Primary Services / MRP List

List of services with presenting complaints and diagnoses for which they will be considered 'Primary Service' and/or Most Responsible Provider (MRP)

This document is intended to be used to decide FIRST consult for anticipated MRP in patients requiring admission

Addiction Medicine

- patients with active substance use disorders who are looking to change their relationship with substances
- patients who are appropriate and willing to be admitted to a unit with a focus on recovery that has restricted movement and limited visiting hours
- beds will be prioritized for certain high priority groups (including those with higher nursing care needs; youth; pregnancy; psychiatric comorbidities; higher burden of medical comorbidities)
- all patients who are being consideration for admission to the unit will need assessment by the Addiction Medicine MD at ACCESS (VCH) (which may occur via AMCT MD)

AIMS (Acute Inpatient Medical Service)

Non operative intracranial bleeds	mBIG category 1 & 2 mBiG category 3 with documented Neurosurgical opinion
Non-operative fractures	With documented orthopedic consultation (maybe done by phone). May go to Geriatrics for patients over 65.
Non operative traumatic injury	With document TTL and/or Orthopedic (maybe done by phone) consultation by ERP. May go to Geriatrics for patients over 65.
Admission without medical indication	May go to Geriatrics for patients over 65.

Anesthesiology

- Post LP headache (as per protocol)
- Airway emergencies/anticipated difficulty in with acute airway
    - *In this role, anesthesiology will not assume 'primary service' responsibility, which will remain that of the referring service.*

Cardiology

- Arrhythmia - Acute or hemodynamically unstable, pacemaker/ICD failure, primary reason for need for admission referral is arrhythmia.
- Acute coronary syndrome
- Chest pain confirmed or highly suspicious to be of an ischemic nature
- Pericarditis requiring continuous monitoring or potential pericardiocentesis. Other pericarditis goes to medicine
- Pericardial tamponade
- Decompensated HF or cardiomyopathy requiring continuous monitoring, inotropes, specialized cardiac observation or intervention. Other HF typically admitted to medicine. In the situation of medicine over capacity/diversion, medicine may ask cardiology to admit other CHF cases.[VS[1]
- Patients actively listed or undergoing evaluation for cardiac transplant, as well as patients with LVAD, with a primary cardiac presentation.
- Post-procedure complications (cardiology not cardiac surgery)
- CHF if severe and requires continuous monitoring or inotropes, other specialized cardiac intervention or awaiting transplantation. Other CHF typically admitted to medicine. In the situation of medicine over capacity/diversion, medicine may ask cardiology to admit other CHF cases.
- Cardiogenic shock
- Suspected cardiac medication-related toxicity
- Symptomatic valvulopathy requiring continuous monitoring or other specialized cardiac procedures/interventions.
- Syncope - with suspected cardiac etiology (sudden onset without presyncope, syncope in association with severe tachycardia or bradycardia, patient with predisposition to cardiac syncope)

Cardiac Surgery

- Thoracic dissection
- Penetrating Cardiac trauma
- Sternal infections

CTU / General Internal Medicine

- Please see back section of this document

Gastroenterology

- Oesophageal obstruction (unless surgical intervention is the likely next step in which case the patient should go to surgery)
- Pancreatitis cryptogenic or of medical cause
- Crohn's disease or ulcerative colitis exacerbations without obstruction or abscess
- Upper & Lower GI Bleeds - if requiring requiring urgent intervention & admission with no significant medical comorbidities

General Surgery

The fundamental principle guiding admission to general surgery is "may require surgical intervention and is a surgical candidate?" If the answer is no, then there is likely a more appropriate service to admit and manage the patient.

- Patients who have had recent surgery and have a postoperative complication
    - These patients should still have some workup/investigations by ER
    - If post op patients have a medical issue only (e.g. CHF, pneumonia, etc.) then appropriate medical service referral
- Diverticulitis/Appendicitis/ Cholecystitis
- Truncal and perianal abscess
    - All other abscesses should be managed by surgeons who operate on the area in question on a regular basis (i.e limb, head and neck)
- Mechanical Bowel Obstruction in patient who is a surgical candidate
    - Confirm by CT - admit to General Surgery
    - If patient/family wishes are for no surgery - Palliative care or Family Practice (MSJ)
    - If known to be Crohn's patient, also consult GI
- Bowel perforation
    - Characterized by peritonitis and evidence of free air on Xray and/or CT
    - Must be surgical candidate (if not, palliative care)
- Alimentary foreign bodies below stomach
- Trauma Isolated Intra -abdominal trauma only
    - Polytrauma with no predominant organ involvement (as determined by Trauma Team Lead) These patients should be transferred to VGH or admitted to the service with the predominant issue (e.g. Major Fracture – Ortho, Pneumothorax - CVT)

