



Differential Diagnosis of Common Complaints Job Aid



U.S. Coast Guard Training Center Petaluma



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DERM	EENT	CV	RESP	GI	GU	GYN	MUS/SKEL	NEURO	MH
Erythema	Red Eye	Cardiac Chest Pain	Acute Cough	Abdominal Pain	STD	Menses	Neck Pain	Altered Mental Status	Mood Disorders
<ul style="list-style-type: none"> • Anthrax (cutaneous) • Cellulitis • Drug Reaction • Furuncle • Urticaria • Viral Exanthemas (measles, mumps, rubella) 	<ul style="list-style-type: none"> • Blepharitis • Chalazion • Chemical Burn • Conjunctivitis, allergic/infectious • Corneal Abrasion • Foreign Body • Glaucoma • Hordeolum • Hyphema • Pinguecula • Pterygium • Retinal detachment • Subconjunctival Hemorrhage • Uveitis 	<ul style="list-style-type: none"> • Acute Coronary Syndrome • Angina Pectoris • Pericarditis 	<ul style="list-style-type: none"> • Bronchitis, Mycoplasm • Bronchitis–Viral • Influenza • Pneumonia, Bacterial • Pneumonia, Mycoplasma • Pneumonia, Viral 	<ul style="list-style-type: none"> • Appendicitis • Cholecystitis • Constipation • Diarrhea • Diverticulitis • Food Poisoning • Gastroenteritis, Acute • GERD • Hepatitis • Hernia, Abdominal • Irritable Bowel Syndrome • Pancreatitis, Acute • PUD 	<ul style="list-style-type: none"> • Chancroid • Chlamydia • Condyloma Acuminata • Gonorrhea • HIV • HSV II • Lymphogran-uloma Venereum • Pediculosis • Syphilis • Trichomoniasis 	<ul style="list-style-type: none"> • Dysfunctional Uterine Bleeding • Dysmenorrhea, Primary <p style="text-align: center;">END</p>	<ul style="list-style-type: none"> • Cervical Disk (HNP) • Muscle Strain, Cervical 	<ul style="list-style-type: none"> • Alcohol Abuse • CVA • Seizure 	<ul style="list-style-type: none"> • Adjustment Disorder • Anxiety • Depression • Suicidal Ideation <p style="text-align: center;">END</p>
Growths	Earache	Non-Cardiac Pain	Chronic Cough	Female Specific Abdominal Pain	Male Complaint		Shoulder Pain	Headache, Emergent	
<ul style="list-style-type: none"> • Molluscum Contagiosum • Wart, Common 	<ul style="list-style-type: none"> • Barotrauma • Cerumen Impaction • Eustachian Tube Dysfunction • Mastoiditis • Otitis Externa • Otitis Media • Perforation of Tympanic Membrane • Serous Otitis Media • Temporomandibular Joint (TMJ) Syndrome 	<ul style="list-style-type: none"> • Anxiety • Costochondritis • GERD • Pleuritis 	<ul style="list-style-type: none"> • COPD • GERD • Tuberculosis 	<ul style="list-style-type: none"> • Ectopic Pregnancy • Endometriosis • Ovarian Cyst 	<ul style="list-style-type: none"> • Epididymitis • Hydrocele, Acute • Inguinal Hernia • Prostatitis, Acute • Testicular Torsion • UTI • Varicocele 		<ul style="list-style-type: none"> • Bicipital Rupture, Proximal • Bicipital Tendonitis • Bursitis, Subacromial • Impingement Syndrome • Rotator Cuff Tear 	<ul style="list-style-type: none"> • Hemorrhage, Subarachnoid • Hypertension Emergency • Meningitis 	

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DERM	EENT	CV	RESP	GI	GU	MUS/SKEL	NEURO
Inflammatory	Stuffy Nose	Syncope	Difficult Breathing	Rectal Pain/Bleeding	Female Complaint	Elbow Pain	Headache, Non-emergent
<ul style="list-style-type: none"> • Acne Vulgaris • Insect Bite/Sting (non-venomous) • Miliaria • Pseudofolliculitis Barbae • Scabies 	<ul style="list-style-type: none"> • Allergic Rhinitis • Common Cold • Epistaxis • Sinusitis 	<ul style="list-style-type: none"> • Arrhythmia • Orthostatic Hypotension • Seizure 	<ul style="list-style-type: none"> • Anaphylaxis • Asthma • Pneumothorax, Spontaneous <p style="text-align: center;">END</p>	<ul style="list-style-type: none"> • Colorectal Cancer • Hemorrhoid • Pilonidal Cyst • Ulcerative Colitis <p style="text-align: center;">END</p>	<ul style="list-style-type: none"> • Bacterial Vaginosis • Bartholin's Cyst • Candidiasis, Vulvovaginal • UTI 	<ul style="list-style-type: none"> • Bursitis, Olecranon • Epicondylitis 	<ul style="list-style-type: none"> • Cluster • Sinusitis • Tension • Vascular
Scaly	Sore Mouth/Throat	Vascular			Hematuria	Wrist pain	Vertigo
<ul style="list-style-type: none"> • Candidiasis (oral) • Pityriasis Rosea • Psoriasis • Seborrheic Dermatitis • Tinea Capitis • Tinea Corporis • Tinea Cruris • Tinea Pedis • Tinea Unguium • Tinea Versicolor 	<ul style="list-style-type: none"> • Aphthous Ulcer • Epiglottitis • Herpes Simplex Virus • Laryngitis • Mononucleosis • Peritonsillar abscess • Pharyngitis, Bacterial • Pharyngitis, Viral • Salivary Stone <p style="text-align: center;">END</p>	<ul style="list-style-type: none"> • Deep Vein Thrombosis • Raynaud's Disease • Varicose Veins <p style="text-align: center;">END</p>			<ul style="list-style-type: none"> • Glomerulonephritis • Pyelonephritis, Acute • Renal Calculi <p style="text-align: center;">END</p>	<ul style="list-style-type: none"> • Carpal Tunnel Syndrome • Ganglion Cyst • Scaphoid Fracture 	<ul style="list-style-type: none"> • Labyrinthitis • Meniere's Disease • Motion Sickness • Vertigo, Benign Positional
						Finger pain	
						<ul style="list-style-type: none"> • Paronychia 	
Continued on Next Page							

