Case Based Review
(Whew!)

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No Interests to Disclose :)
Goals

- To integrate what you have learned so far
- Work through some cases
- Time for questions
EtoH + car = MVC

- 30 yo F rear seat passenger, unrestrained
- cc: back pain, gluteal pain
- VS field 109/74, 94, 18, 99% RA
- BP dropped 80/P, 120, 20 95% RA GCS 15
Supine CXR insensitive
Ultrasound should show pleural movement & artifacts
Normal

Abnormal
Can confirm with M Mode side by side

Normal Lung

M Mode Marker at Pleura

Pneumothorax

No Motion Chest Wall

Positive Motion Lung

Waves on Beach or Seashore Sign

No Motion Lung

Barcode or Stratosphere Sign
RUQ: Hemoperitoneum

Normal

Abnormal
RUQ: Hemothorax

Normal

Abnormal
Pelvic View Tranverse Female

Abnormal
• 2:30 pm

• 45 y/o male w/o pmh presents w/abd pain, subjective fever @home, n/v and diffusely tender abdomen

• States pain increase with PO intake, crampy and burning in nature, radiates to entire abdomen
Objective

- VS - 100.6, 110, 14, 140/80, 100%RA
- Labs - CBC, Chem (LFT and Bili) - WNL
- PE - in mod distress and mildly dehydrated
Fluid

"halo sign"

perichol fluid
Double Barrel Sign - Dispo?
Flank Pain

- 42 yo man
- c/o left flank pain, radiating to groin
- denies hematuria, dysuria
- 168/83 HR 55 T 36.9 RR 14
- diaphoretic, in distress
- abd non-tender, nl BS
data

- UA: RBC > 50
- 12.6 > 15 < 300
- nl lytes
next steps?

- more imaging?
- treatment?
- follow up?
AAA - Next Steps?

- If HD stable
  - Can go to CT
  - Outcomes better with elective surgery
- If HD unstable
  - Clinical rupture
  - Surgery consult OR
Dissection
Crashing Patient!

42 yo female presents with BP 75/42, HR 135, T 38.2, SaO2 96% RA

- SOB, epigastric pain, N/V
- EKG - ST elevations inferolateral leads
- 5.2 lactate VBG
- line, labs...P, CXR...P
Pericardial Effusion

Parasternal Long

Parasternal Short

Thoracic Aorta

RV
IVC Plethora
Pericardioscentesis

- Facilitate rapid intervention
- Choose best approach
- Avoid unnecessary errors
Syncope

VS: 89/P, 95, 98%, 37.6

- 30 yo F
- cc: fainting x 2
- brief loc at clinic then @ triage.
- assd sweating, pallor, light headed, VB x 1 day
Next steps

- Uh oh! No IV access...
- Still Hypotensive
- Ordered emergent blood...
- Need Central Access
Follow Up

- 2L NS, 2L PRBC
- Stat OR Booking
- Right Fallopian Ruptured Ectopic
Pitfalls

- Clotted blood
- Indeterminate scans
- Failure to do FAST
- Reliance on discriminatory zone
- Fertility treatment
References

• Andrulis DP. “Study of How Urban Hospitals Address Sociocultural Barriers to Health Care Access”: http://www.rwjf.org/portfolios/resources/grantsreport.jsp?filename=023299s.htm&iaid=133