Geriatrics

- Acute delirium or exacerbation of dementia behavioral symptoms who cannot safely be discharged home
- Falls in older patients
- Acute medical conditions in elderly who are hemodynamically stable
- Frail older adults who are acutely unsafe at home
- Complex discharge issues

Gynecology

- Pelvic inflammatory disease
- Complicated endometriosis
- Ectopic pregnancy
- First trimester pregnancy complications
- Other conditions of reproductive organs in females
- Gynecological infections/abscess (i.e. Bartholin's cyst/abscesses)

Hematology

- Congenital bleeding disorder
- Acute thrombocytopenia
- Complications of hematological malignancy

- Sickle Cell Disease complications

Intensive Care (Critical Care)

- Any diagnoses where patients require:
  - Requires mechanical ventilation
  - Requires inotropes to manage hypotension (excluding cardiogenic shock)
  - Requires continuous monitoring (unless in CCU)
  - Acute overdose requiring dialysis
  - Shock not responsive to 5 L normal saline
  - Is likely to need either of the above imminently

HAU / MET: Patients too unstable for the medical units, but not requiring ICU care

- Consult ICU who will decide if patent requires ICU/HAU admission

Maternity

- Obstetrical conditions or complications of 2nd / 3rd trimester
- For non-obstetrical conditions in a pregnant person, MRP should generally be as for a non-pregnant person (based on primary diagnosis/reason for admission), with Obstetrics consultation as required.

Nephrology

- Renal Transplant Recipients:
  - Within first three months post transplant regardless of diagnosis if non surgical
  - Suspected acute rejection
  - Complication of Transplant (eg. opportunistic infection)

- Peritoneal dialysis patients:
  - PD-Peritonitis, PD related problems (eg. failure to drain, volume overload etc.)
  - As peritoneal dialysis is only performed by the 6B nurses renal should be contacted early regarding all PD patients who are PD admitted determine disposition and arrange PD

- HD Patients:
  - Dialysis related medical issues
  - Vascular access problems (eg. Clotted fistula, tunnel infection, bleeding from permcath)
  - Need for acute dialysis in a chronic HD patient
  - Acute need for dialysis

Neurology

- Stroke. Neurology is to assess and write admission orders and utilize preprinted order (PPO) sets. The consultant neurologist must communicate directly with the medicine team who will then admit.
- Neurology admits include neurological conditions in otherwise medically stable patients, which may include:
  - MS Exacerbations, optic neuritis
  - Refractory migraine headache
  - Adjustment of medications for Parkinson's Disease

    - Pain management for radiculopathy
    - Awaiting MRI to r/o cord lesion or cauda equina syndrome
    - recurrent/uncontrolled seizures requiring admission

- Medicine/AIMS/Geriatrics admits the following conditions with neurologic consultation:
    - TIA
    - Vertigo
    - Acute intracranial bleed (refer to head injury/intracranial bleed/intracranial process flow chart)
    - Seizure (status epilepticus or continuous monitoring required goes to ICU)
    - Acute Neurologic symptoms of unknown etiology
    - Other acute neurologic conditions

Ophthalmology

- Acute eye trauma with suspected globe rupture, hyphema or extensive abrasion
- Intraocular foreign body
- Herpes keratitis
- Suspected retinal detachment
- Extensive lid laceration, or with marginal involvement
- Acute lens dislocation/subluxation
- Acute glaucoma
- Acute Iritis/iridocyclitis
- Endophthalmitis
- Orbital cellulitis
- Orbital neuritis
- Acute vision loss

Otolaryngology

- Epistaxis
- Airway compromise
- Peritonsillar abscess (hold after 11 PM unless airway concern; call on-call Resident in AM)
- Neck Abscess
- Foreign body in aerodigestive tract
- Sudden hearing loss within 2 weeks of onset (can be referred to Rapid Access Clinic for urgent care)
- Acute vestibular event (can be referred to Rapid Access Clinic for urgent care)
- Complications of acute infections in the head and neck
- New diagnosis of ENT malignancy
- Parotitis
- Epiglottitis
- Neck trauma

Orthopedics

- Acute fracture (except facial, hand or spine) requiring surgical management
- Tendon rupture/laceration
- Suspected compartment syndrome

- Deep foot and limb (excluding hand) infections will be admitted to medicine with ortho consult, unless operative procedure/amputation required then ortho will admit
- Septic joint/Osteomyelitis goes to medicine with ortho consult unless an operative intervention with specialized nursing care is required.
- Complications of orthopaedic surgery

Palliative Care

- Patients actively followed by palliative care service.
- Patients with a DNR and an irreversible illness, experiencing moderate to severe symptoms

