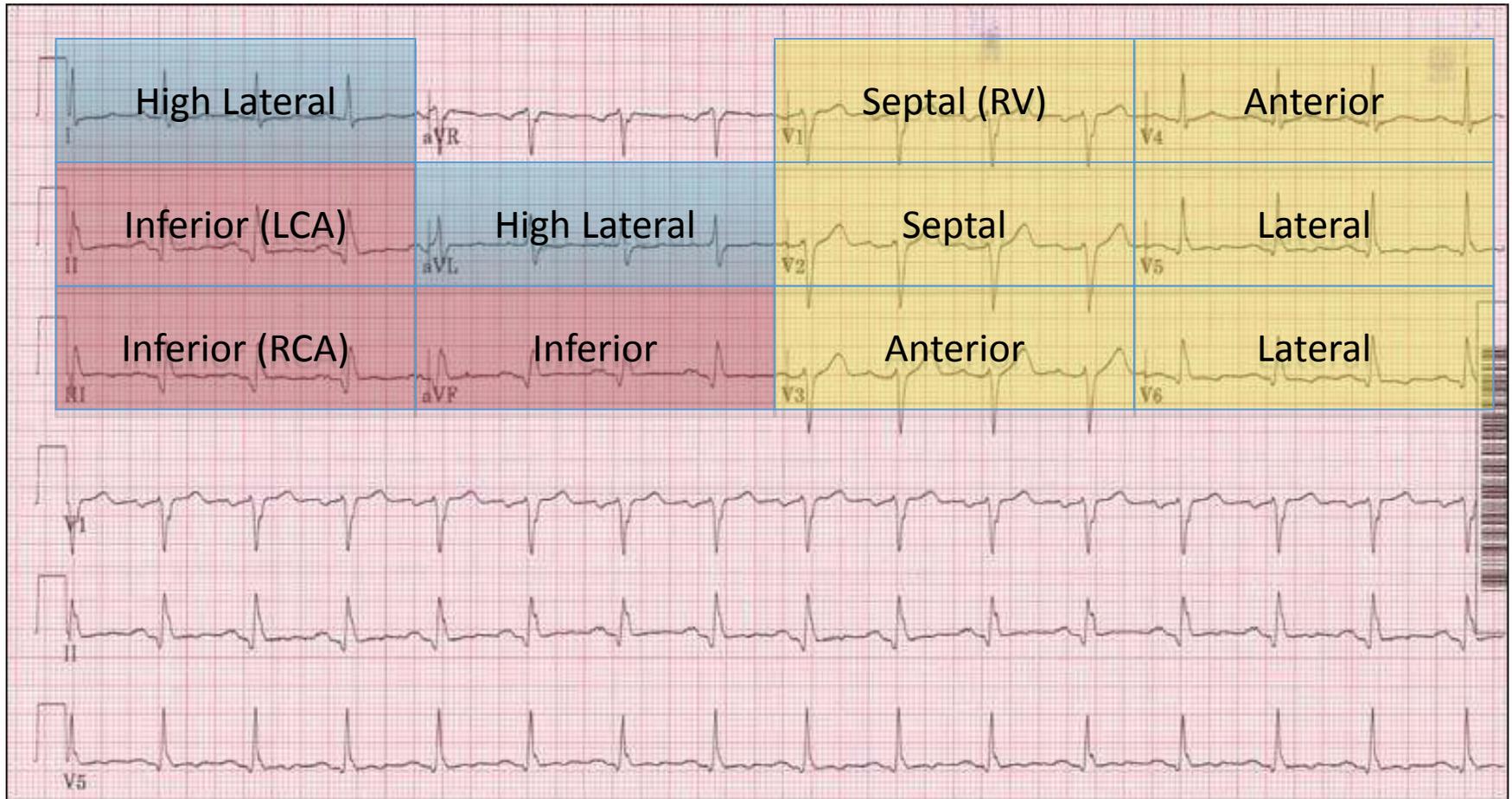


- V1 & V2 often misplaced in 2nd or 3rd intercostal spaces
- Reduction in initial R wave → poor R wave progression
 - rSr' complex with TWI

Lead Groups



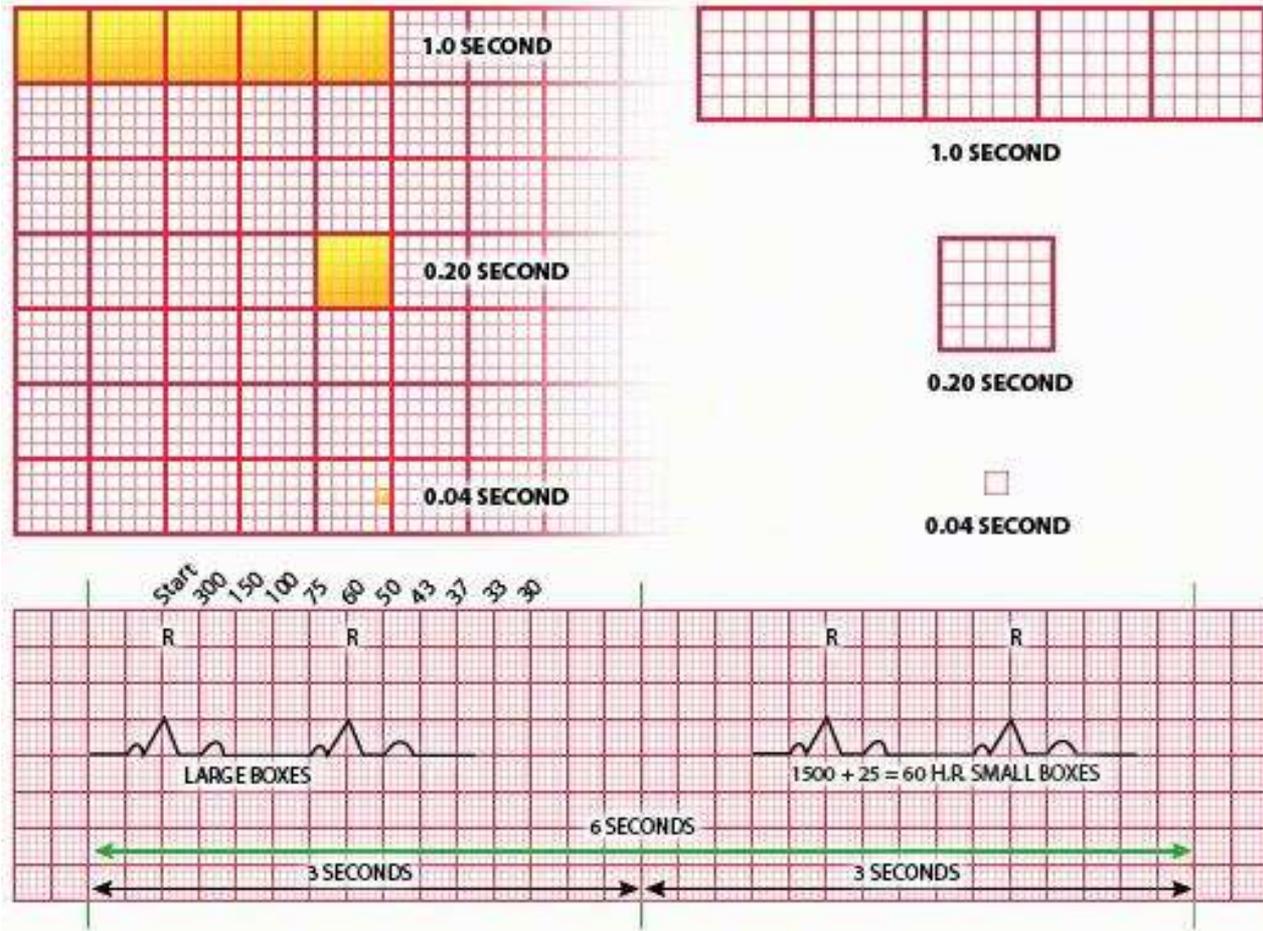
Anatomic Associations



Basic Interpretation

Scale Detail

Rate



- $HR = 300 / \# \text{ large boxes}$
 - 300, 150, 100, 75, 60, 50, 43, 37, 33
- $HR = \text{QRS Complex in 10-Second EKG Strip} * 6$

Rhythm

- Are P waves present?
- Is there a P wave before every QRS complex and a QRS complex after every P wave?

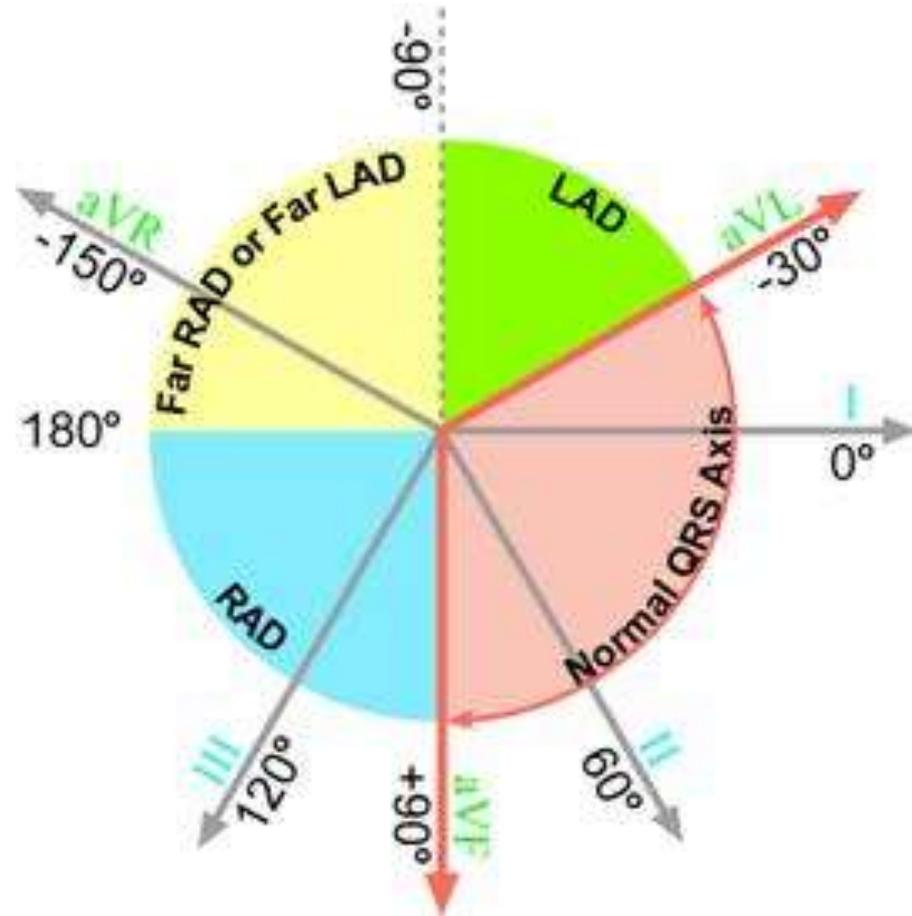
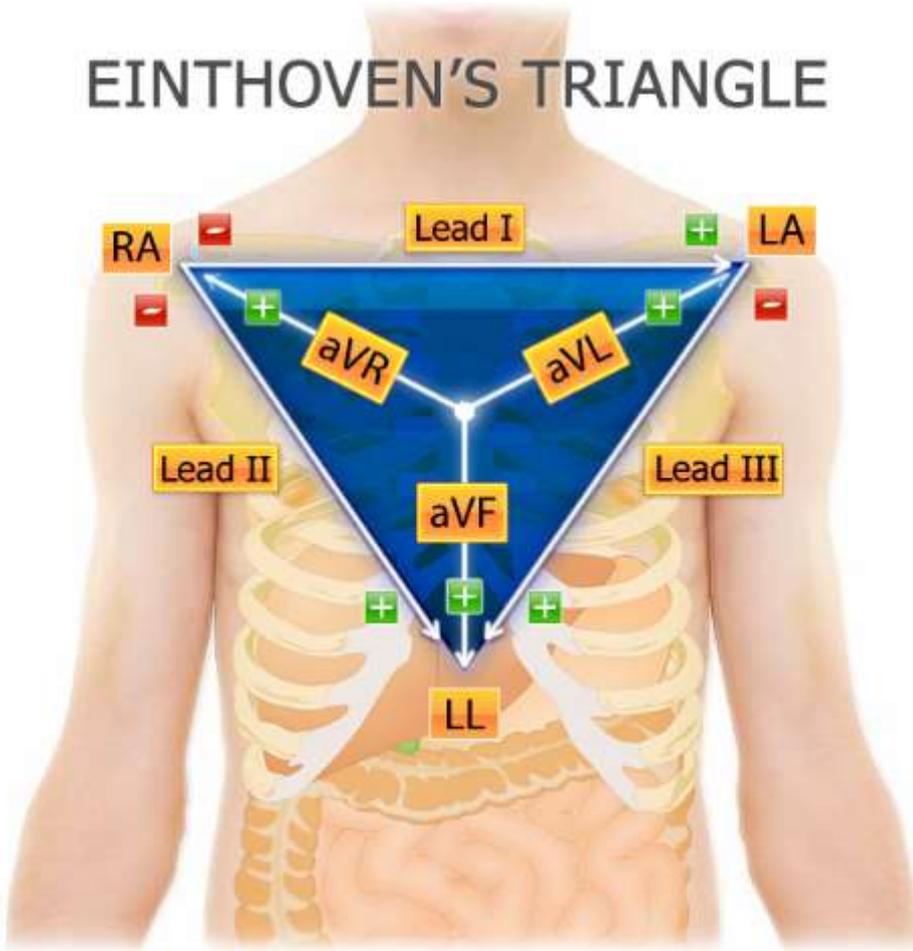


- Are the P waves and QRS complexes regular?
- Is the PR interval constant?



