MARSHALL & RUEDY'S

On Call

Principles & Protocols

Australasian and UK edition

4E

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SECTION A

General principles

1

Approach to the diagnosis and management of on-call problems

Clinical problem-solving is a fundamental skill for the doctor on call. Traditionally, this is approached in an orderly, systematic manner. This includes focused history-taking and physical examination, review of available investigations, formulation of the provisional and differential diagnoses, making a management plan and calling for help when required.

History-taking and physical examination may take 20–30 minutes for a patient with a single problem seeing a new doctor for the first time. Or they may take longer for an older patient with multiple complaints.

Clearly, if a patient is found unconscious in bed, the chief complaint is 'coma' and the history of the presenting illness is limited to the information provided by witnesses, nursing staff or the patient's medical records. In this situation, the doctor is trained to proceed with a simultaneous history, examination, investigation and treatment approach, often starting with treatment. The initial steps that must be completed within the first 5–10 minutes to save life are known as the DRS ABCDE approach (Danger, Response, Send for help, Airway, Breathing, Circulation, Disability, Environment), as outlined further in Chapter 8.

When on call, the trainee or junior doctor is often faced with a well-defined problem (e.g. fever, chest pain, collapse), yet may feel ill-equipped to begin clinical problem-solving unless a comprehensive history and physical examination are obtained. Anything less induces guilt over a task only partially completed. However, few on-call problems should involve more than 30 minutes of the doctor's time, because excessive time spent with one patient will deny adequate treatment time to another more seriously ill patient.

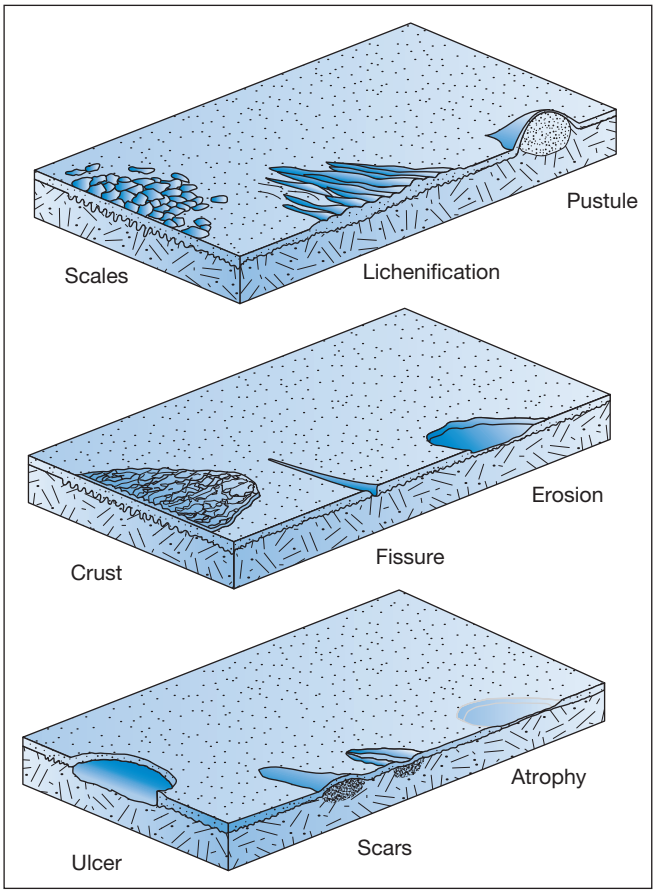

Figure 36.2 Secondary skin lesions.

- **Grouped:** local collection of similar lesions, such as the vesicular lesions of herpes zoster or herpes simplex
- **Koebner phenomenon:** Skin lesions along lines of trauma, including scratching in psoriasis, lichen planus and vitiligo

Management

Immediate management

Angio-oedema and anaphylaxis (see Chapter 10)

- Call your senior urgently, but do not delay first-line treatment.
- Give 1:1000 adrenaline up to 500 micrograms (0.5 mL) IM every 5 minutes, according to age, body mass, comorbidity such as

Table 36.1 Spectrum of rashes

Condition	Rash	Distribution	Mucous membranes	Epidermal detachment TBSA	Mortality
EM minor	1–2 cm target lesions	Acral—palms, soles, dorsum of hands	Not affected	None	0
EM major	Target lesions Oedematous papules	Acral	One or more mildly affected	<10%	Up to 5%
SJS	Blistering, purpuric macules	Generalised	Mucosal erosions	10%	10%
TEN	Blistering, purpuric macules	Generalised	Mucosal erosions	30%	30%

EM, erythema multiforme; SJS, Stevens–Johnson syndrome; TEN, toxic epidermal necrolysis; TBSA, total body surface area.

- Look for the underlying cause. Withdraw any possible causative drug.
- Administer empiric antibiotics only if evidence of secondary infection exists.
- All care is supportive with hydration and skin care, and may include steroids in SJS and TEN. Seek senior advice.

Milder cases require symptomatic care only that can generally wait for the patient's usual team.

Drug reactions

- Stop any medication implicated, as a minor rash may rapidly progress.
- If the offending medication is essential to the patient's management, leave a message for the patient's usual team to choose an alternative.