Plastic Surgery

- Hand injuries
- Tendon or nerve lacerations of the forearm/hand
- Deep hand infections (to be admitted by a medical service if management is non-operative)
- Septic joint/osteomyelitis of the hand requiring surgical intervention
- Bony facial trauma
- Large or complex facial lacerations
- Suspected necrotizing skin/soft tissue infections
- Mandibular trauma
- Severe burns (which Plastics will transfer to Burn Unit at VGH)

Psychiatry/Mental Health Program

- Acute suicidal ideation or attempt
- De-compensated or acute psychosis of established psychiatric origin
- Mania of established psychiatric origin
- Other urgent and significant primary psychiatric conditions
- Patients with behavioural disturbances associated with organic brain disease (including delirium, Alzheimer's Disease, other forms of dementia, acquired brain injury, Huntington's Disease, brain tumors, etc.) are NOT normally within Psychiatry's zone of patient care responsibility as MRP but may be seen in consultation with a view to a collaborative determination of an appropriate disposition

Respirology

- Cystic fibrosis
- Pulmonary fibrosis/interstitial lung disease
- Bronchogenic carcinoma
- Pulmonary Hypertension
- Pneumothorax +/- pleural effusions requiring chest tubes and admission

Urban Health

- HIV-positive requiring admission for INFECTION OR HIV related complication (malignancy, adverse drug reaction)
- HIV-negative but with active addictions issues and admission for INFECTION (e.g., meningitis, sinusitis, PNA, TB, IE, GI infections, GU infections, MSK infections, SSTI, sepsis)
- NOT for Urban Health: drug overdose causing obtundation, COPDE, ESRD on dialysis, or GIB, or IBD.

Urology

- Ureteric/renal stones
- Pyelonephritis/Fever in the setting of urinary obstruction
- Obstructive uropathy
- Complications of UGT cancer followed by urology
- Gross hematuria with clots
- Fourniers Gangrene

Vascular Surgery

- Acute ischemic limb
- Aortic aneurysm
- Necrotic digits/extremities

CTU / GIM at MSJ (or Family Practice) Admissions by diagnosis

General Internal Medicine (GIM) will be the initial contact for the following suspected diagnoses if admission to GIM is expected, **unless single-system sub-specialty admission is appropriate**.

If the CTU service is overcapacity, early referral to single subspecialty service is encouraged.

Conditions noted with * are appropriate for subspecialty referral when present in isolation (no other issue which would require admission).

<u>Conditions/MRDx</u>

Acid Base/Electrolyte

- Alcohol keto-acidosis
- Hyponatremia
- Hypernatremia
- Hyperkalemia
- Recalcitrant Hypercalcemia

Cardiac/Vascular Disease

- Hypertensive emergency goes to critical care if hypertension is associated with: Acute organ damage or decompensation (example: retinopathy, visual disturbance, encephalopathy, renal failure, CHF), aortic dissection, pregnancy, catecholamine crisis or requires monitoring for other reason.
- Decompensation of chronic congestive heart failure*

Dermatologic Disease

- Cellulitis
- Acute dermatologic crisis
- Vasculitis
- For severe diffuse disease be sure to consult dermatology and consider burn unit as necessary.

Endocrine

- Acute Diabetes mellitus
- Diabetic keto-acidosis
- Severe hyper and hypothyroidism

Gastroenterology

- Acute GI Bleed* if not requiring requiring urgent endoscopy OR patient has significant medical comorbidities
- Liver disease and manifestations

Infectious disease

- Tropical illness/fever
- Infectious disease with a suspected resistant organism

Medical Oncology (Oncology patients presenting with problems unrelated to their cancer should be referred to the most appropriate service for their acute condition)

- Most oncology will go to medicine with appropriate consult to BCCA.
- Hematologic malignancy goes to Hematology
- Malignancy presenting with complication requiring surgical intervention goes to surgery.

Nephrology (requires flow chart/algorithm)

New Patients with Acute Kidney Injury

- New patients with acute kidney injury should be first referred to medicine. Renal to consult at same time if patient has indication for acute dialysis

Rheumatology

- Acute joint disease (non-traumatic, non infective)
- Acute auto-immune disease
- Any of the connective tissue diseases: Rheumatoid Arthritis, SLE, Polymyositis, Dermatomyositis, Systemic Sclerosis, MCTD, Sjogren Syndrome, Undifferentiated Connective Tissue Disease, Adult Onset Still's Disease, Polymyalgia Rheumatica.
- Seronegative Spondyloarthropathies (Ankylosing Spondylitis, Psoriatic Arthritis, Enteropathic-related or Reactive).
- Vasculitis

Respirology

- COPD/ asthma*
- Hemoptysis NYD *
- Bronchiectasis*
  Pulmonary hypertension*