Axis

EINTHOVEN'S TRIANGLE



Intervals

- P wave <120 msec
 - Upright in lead II, V1
 - Usually upright in I, aVL, aVF
- PR 120 – 200 msec
 - May be displaced in opposite direction of P-wave
 - Elevation <0.5mm
 - Depression <0.8mm
- QRS <110 (120) msec
 - Shorter avg in women
- QT 350-440 (460) msec
 - <50% of RR interval

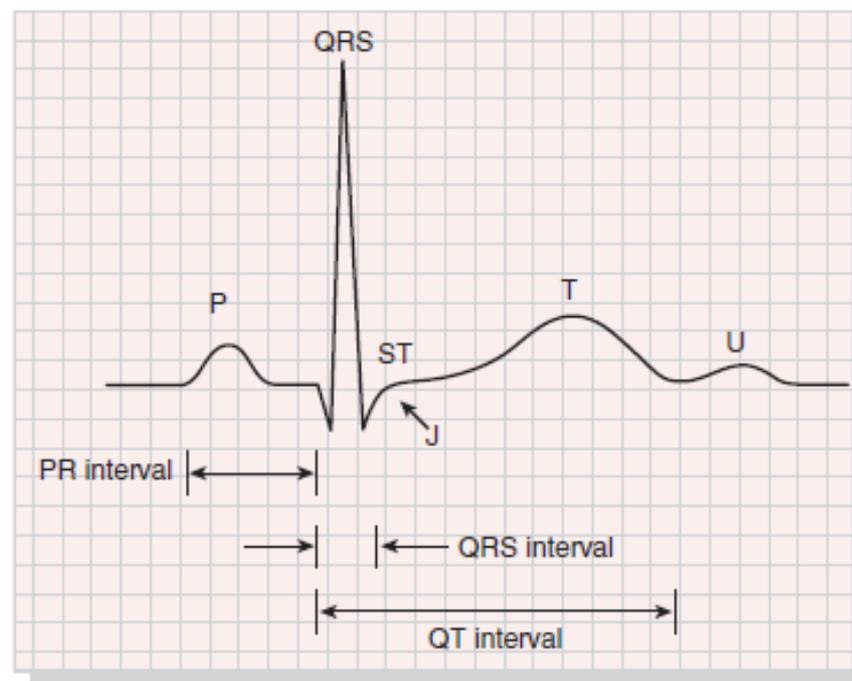


TABLE 13-4 Common Diagnostic Criteria for Left Ventricular Hypertrophy

MEASUREMENT	CRITERIA
Sokolow-Lyon voltages	$SV_1 + RV_5 > 3.5$ mV $RaVL > 1.1$ mV
Romhilt-Estes point score system*	Any limb lead R wave or S wave > 2.0 mV (3 points) or SV_1 or $SV_2 \geq 3.0$ mV (3 points) or RV_5 to $RV_6 \geq 3.0$ mV (3 points) ST-T wave abnormality, no digitalis therapy (3 points) ST-T wave abnormality, digitalis therapy (1 point) Left atrial abnormality (3 points) Left axis deviation ≥ -30 degrees (2 points) QRS duration ≥ 90 msec (1 point) Intrinsicoid deflection in V_5 or $V_6 \geq 50$ msec (1 point)
Cornell voltage criteria	$SV_3 + RaVL \geq 2.8$ mV (for men) $SV_3 + RaVL > 2.0$ mV (for women)
Cornell regression equation	Risk of LVH = $1/(1 + e^{-0.04V})$
Cornell voltage duration measurement	QRS duration \times Cornell voltage $> 2,436$ mm-sec ² QRS duration \times sum of voltages in all leads $> 1,742$ mm-sec

TABLE 13-5 Common Diagnostic Criteria for Right Ventricular Hypertrophy

R in $V_1 \geq 0.7$ mV
QR in V_1
R/S in $V_1 > 1$ with R > 0.5 mV
R/S in V_5 or $V_6 < 1$
S in V_5 or $V_6 > 0.7$ mV
R in V_5 or $V_6 \geq 0.4$ mV with S in $V_1 \leq 0.2$ mV
Right axis deviation (>90 degrees)
S_1Q_3 pattern
$S_1S_2S_3$ pattern
P pulmonale

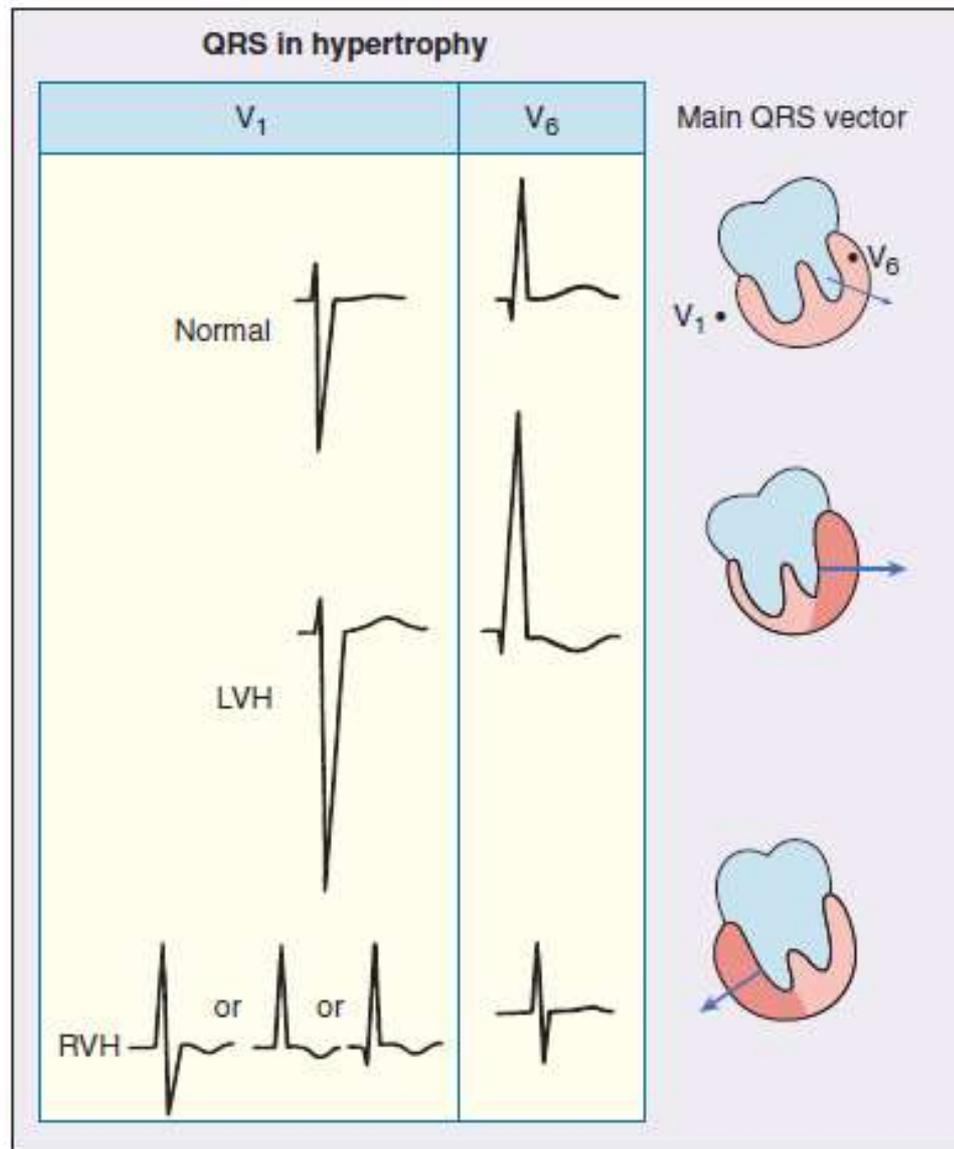
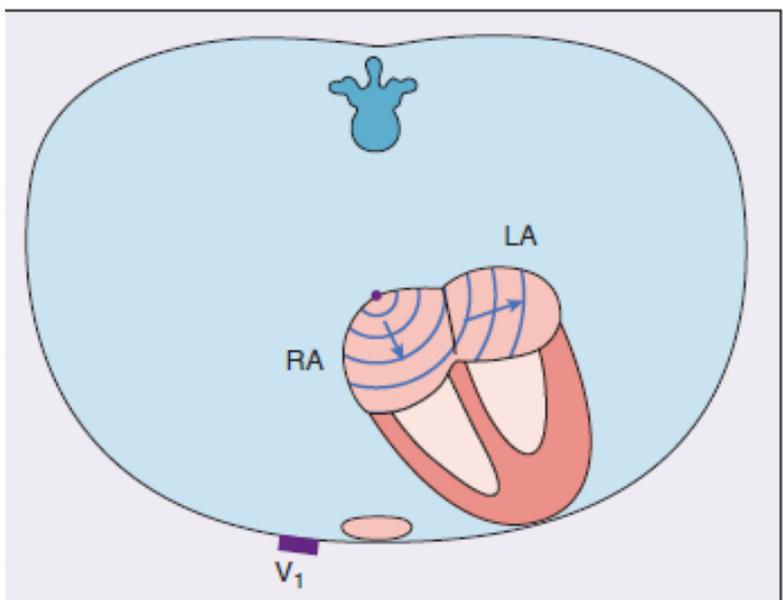


TABLE 13-3 Common Diagnostic Criteria for Left and Right Atrial Abnormalities

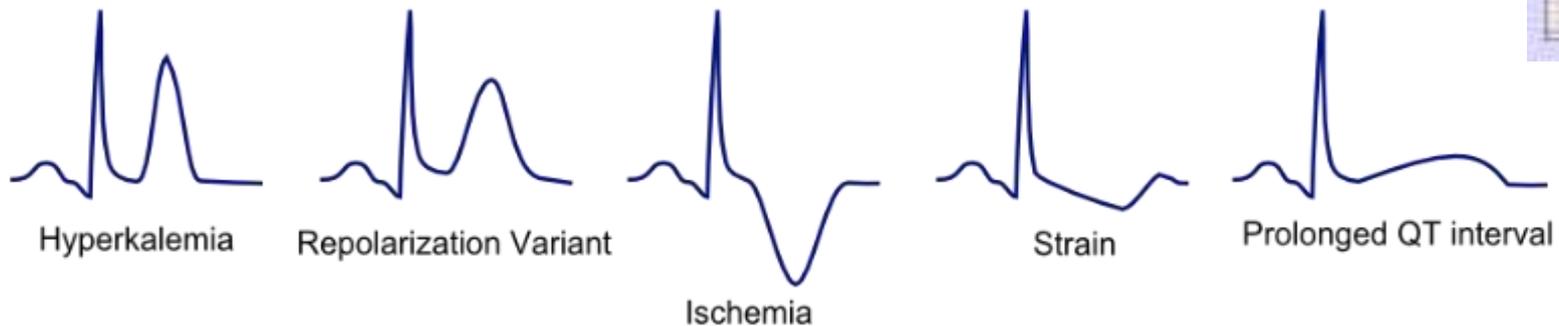
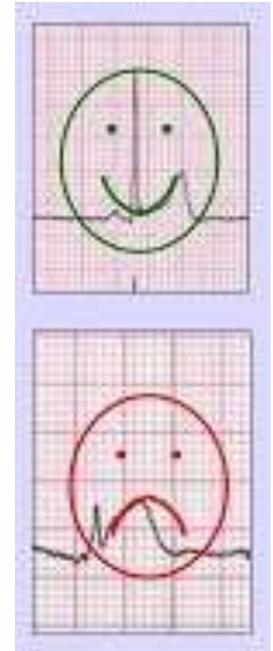
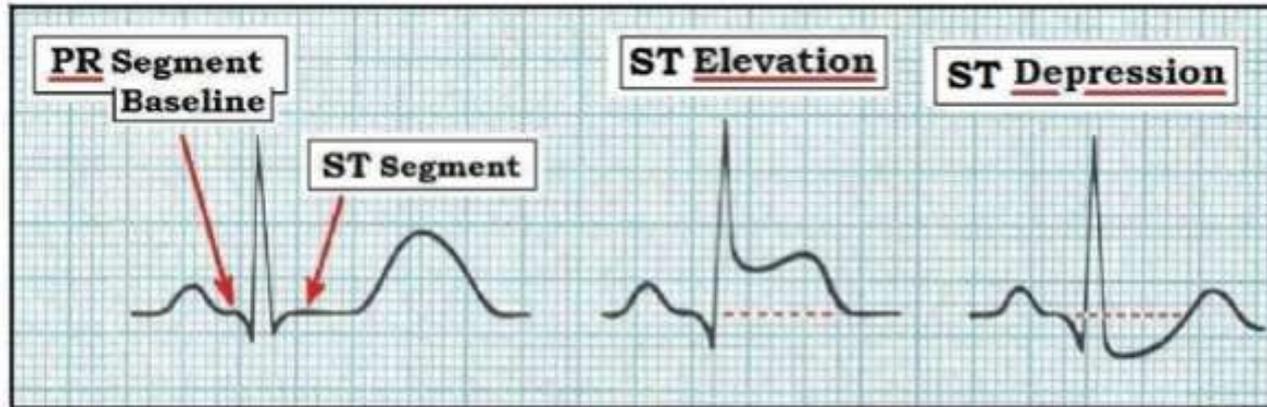
LEFT ATRIAL ABNORMALITY	RIGHT ATRIAL ABNORMALITY*
Prolonged P wave duration > 120 msec in lead II	Peaked P waves with amplitudes in lead II > 0.25 mV (P pulmonale)
Prominent notching of P wave, usually most obvious in lead II, with interval between notches of 0.40 msec (P mitrale)	Prominent initial positivity in lead V ₁ or V ₂ > 0.15 mV
Ratio between the duration of the P wave in lead II and duration of the PR segment > 1.6	Increased area under initial positive portion of the P wave in lead V ₁ to > 0.06 mm-sec
Increased duration and depth of terminal-negative portion of P wave in lead V ₁ (P terminal force) so that area subtended by it > 0.04 mm-sec	Rightward shift of mean P wave axis to more than +75 degrees
Leftward shift of mean P wave axis to between -30 and -45 degrees	



