MEDCINE MANAGEMENT IN A NUTSHELL

Angina	MONA: Morphine, O2, Nitroglycerine, Aspirin
STMI	MONA + β-blockers, clopidogrel. Emergent angiography and PCI should be performed; if possible
NSTEMI	Anticoag, Antiplt, BB, Nitrates, Statins, ACEi/ARBs
Valvular Heart disease	Replacement, only MS balloon valvuloplasty
Arrhythmia (A-fib)	If unstable: shock (cardioversion), If stable: Rate control with CCBs= Verapamil or Diltiazam or BB. then if new <48hr (shock), if >48hr or unknown do TEE if there's thrombus give 3wks anticoag (warfarin) then reTEE if clean shock
Pericarditis	NSAIDs + Colchicine
Heart Failure	ACEi/ARB + BB + Diuretic
Asthma Exacerbation	Give oxygen, Nebulizer (Ipratropium and albuterol), give steroids PO or IV
COPD Exacerbation	Supplemental oxygen should also be initiated and titrated to achieve an oxygen saturation of 88% to 92% Inc Bronchodilators, oral corticosteroids, and antibiotics (FQ+macrolide).
Pneumonia	**CAP**: 3rd gen Ceph (Ceftriaxone) + Azithro or Moxifloxacin. **HAP**: Piptazo + Vancomycin
TB	**R**ifampicin, **I**soniazid, **P**yrazinamide, **E**thambutol
Pulmonary Embolism	Anticoag: Bridge by Heparin for 5 days then Warfarin
GI Bleeding	Resuscitation, Prescope therapy with PPI (Omeprazole) and octreotide, Endoscopy within 6-24hrs or Colonoscopy if lower GI, Surgery
IBD	Mesalamine, 6mercaptopurine, Azathioprine, methotrexate. In severe cases, Surgical resection is curative for UC, in Crohn's we can use TNFi infliximab. **FLARE:** steroid prednisone + Abs (Cipro+MTz)
Celiac Disease	Gluten-free diet
Liver cirrhosis	Determine the etiology of chronic liver disease/cirrhosis and treat in order to slow or reverse the progression of liver disease. Prevent superimposed insult to the liver (Vaccinations, hepatotoxic medications, Alcohol). Treat symptoms.
Ascites	Salt Restriction (<2g/day) Diuretics (Furosemide and Spironolactone).

	Paracentesis + albumin (if >5L), If refractory TIPS
Hepatitis C	NO vaccine, curable with Antiviral therapy
Hepatitis B	Vaccine available, not curable but we treat with antiviral to prevent progression of the disease, particularly to cirrhosis, liver failure, and hepatocellular carcinoma (HCC).
Pancreatitis	NPO, IV hydration, Analgesia
DKA	IV fluid NS/RL, Correct K, No insulin until >3.3, IV insulin 0.5/kg/hr until Blood glucose 12-14mmol/l
HHS	NS IV plus insulin infusion. Target plasma glucose in acute treatment is between(13.9 to 16.7 mmol/L). Give potassium replacement depending on serum potassium levels.
Cushing	Treatment of Cushing syndrome involves identifying the underlying cause Exogenous medication (gradually decrease), Pituitary adenoma (Surgical excision), Ectopic ACTH or Met Adrenal carcinoma give adrenal steroid inhibitors (Ketoconazole + Mytrapone)
Acute Addisonian crisis	IV fluids + electrolytes correction + Dexamethasone
CKD	o Prevent CKD o Treatment of the underlying condition o Delaying or halting the progression of CKD o Treating the complications - BP should be <130/80 if proteinuria give ACEi if w/o give CCB or Diuretics - Renal diet: low Na, K, Ph, Mg and low protein, water <2L - Metabolic acidosis: oral alkali supplementation - hypoCa: give Ca - hyperPTH: Calcitriol, vit D - Uremia: Hemodialysis, Peritoneal dialysis, renal transplant
Pyelonephritis	IV Ceftriaxone 10d, if Ambulatory PO Ciprofloxacin for 10d
SLE	● NSAIDs for mild joint symptoms. ● Corticosteroids7 for acute exacerbations . ● Hydroxychloroquine89 used for isolated skin and joint . ● Cyclophosphamide10 Used for severe cases of lupus nephritis11. ● Avoid sun exposure because it can exacerbate cutaneous rashes.
RA	NSAIDs (ibuprofen)+ DMARDs (Methotrexate) + Biologics (Infliximab). Flare: steroid
MS	Acute attack: high dose **steroids** IV for 5 days. Prevent relapse/slow progression: **B-Interferon**
GBS	Early plasma exchange is vital. Need close respiratory monitoring.

PARKINSON	Drug of choice: Levodopa + Carbidopa Dopamine agonists (e.g. Pramipexole): may control the symptoms and delay the need for Levodopa
Ischemic stroke	Tissue plasminogen activator is given if the patient presents within 3 hours of symptom onset, Contraindications for tPA: ● Stroke or serious head trauma within 3 months ● Hemorrhage (GI or GU) within 21 days ● Surgery within 14 days ● History of intracranial hemorrhage ● BP >185/110 mm Hg ● Current use of anticoagulants ● Platelets <100,000/mm3 ● Coagulopathy (PT >15 seconds) Antiplatelet therapy is most useful in secondary prevention of ischemic stroke. Aspirin is considered first-line treatment (start 24 hours after TPA).
Bacterial Meningitis	Ceftriaxone, Vancomycin, Steroid, +/- ampicillin
Seizure	1. Keep calm, ensure that all measures have been taken to protect the patient from physical injury and aspiration of gastric contents, administer oxygen by nasal cannula or face mask 2. Watch and wait for 2 minutes 3. BENZODIAZEPINES: 5 mg Diazepam slowly (over 3-5 minutes)" If seizure does not stop " another 5 mg 4. If seizure does not stop with full dose of benzodiazepines give "Phenytoin" 5. If the seizure persists > 30 minutes " transfer to ICU for probable intubation and give phenobarbital
SCA	- Management of vaso-occlusive crisis (IV fluids+Analgesia) - Management of chronic pain synd (Hydroxyurea + NSAIDs/Aceta) - Acute pain: morphine - Hemolytic anemia: Transfuse - Prevention of infection: Immunization, prophylactic penicillin - Stroke: transfuse, hydroxyurea
LYMPHOMA	Chemotherapy, Radiation therapy, immunotherapy.
LEUKEMIA	Chemotherapy, Biological therapy, Targeted therapy, Radiation therapy.

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لا تنسوني بدعوة صادقة في ظهر الغيب