	Normal	Right	Left
II			
V ₁			

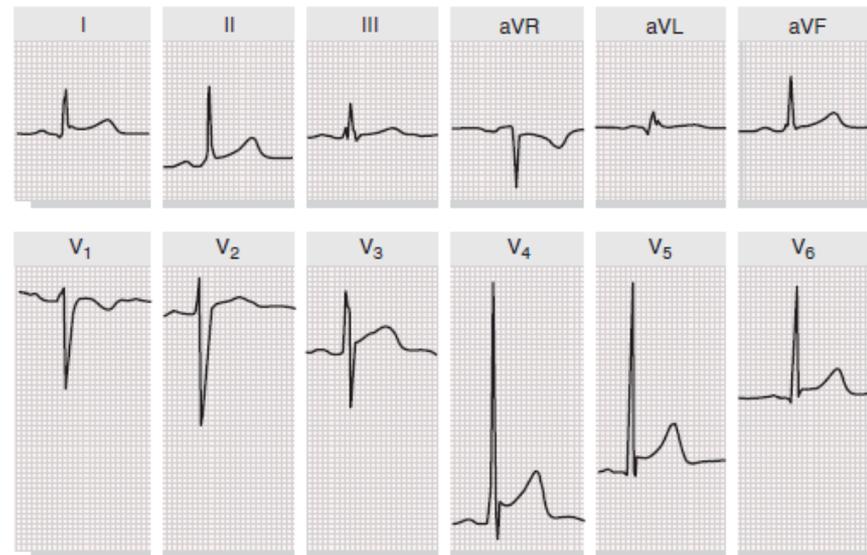
Morphology

ST segment & T wave



ST Segment

- Can vary from 0.5mm below to 1mm above in limb leads & up to 3mm in precordial leads in early repol
- Nonspecific ST segment = slight (<1mm) depression or elevation
- Can be elevated in normal (men, African Americans)
 - Typically highest in lead V2



PRACTICE GUIDELINE

2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction

A Report of the American College of Cardiology Foundation/
American Heart Association Task Force on Practice Guidelines

*Developed in Collaboration With the American College of Emergency Physicians and
Society for Cardiovascular Angiography and Interventions*

- New ST elevation at the J point in at least 2 contiguous leads of ≥ 2 mm in men or ≥ 1.5 mm in women in leads V2-V3 and/or ≥ 1 mm in other contiguous precordial or limb leads
 - In the absence of LVH or LBBB

AHA/ACCF/HRS Recommendations for the Standardization and Interpretation of the Electrocardiogram

Part VI: Acute Ischemia/Infarction

A Scientific Statement From the American Heart Association
Committee, Council on Clinical Cardiology, the American College of Cardiology
and the Heart Rhythm Society

Endorsed by the International Society for Computerized Electrocardiography

Galen S. Wagner, MD; Peter Macfarlane, DSc; Heir
Mark Josephson, MD, FACC, FHRS; Anton Gorgel
Olle Pahlm, MD, PhD; Borys Surawicz, MD, FAHA, FACC
Rory Childers, MD; Leonard S. Gettes, MD

Recommendations

1. For men 40 years of age and older, the threshold value for abnormal J-point elevation should be 0.2 mV (2 mm) in leads V₂ and V₃ and 0.1 mV (1 mm) in all other leads.
2. For men less than 40 years of age, the threshold values for abnormal J-point elevation in leads V₂ and V₃ should be 0.25 mV (2.5 mm).
3. For women, the threshold value for abnormal J-point elevation should be 0.15 mV (1.5 mm) in leads V₂ and V₃ and greater than 0.1 mV (1 mm) in all other leads.
4. For men and women, the threshold for abnormal J-point elevation in V_{3R} and V_{4R} should be 0.05 mV (0.5 mm), except for males less than 30 years of age, for whom 0.1 mV (1 mm) is more appropriate.
5. For men and women, the threshold value for abnormal J-point elevation in V₇ through V₉ should be 0.05 mV (0.5 mm).
6. For men and women of all ages, the threshold value for abnormal J-point depression should be -0.05 mV (-0.5 mm) in leads V₂ and V₃ and -0.1 mV (-1 mm) in all other leads.

Blocks

AV Nodal Blocks

- 1st Degree AVB:
 - Prolonged PR interval. Benign.
- 2nd Degree AVB
 - [Type I \(Wenckebach's\)](#): progressive prolongation of the PR interval before the missed QRS complex
 - [Type II \(Mobitz II\)](#): absence of progressive prolongation of the PR interval before the missed QRS complex.
 - [High grade AV block](#): 2nd degree AV block with a high P:QRS ratio, producing a very slow ventricular rate.
- 3rd Degree AVB / Complete Heart Block:
 - P-waves and QRS complexes completely out of sync without conduction

TABLE 13-7 Common Diagnostic Criteria for Bundle Branch Blocks

Complete Left Bundle Branch Block

- QRS duration ≥ 120 msec
- Broad, notched, or slurred R waves in leads I, aVL, V₅ and V₆
- Small or absent initial r waves in right precordial leads (V₁ and V₂) followed by deep S waves
- Absent septal q waves in leads I, V₅, and V₆
- Prolonged time to peak R wave (>60 msec) in V₅ and V₆

Complete Right Bundle Branch Block

- QRS duration ≥ 120 msec
- rsr', rsR', or rSR' patterns in leads V₁ and V₂
- S waves in leads I and V₆ ≥ 40 msec wide
- Normal time to peak R wave in leads V₅ and V₆ but >50 msec in V₁

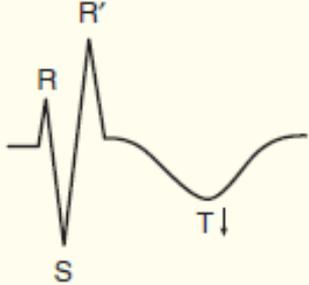
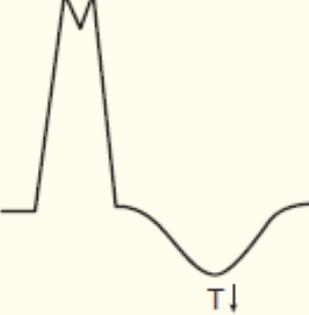
	V ₁	V ₆
Normal		
RBBB		
LBBB		

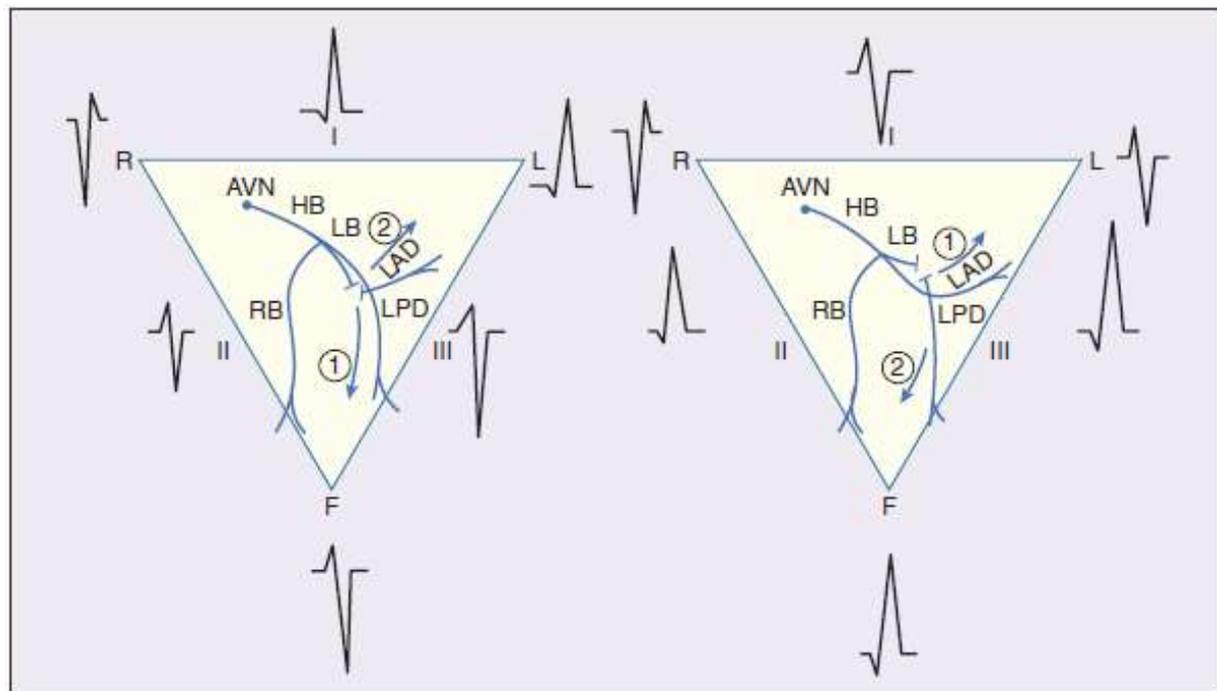
TABLE 13-6 Common Diagnostic Criteria for Unifascicular Blocks

Left Anterior Fascicular Block

Frontal plane mean QRS axis = -45 to -90 degrees
qR pattern in lead aVL
QRS duration < 120 msec
Time to peak R wave in aVL ≥ 45 msec

Left Posterior Fascicular Block

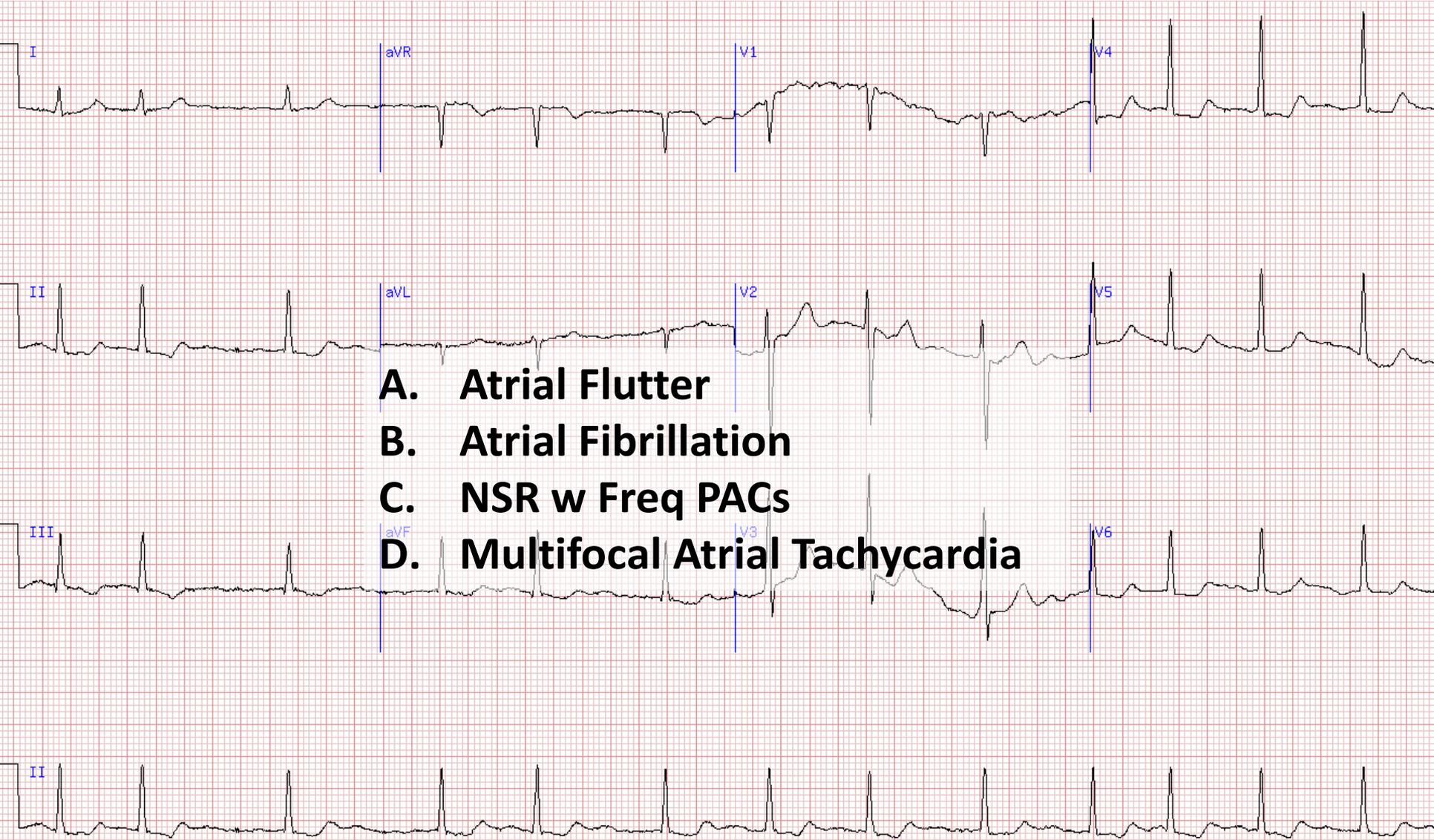
Frontal plane mean QRS axis = $+90$ to $+180$ degrees
rS pattern in leads I and aVL with qR patterns in leads III and aVF
QRS duration < 120 msec
Exclusion of other factors causing right axis deviation (e.g., right ventricular overload patterns, lateral infarction)



Cases

Case #174 *

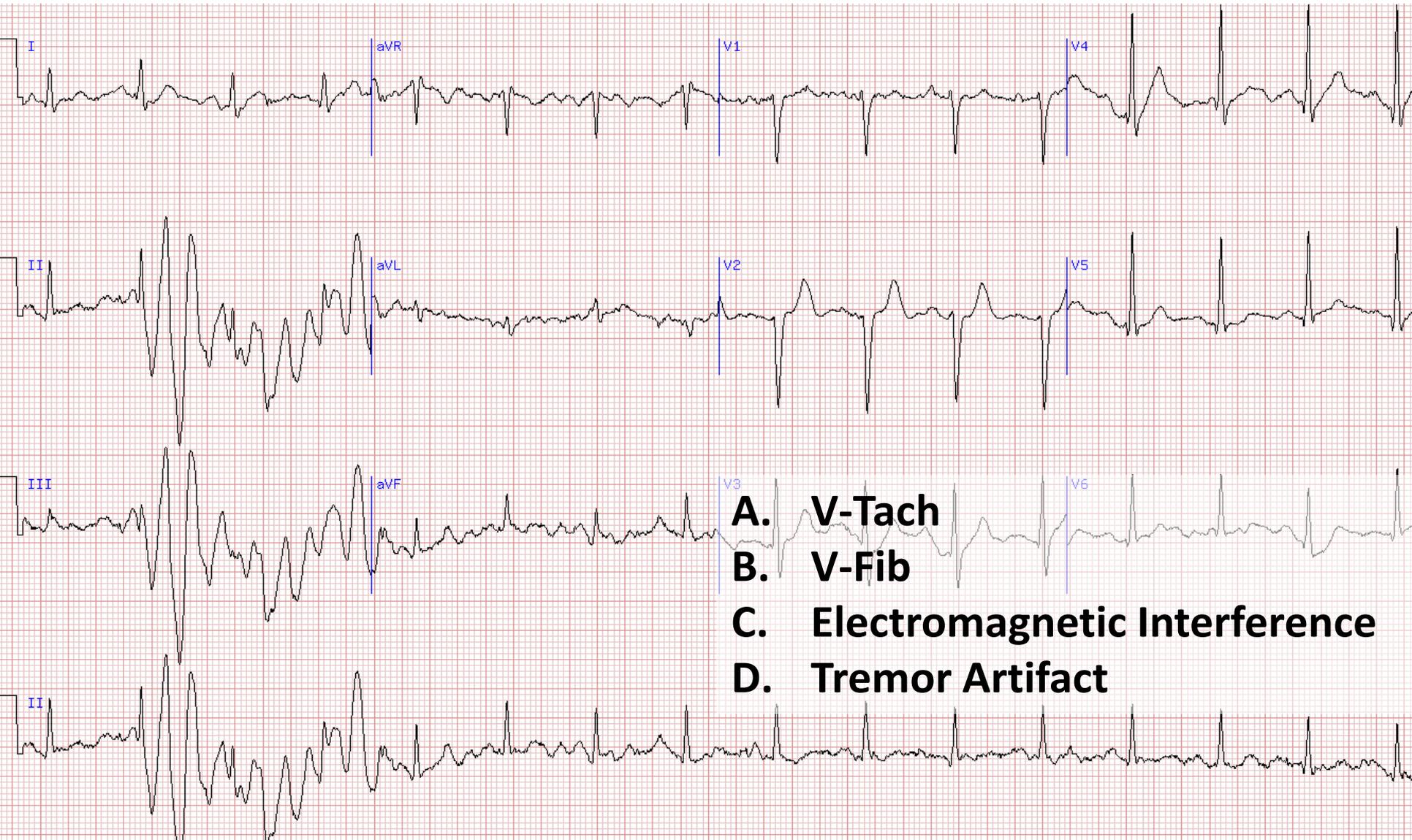
19 y/o male w palpitations. What is the rhythm?



- A. Atrial Flutter
- B. Atrial Fibrillation
- C. NSR w Freq PACs
- D. Multifocal Atrial Tachycardia

Case #45 **

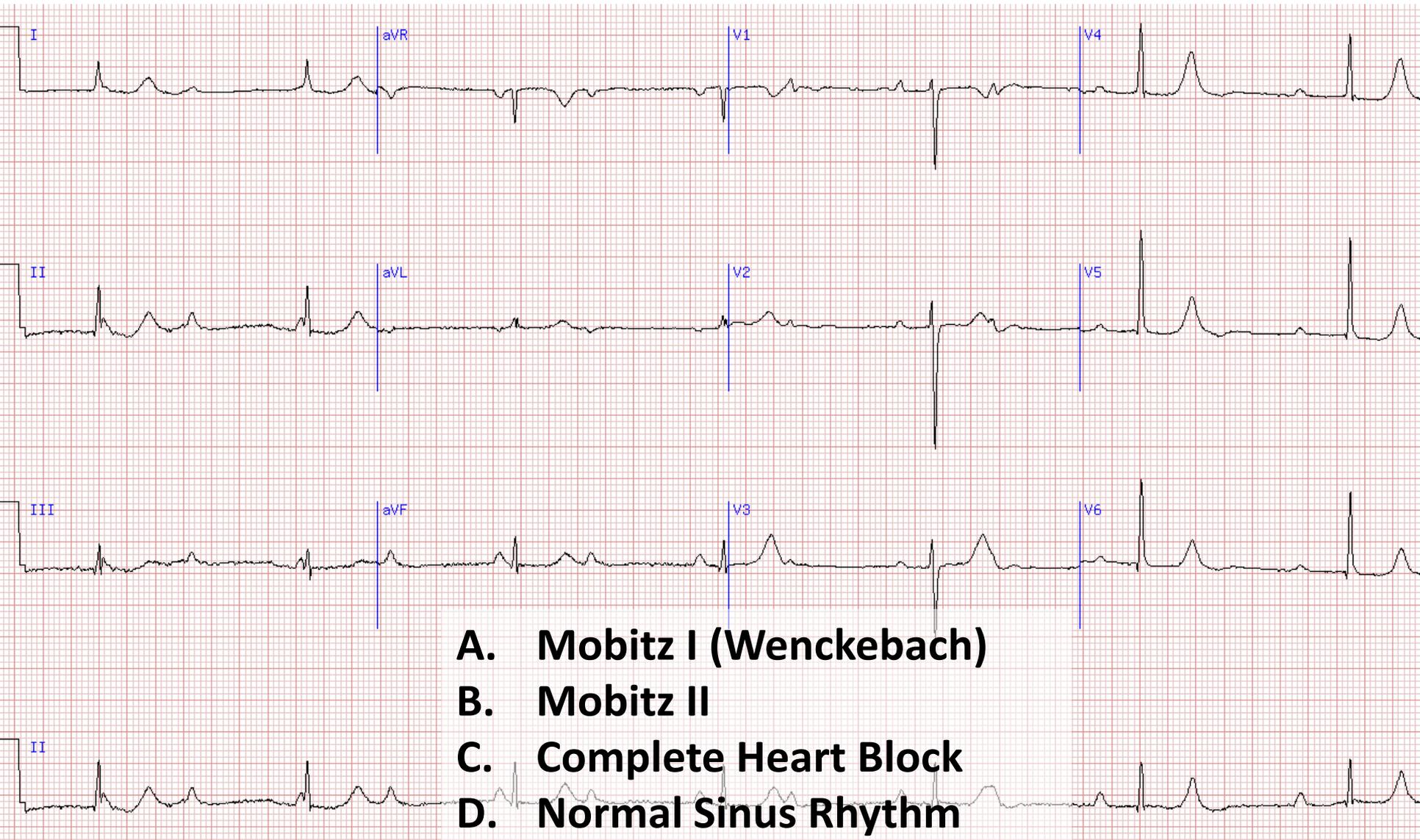
What does this tracing show?



- A. V-Tach**
- B. V-Fib**
- C. Electromagnetic Interference**
- D. Tremor Artifact**

Case #21 *

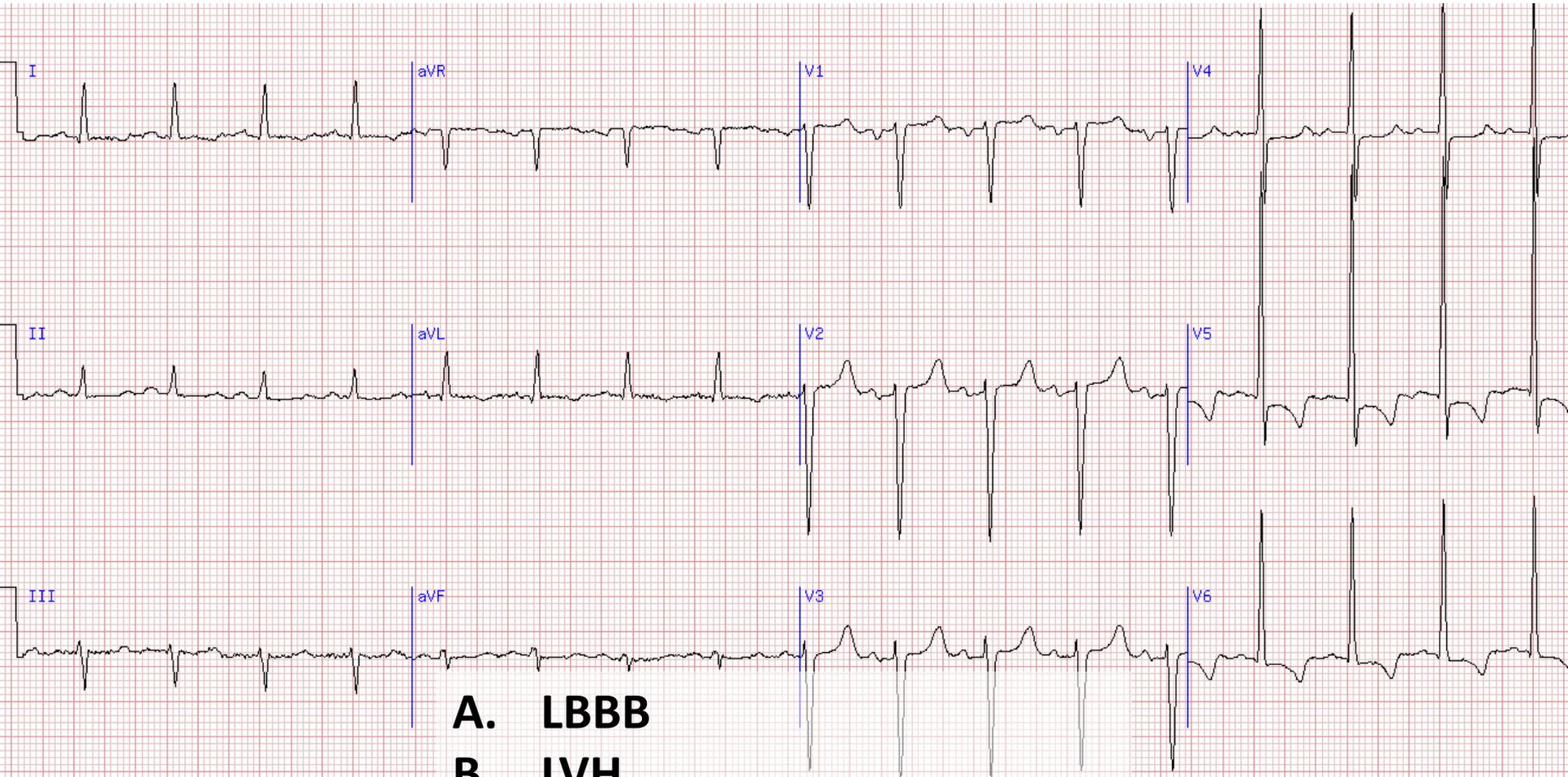
Asymptomatic female. What is the rhythm?



- A. Mobitz I (Wenckebach)
- B. Mobitz II
- C. Complete Heart Block
- D. Normal Sinus Rhythm

Case #240 *

35 y/o smoker, asymptomatic. What is the diagnosis?

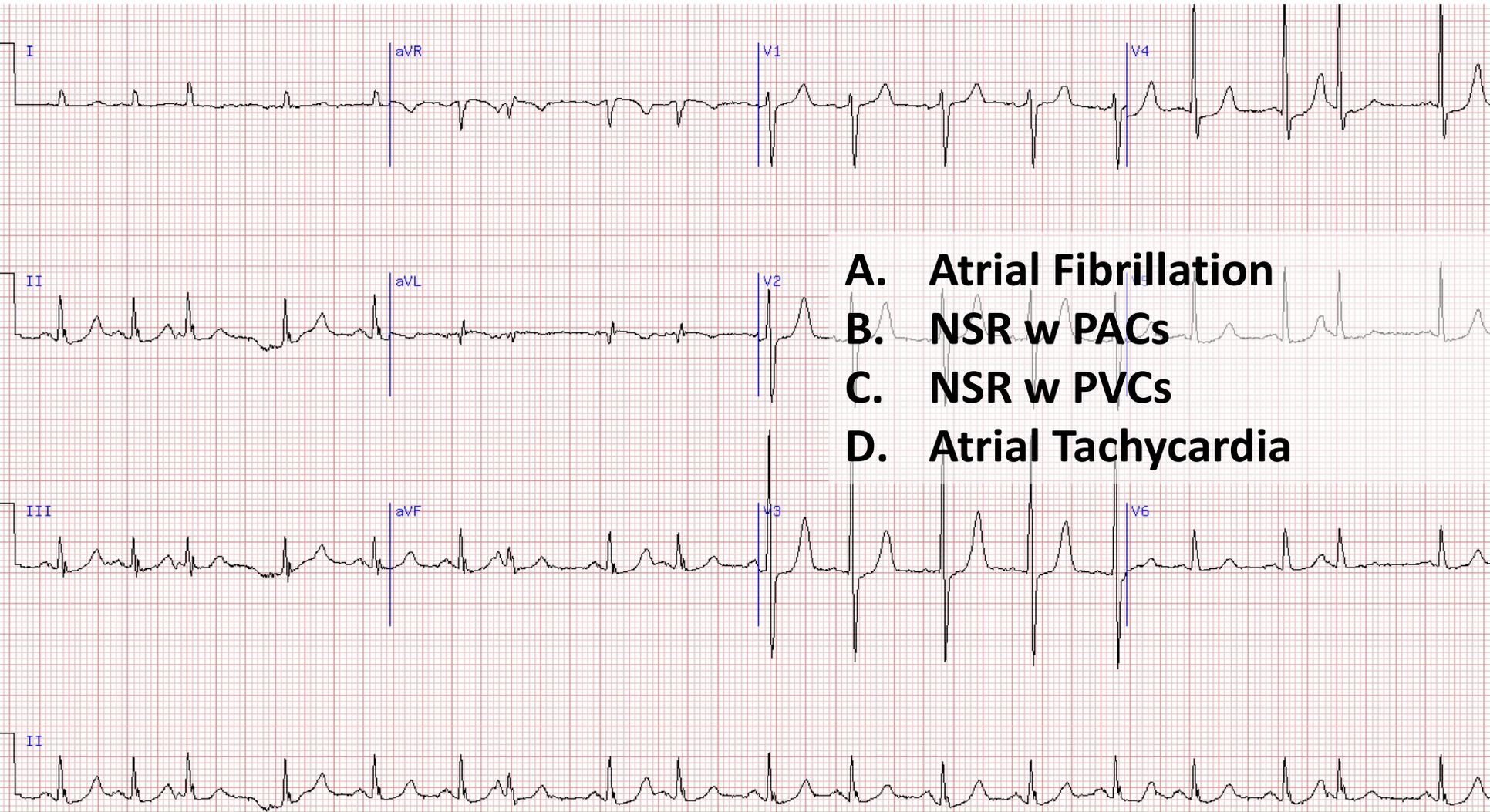


- A. LBBB
- B. LVH
- C. NSR with Lateral Ischemia



Case #227 **

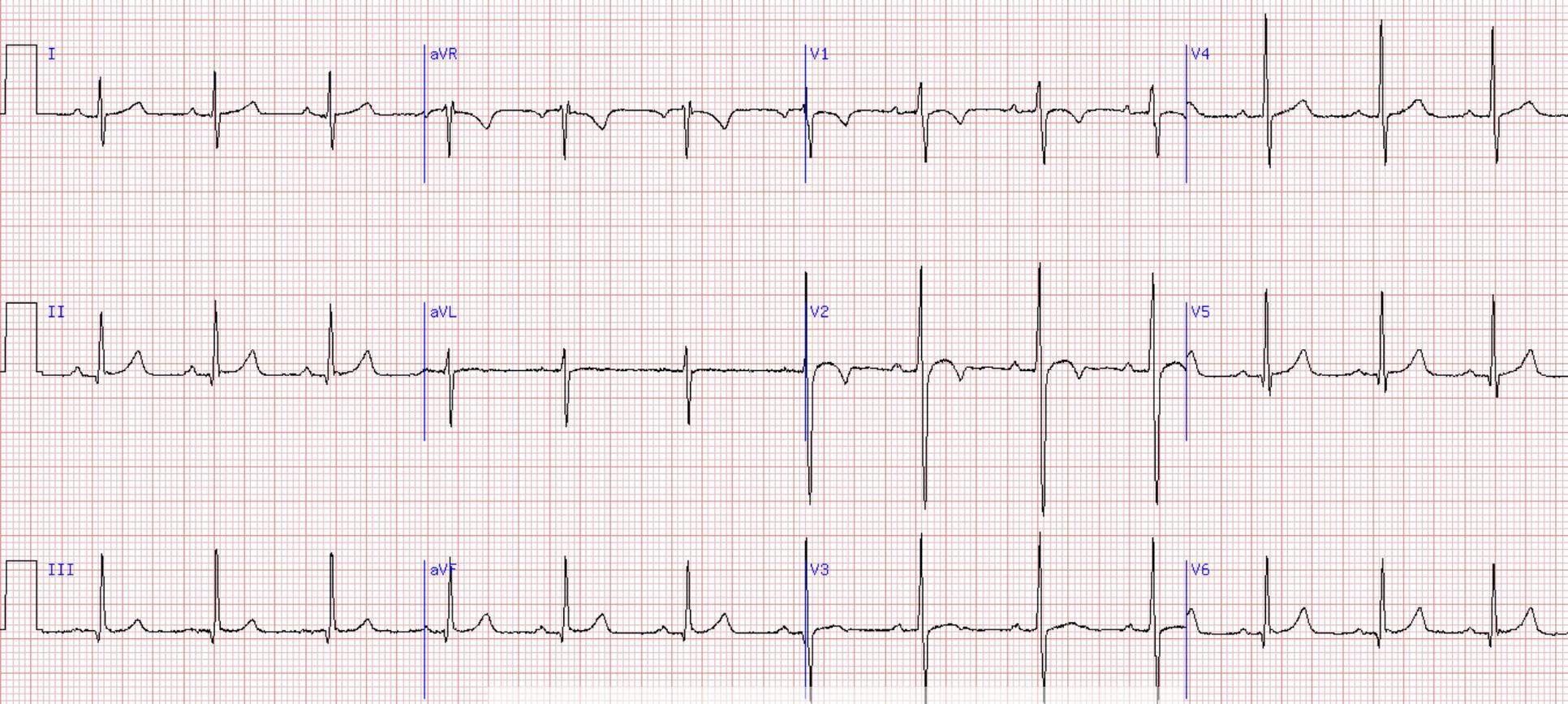
19 y/o with palpitations. What is the diagnosis?



- A. Atrial Fibrillation**
- B. NSR w PACs**
- C. NSR w PVCs**
- D. Atrial Tachycardia**

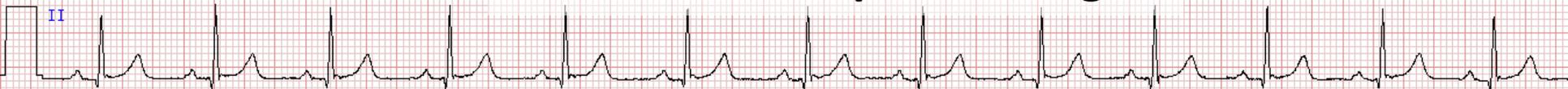
Case #107 ***

Pt w chest pain. What is the first question to ask?



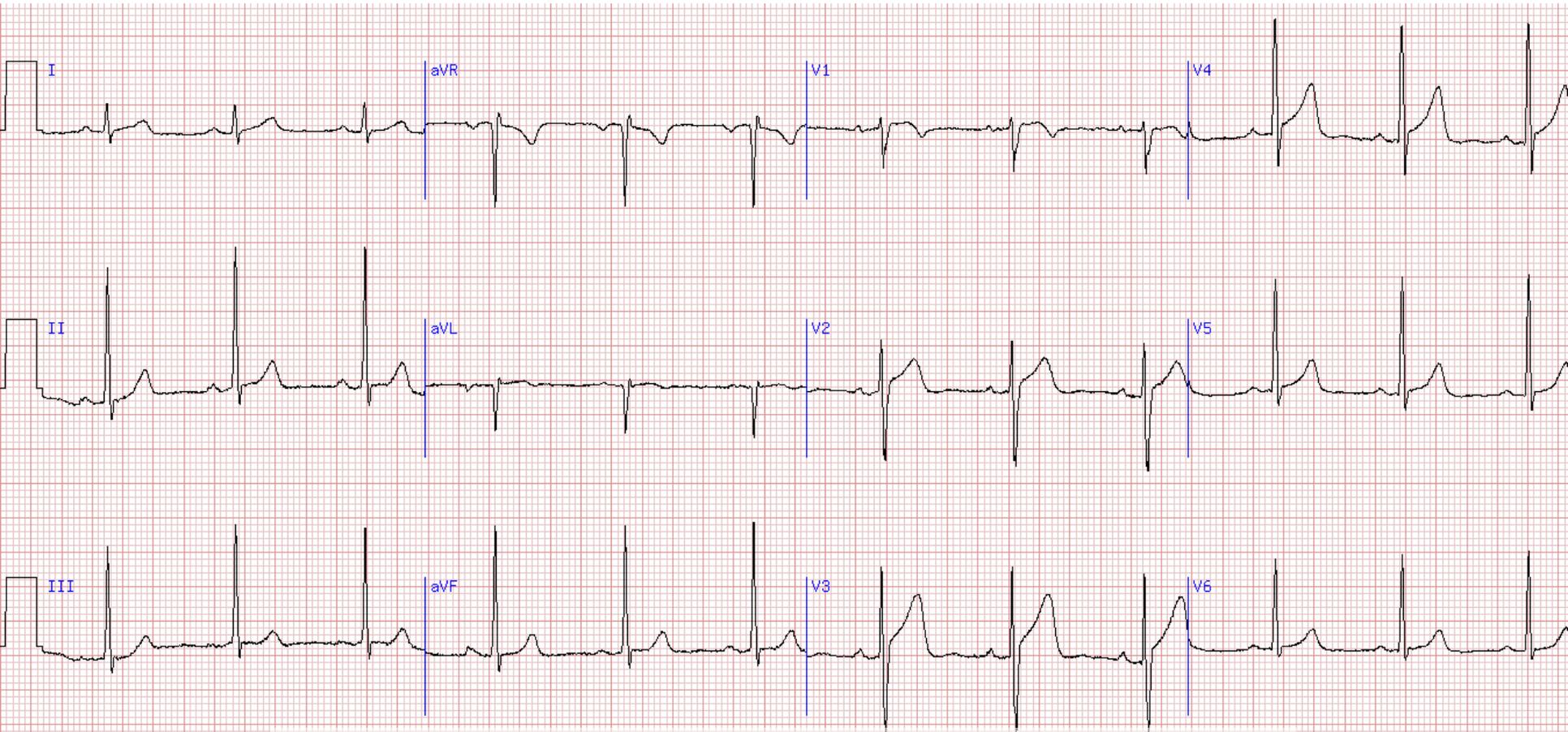
A. Male or female?

B. What is the patient's age?



Case #313 **

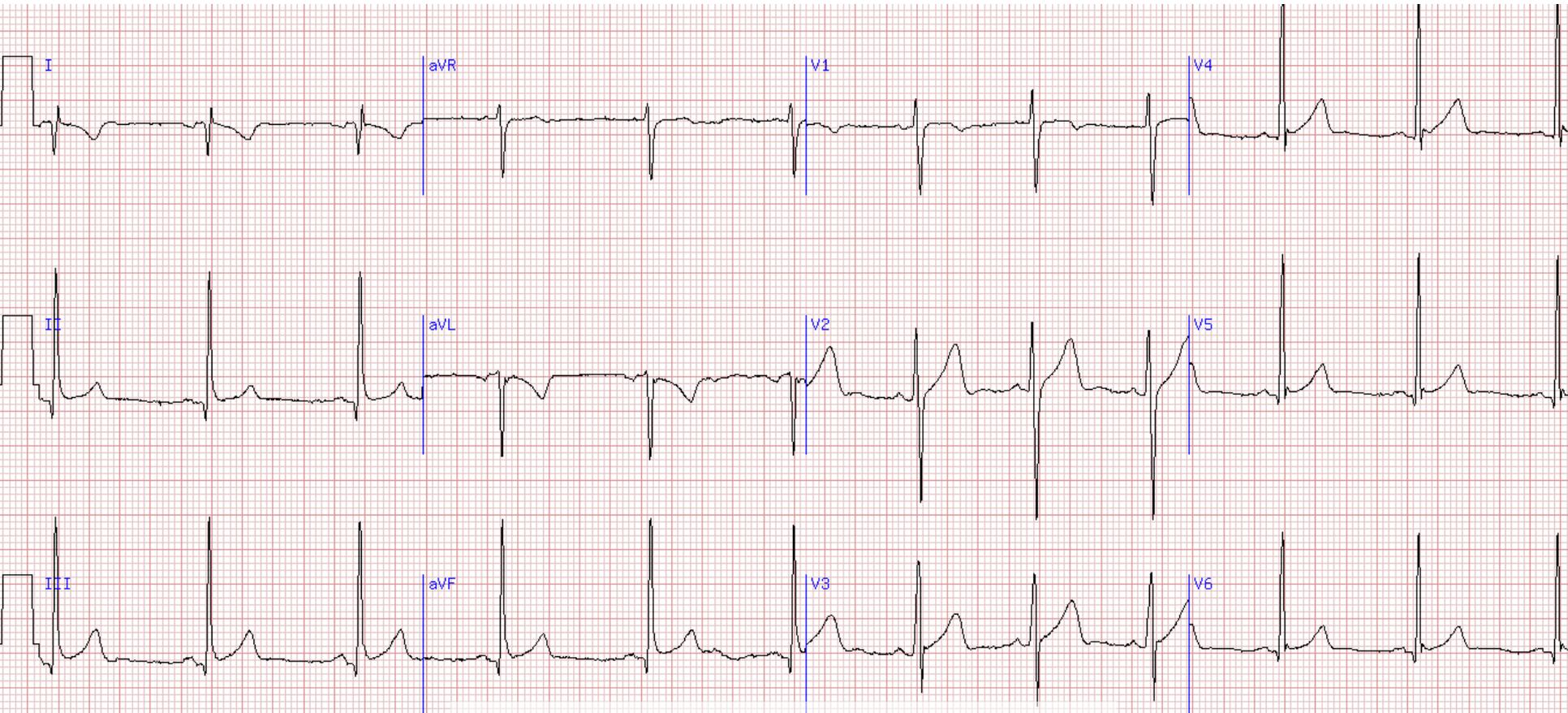
40 y/o man w/ chest pain. Diagnosis?



- A. STEMI
- B. Acute Pericarditis
- C. Normal Variant Early Repolarization
- D. Pulmonary Embolus (Acute RV Overload)

Case #2 **

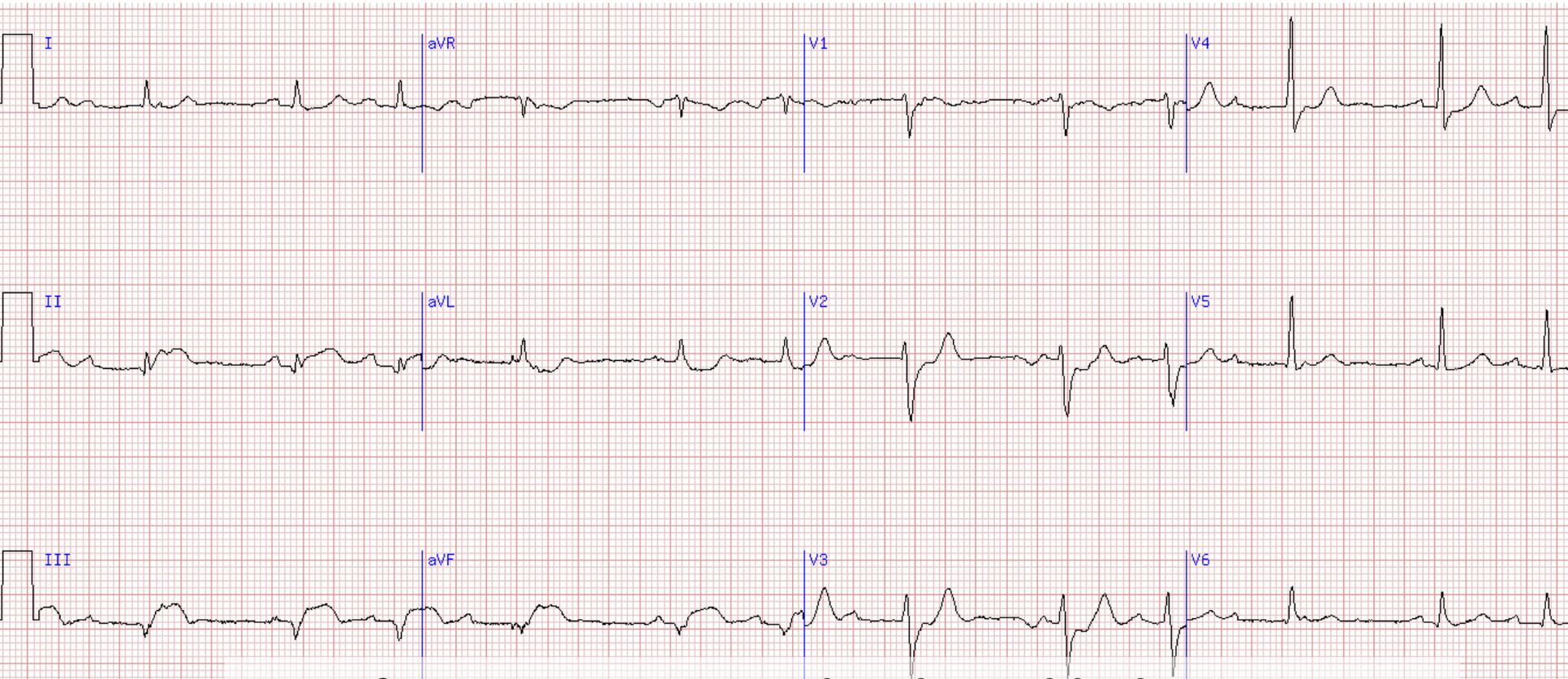
18 y/o asymptomatic male. What does this ECG show?



- A. Limb lead reversal**
- B. Ectopic atrial rhythm**
- C. Dextrocardia**
- D. Multifocal atrial rhythm**

Case #16 **

42 y/o female with chest pain. Diagnosis?

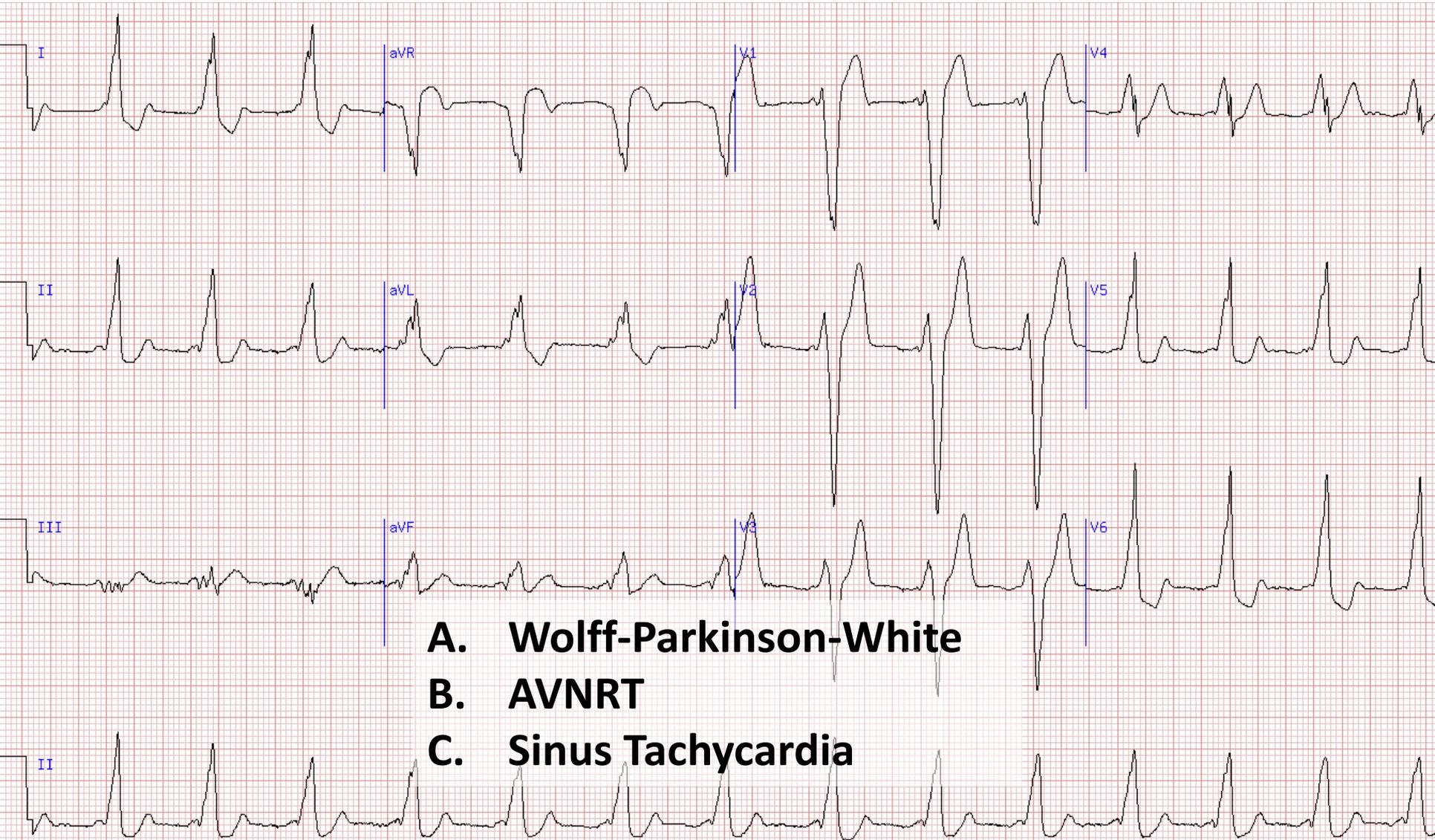


- A. Inferior STEMI w complete heart block**
- B. Non-specific ST changes w 2nd Degree AVB Type 1**
- C. Inferior STEMI w 2nd Degree AVB Type 1**



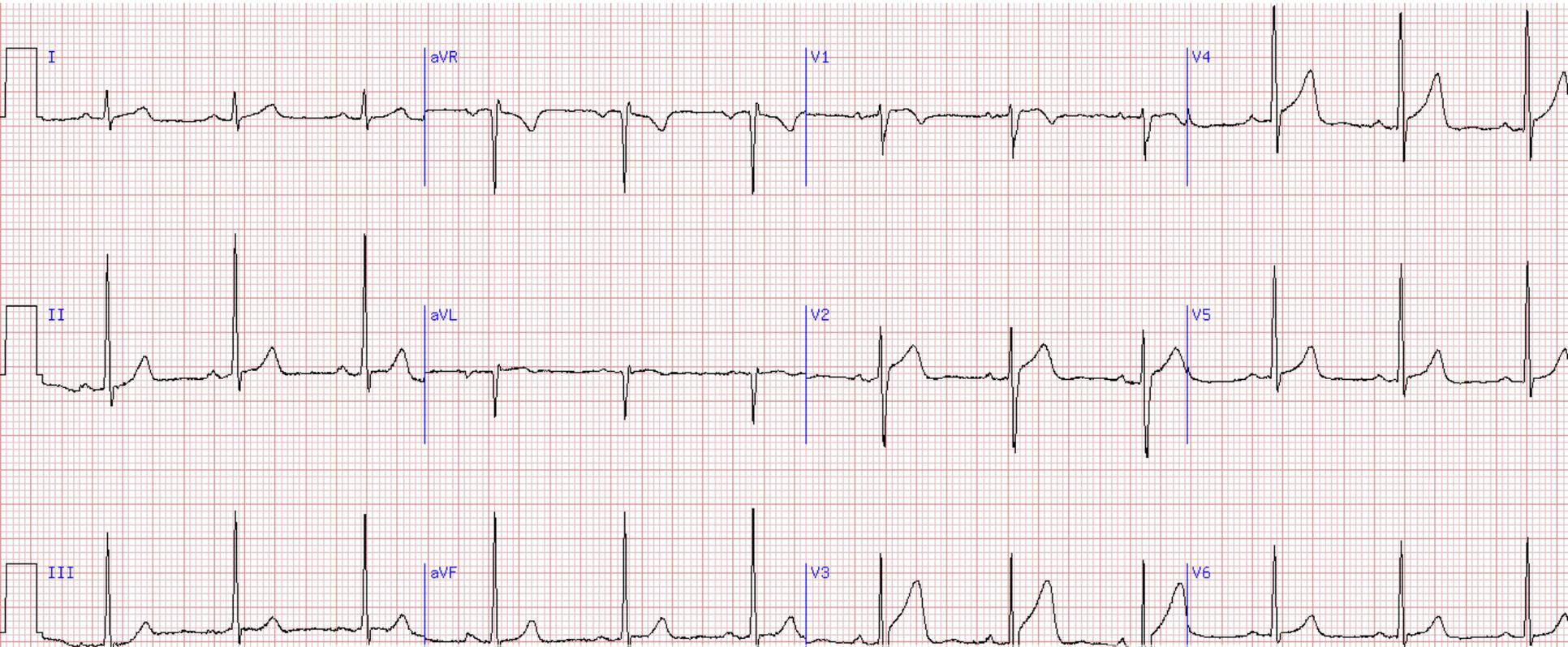
Case #97 **

23 year-old female with palpitations. Dx?

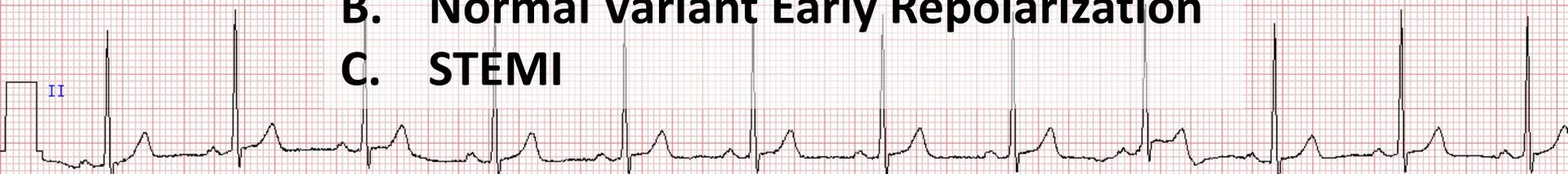


Case #313 **

38 year-old male with chest pain. Diagnosis?

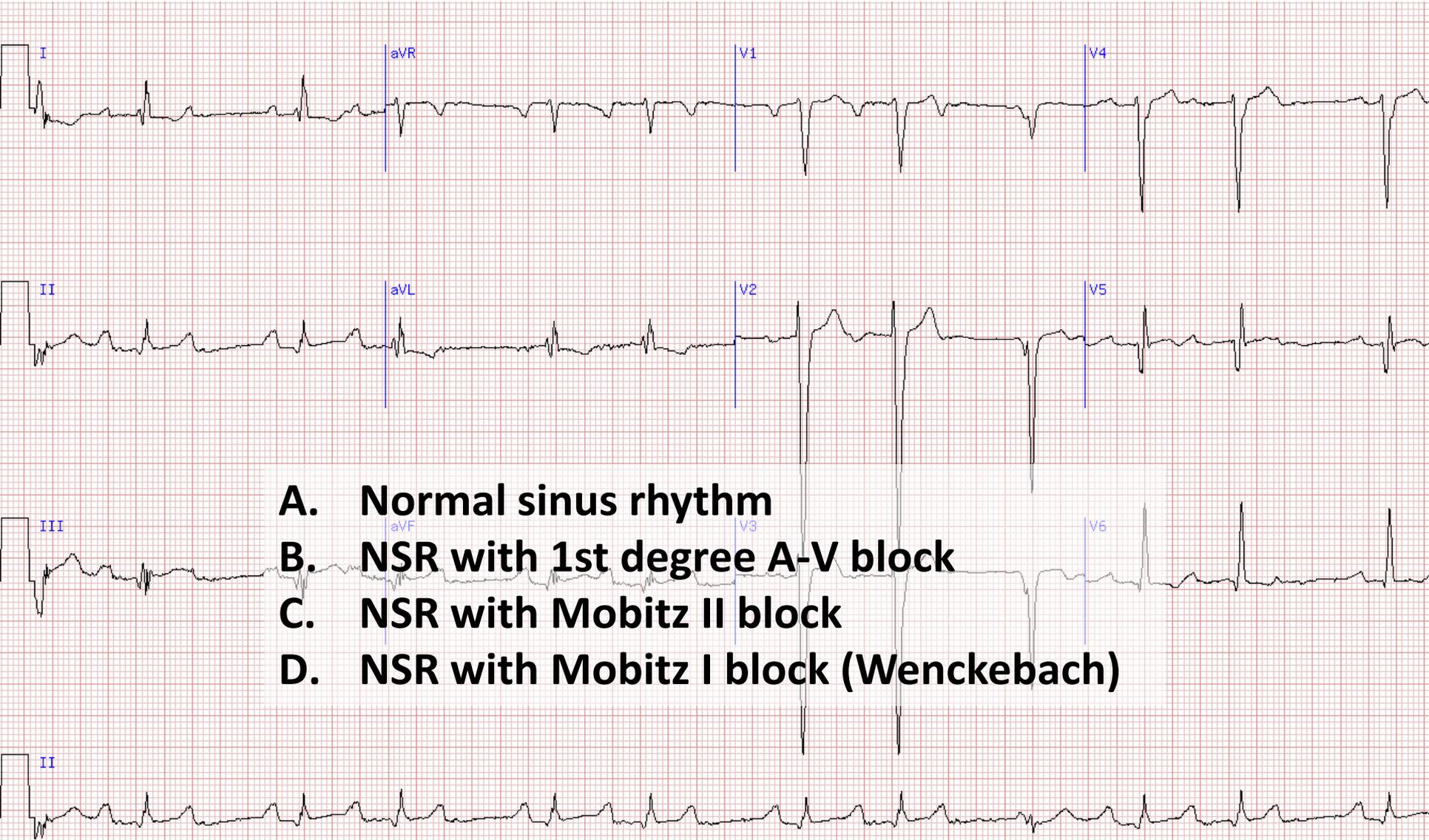


- A. Acute Pericarditis**
- B. Normal Variant Early Repolarization**
- C. STEMI**



Case #244 ***

What is the conduction pattern?

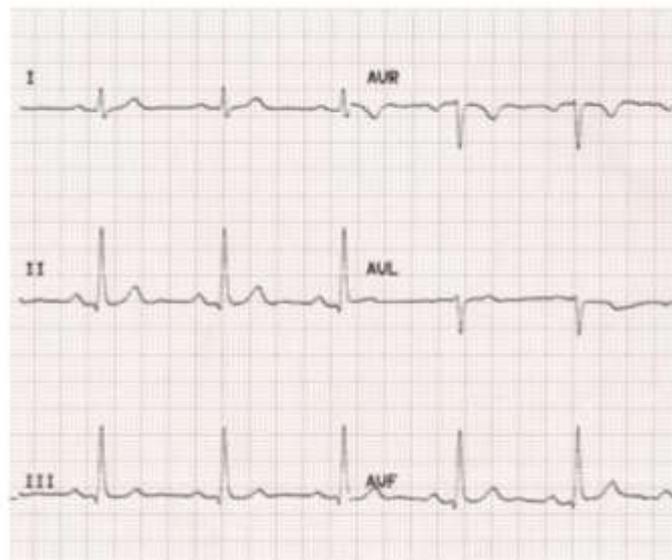
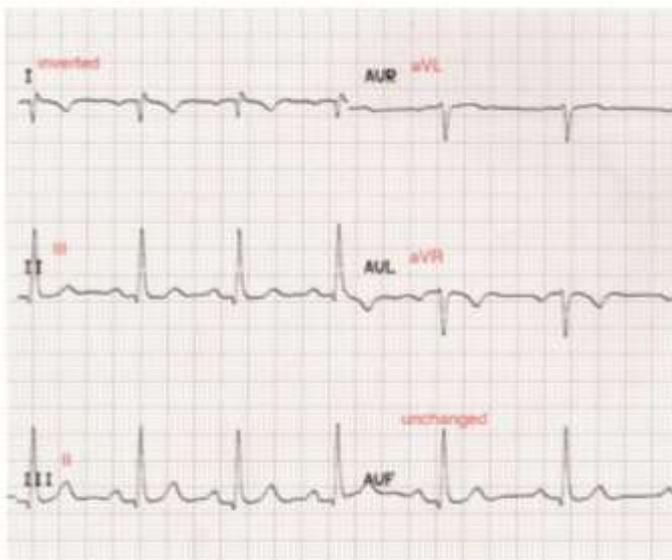


- A. Normal sinus rhythm
- B. NSR with 1st degree A-V block
- C. NSR with Mobitz II block
- D. NSR with Mobitz I block (Wenckebach)

Other Stuff

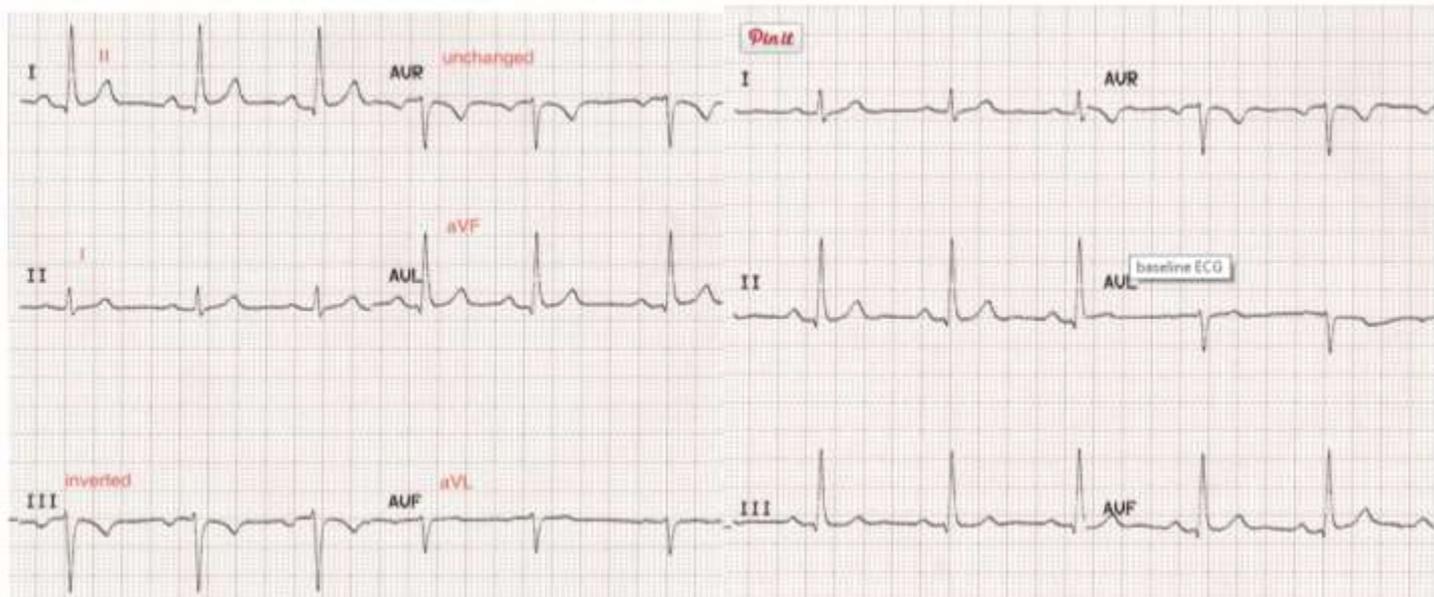
LA/RA Reversal

- Lead I becomes inverted
- Leads II and III switch places
- Lead aVF unchanged
- Leads aVL and aVR switch places
 - aVR becomes positive
- May be marked RAD



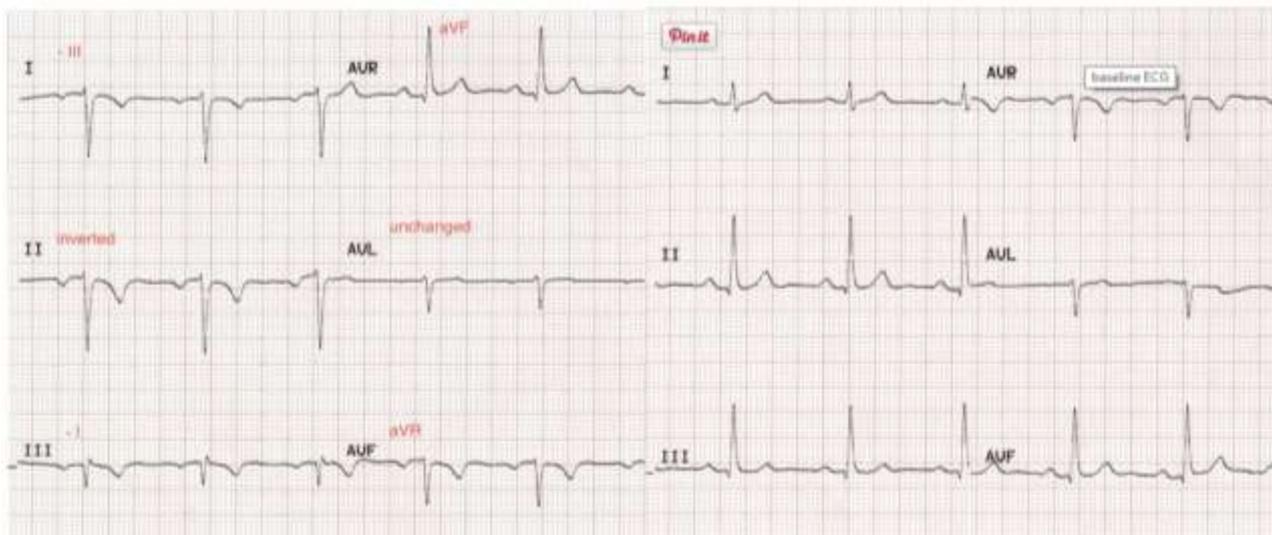
LA/LL Reversal

- Lead III becomes inverted
- Leads I and II switch places
- P wave larger in lead I
- Leads aVL and aVF switch places
- Lead aVR remains unchanged

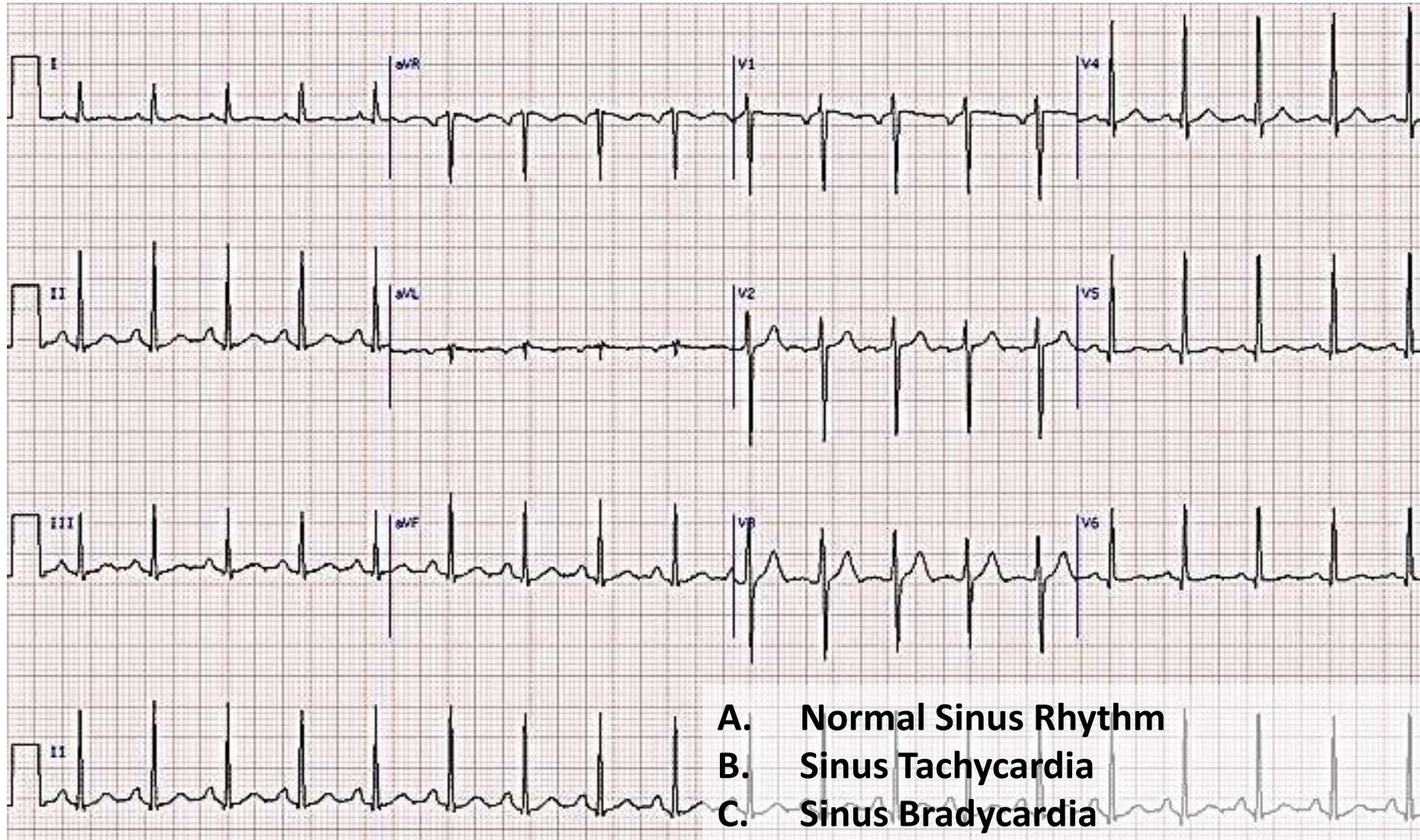


RA/LL Reversal

- Lead II becomes inverted
- Leads I and III inverted and switch places
- Lead aVL is unchanged
- Leads aVR and aVF switch places
 - aVR upright
- Leads I, II, III, aVF all inverted



1) The following 12 lead ECG represents:



- A. Normal Sinus Rhythm
- B. Sinus Tachycardia
- C. Sinus Bradycardia
- D. Sinus Rhythm w/ 1st degree AV Block
- E. Anterior ischemic changes

2) Which lead usually corresponds most closely with the overall vector of depolarization of the heart?

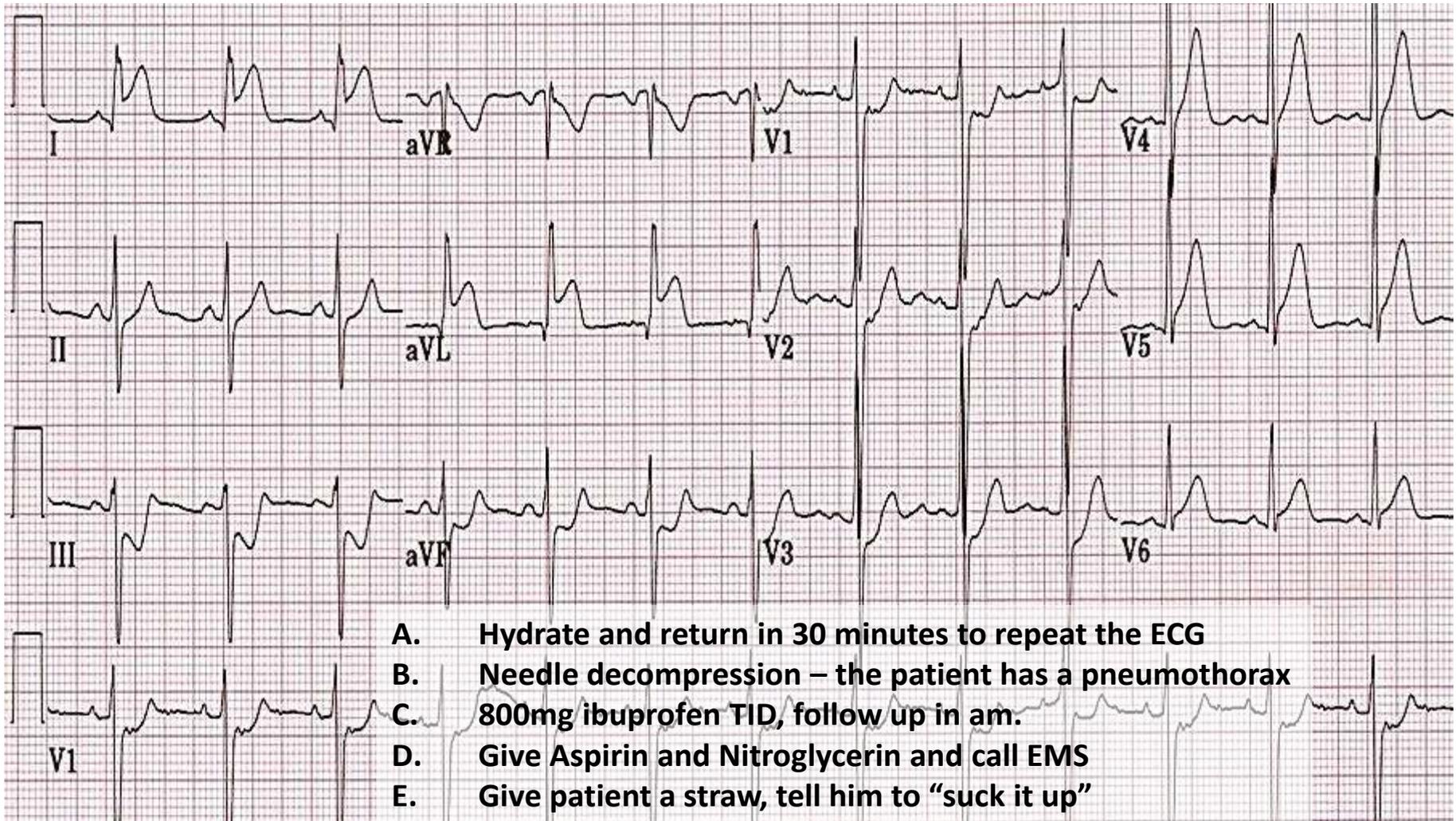
- A. Lead I
- B. Lead II
- C. Lead III
- D. Lead V2
- E. Lead aVR

3) An ECG tracing that shows p-waves and QRS complexes completely out of sync without conduction probably represents:

- A. 1st Degree AV Block
- B. 2nd Degree (Type I – Wenkebach's) AV Block
- C. 2nd Degree (Type II – Mobitz) AV Block
- D. 2nd Degree (High grade) AV Block
- E. 3rd Degree/ Complete Heart Block

4) A 42 y/o patient presents to you 30 minutes after completing his PFA. He is complaining of “discomfort” and holding a fist to his chest, though he is conversant and fully alert. He is a non-smoker with no history of cardiovascular disease; he has no family history of heart problems.

You obtain the following ECG. The most appropriate next step is to:



- A. Hydrate and return in 30 minutes to repeat the ECG
- B. Needle decompression – the patient has a pneumothorax
- C. 800mg ibuprofen TID, follow up in am.
- D. Give Aspirin and Nitroglycerin and call EMS
- E. Give patient a straw, tell him to “suck it up”



Fleet Dental

Sara A. Chilcutt LT DC USN

Fleet Division Officer/ Fleet Liaison Officer

NBHC Naval Base San Diego

Fleet Office: (619) 556-4797

Front Desk: (619) 556-8239/40

sara.a.chilcutt.mil@mail.mil

FLEET WOMEN'S HEALTH

LCDR Potswald

Senior Medical Officer

(619)556-8108/2801

Naval Branch Health Clinic

Naval Base San Diego

2450 Craven St., Bldg. 3300

San Diego, CA 92136

MRD Clinic(Dryside)

Contact:

-HM2 White 619-556-2802

Zachary.m.white16.mil@mail.mil

OPTOMETRY



**MISSION: “OPTOMETRY
READINESS” FOR THE
FLEET**

FLEET LIAISON



- Meet medical readiness among the fleet without compromising lost work hours by providing an opportunity to coordinate eye exams either on-board, underway, or open clinic schedules to include availabilities conducive to ships needs.
- Work closely with IDCs to ensure all who require eyewear are equipped to be deployable
- Provide lectures and trainings on eye trauma
- Point of contact for any optometry related questions/concerns

NMCSD Optometry Clinics



- 6 clinics

* NMCSD	0600-1600
*North Island	0700-1600
*MCRD	0700-1530
*NTC	0700-1530
*Naval Station	0630-1530
*Miramar	0630-1600

Walk-In Clinic



- Miramar (AM only)
Tuesday
Thursday
- Naval Station (AM only)
Tuesday
Thursday
Friday

*****First come, First Serve*****

POC



- **LT Brent Collins**
 - DIVO, NAVAL STATION 32ND ST. OPTOMETRY DEPARTMENT
 - FLEET LIASION COORDINATOR
 - 619-556-8065/8063
 - brent.d.collins2.mil@mail.mil



Fleet Mental Health

CDR S. King Hollis, PMHNP

Mental Health Fleet Liaison

NAVSTA Fleet Mental Health

NMCSD

619-556-8090



HPV Knowledge and HPV Vaccine Uptake Among U.S. Navy Personnel 18 to 26 Years of Age

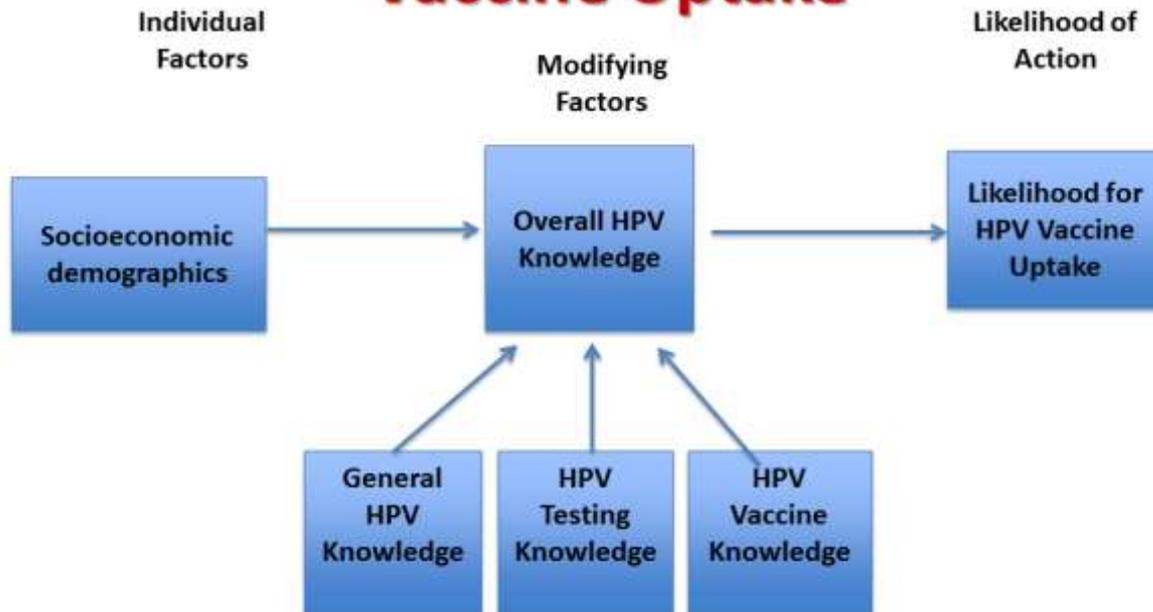
Jennifer Buechel, CDR, NC, USN

Introduction

- PhD Candidate at the University of San Diego, California
- Federally funded grant under the Tri-Service Nursing Research Program (TSNRP)
- Survey sponsorship from Commander, Naval Surface Force, U.S. Pacific Fleet (COMNAVSURFPAC)
- Study recruitment phase began late May 2015

Study Purpose

Model of Factors that Influence HPV Vaccine Uptake



Study Methods

- Inclusion Criteria:
 - Active duty (or reserve on active status) in the U.S. Navy
 - 18 to 26 years of age
 - *Goal of 250 participants*
- Data Collection:
 - Electronic survey using Max Survey software
- Recruitment Strategies:
 - First: Batch emails
 - Second: Advertisements
 - Third: In-person solicitation

Contact Information

CDR Buechel

Email: jbuechel@sandiego.edu

Primary #: 734-250-4190

Secondary #: 619-825-7385



Medical Readiness Division

MRD_SD_GMO@navy.mil

(619) 556-5191

Bldg 116

San Diego, CA 92136



Active Duty Clinic-Gen Surgery

- Director, MRD CDR Hoang has volunteered to see common general surgery pathology on Fridays at Dept of Surgery, NMCSO to fast track fleet referrals, including:
 - Soft tissue (lipoma, epidermal inclusion cyst, pilonidal cyst);
 - Anal disease (hemorrhoid, anal/rectal abscess);
 - Screening colonoscopy
 - Symptomatic cholelithiasis
 - Hernia (ventral, incisional, inguinal, umbilical)

 - Gen surg matrix referral rules still apply.
- Conditions requiring long term follow up will not be included in active duty clinic, unless discussed with MRD Physician Supervisors.
- Include “forward to Dr. Hoang” in body of the referral.



Upcoming Meetings

- October 28th @ 1000-1200
 - Ophthalmologic Emergencies
 - Prev Med Programs/INSURV
 - ACR
- November 19th @ 1000-1200
 - TBD
- December NO MEETING!



CME – Registration Help

Following the meeting:

Computers in lobby

Register and/or Login to redeem CME's



CME – how to

Commander Naval Surface Force, U.S. Pacific Fleet

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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: \[fmlo-list@med.navy.mil\]\(mailto:fmlo-list@med.navy.mil\)](#)
- [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](#)



CME – how to

A screenshot of a web browser window. The address bar shows the URL: http://www.public.navy.mil/nmcsd/Commander_Naval_Surface_Force_CME_CREDITS-Contact_Hours_0... The browser title is "CME CREDITS/CONTACT HOURS ONLINE". The page content includes two main sections, A and B, each with a list of instructions. Section A is titled "To view CME/CNE activities offered at Naval Medical Center San Diego:" and includes four steps (a-d). Step a includes a URL: https://cmetracker.net/NMCSD/Login?FormName=GetCertificate. Section B is titled "To Claim CME Credits/Contact Hours online you must have the following information:" and includes four steps (a-d). Step a includes a URL: https://cmetracker.net/NMCSD/Login?FormName=GetCertificate. The browser's taskbar at the bottom shows various application icons and the system clock showing 1438 4/28/2015.

CME CREDITS/CONTACT HOURS ONLINE

A. To view CME/CNE activities offered at Naval Medical Center San Diego:

- Log in: Ctrl+Click to follow ULR CME link or copy/ cut and paste URL address onto your web browser.
<https://cmetracker.net/NMCSD/Login?FormName=GetCertificate>
- On the "Menu" bar top right hand corner click on "Activity Catalog."
- Scroll up or down to view list of activities.
- For additional questions and/or information about the activity please contact person listed under "Point of Contact."

B. To Claim CME Credits/Contact Hours online you must have the following information:

- URL CME Link Login:
<https://cmetracker.net/NMCSD/Login?FormName=GetCertificate>
- Military E-mail Address and Password
- CME Activity Code (CMEC/CNEC to provide after CME/CNE activity session)
- Cut-off Date to Claim CME Credits/Contact Hours (CMEC/CNEC to provide after CME/CNE activity session)



CME – how to

NOTE: New Users – Will only need to create a Password **ONCE**. All users **must use the same password** when signing in to access the following functions: Certificate, Transcript, Profile, Activity Catalog and Registration.

C. Instructions/Steps to Claim CME Credits/Contact Hours.

1. Login: Ctrl+Click to follow ULR CME link or copy/ cut and paste URL address onto your web browser.
2. Follow the steps on the CME Certificate screen page. (Need Military E-mail Address and Password)
3. "Sign In"
4. Evaluation screen page is next. Complete the Evaluation and Click on "Submit Response." (Must be done to receive CME Credits/Contact Hours).
5. Certificate Preparation screen page is next. Follow steps to "Claim Credits/Contact Hours" and Click on "Continue."
6. On the next screen page Click on "Display Certificate" to view the Certificate and Click on "Print Certificate" if you want a copy or
7. Click on "Close" and "Done" to exit.
8. If you don't want to display/view the certificate simply click on "Done" button.

D. Instructions/Steps to view/get CME/CNE Transcripts Online





CME – how to



NAVAL MEDICAL CENTER
SAN DIEGO
THE PRIDE OF NAVY MEDICINE

[My Profile](#) [My Certificate](#) [My Transcript](#) [My Registrations](#) [Activity Catalog](#)

CME Certificate

Sign In

Welcome!

To evaluate the program and display your certificate, please follow the steps below:

1. Enter your Military Email Address:
2. Please select one of the following:
 - I already have a password, and my password is: [Forgot Password?](#)
 - I am a new user (You'll create a password later)
3. Enter CME Activity Code
4.

(be sure your browser allows pop-ups)

[If you would like to view or print a past certificate, please click here](#)
*Note-Reprint of certificates valid only for certificates received after 10-1-11.



CME Information

- CME Code (To claim credit online): **8043**
 - Closing Date (To claim credit online): **09 OCT 2015**
 - To complete CME
 - Log onto the MRD IDC website and click on the CME credit link
- 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/cmesurvey/Item/newifs.aspx?List=be0f840e%2D0489%2D4b5a%2Db8de%2D9c4cd1a323e5&Web=0901130e%2Dd444%2D45b8%2D8bc7%2D5b9ec10dca77>



Post Tests

Please put your name on the quiz!

CME Code:

8043