DERM	MUS/SKEL	NEURO
Vesicular	Lower Back Pain	Facial Neuropathy
<ul style="list-style-type: none"> • Atopic Dermatitis • Contact Dermatitis • Eczematous Dermatitis/ Dyshidrosis • Herpes Simplex Virus • Herpes Zoster • Impetigo • Smallpox • Varicella (Chickenpox) 	<ul style="list-style-type: none"> • Mechanical, Muscular Strain • Neurological, Herniated Disk • Prostatitis • Pyelonephritis • Renal Calculi 	<ul style="list-style-type: none"> • Bell's Palsy • Cerebrovascular accident (CVA) • Trigeminal Neuralgia
END	Knee Pain	END
	<ul style="list-style-type: none"> • Bursitis, Patellar • Collateral Ligament Tear • Cruciate Ligament Tear • Meniscal Tear • Patellofemoral Syndrome • Popliteal Cyst 	
	Ankle Pain	
	<ul style="list-style-type: none"> • Achilles Tendon Rupture • Ankle Sprain 	
	Foot Pain	
	<ul style="list-style-type: none"> • Fifth Metatarsal Fracture • Heel Spur • Plantar Fasciitis 	
	Toe Pain	
	<ul style="list-style-type: none"> • Ingrown Toenail 	
	Leg Pain	
	<ul style="list-style-type: none"> • Shin Splints 	
	END	
END		

GUIDE TO SCOPE OF PRACTICE FOR HS TECHNICIANS

A Health Services Technician (HS) provides supportive services to medical officers and basic primary health care in their absence. Each HS who provides medical treatment to patients at a Coast Guard clinic shall have an assigned Designated Supervising Medical Officer (DSMO) from that facility. One of the primary goals of the HS is to eventually work independently after completion of the Independent Duty Health Services Technician School.

An Independent Duty Health Services Technician (IDHS) works outside of a clinical setting, and is supervised by a Designated Medical Officer Advisor (DMOA). The IDHS practices independently, though acts as the 'eyes, ears and hands' in consultation with the DMOA or Duty Flight Surgeon when a situation is beyond the scope of technician health care.

This job aid captures all of the medical conditions that the HS3 (A for apprentice), HS2 (J for journeyman), and IDHS (M for master) should be familiar with. This job aid is divided into nine categories by body system plus a tenth for mental health conditions. The categories are further broken down into patient chief complaints or presenting situation. The chief complaints have a list of conditions with corresponding potential differential diagnosis. Though the condition's pathogenesis is not discussed here, each condition is presented with:

- A definition
- Key features
- Differentiating signs and symptoms
- Differentiating objective findings
- Common diagnostic test considerations
- Proposed treatment
- Recommended follow-up

As you use the following guide to determine if a condition is within your scope of practice, remember that the "A" is for Apprentice and indicates that the HS, in achieving their rank, has included that condition in their scope of practice.

DERMATOLOGICAL				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Erythema	Anthrax (cutaneous)	A	J	M
	Cellulitis	A	J	M
	Drug Reaction	A	J	M
	Furuncle	A	J	M
	Urticaria	A	J	M
	Viral Exanthemas (measles, mumps, rubella)		A	M
Growths	Molluscum Contagiosum		A	M
	Wart (common)	A	J	M
Inflammatory	Acne Vulgaris	A	J	M
	Insect bite/sting (nonvenomous)		A	M
	Miliaria		A	M
	Pseudofolliculitis, Barbae		A	M
	Scabies		A	M
Scaly	Candidiasis(oral)		A	M
	Pityriasis Rosea		A	M
	Psoriasis		A	M
	Seborrheic Dermatitis		A	M
	Tinea Capitis		A	M
	Tinea Corporis	A	J	M
	Tinea Cruris	A	J	M
	Tinea Pedis	A	J	M
	Tinea Unguium		A	M
Tinea Versicolor	A	J	M	

DERMATOLOGICAL, Continued				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Vesicular	Atopic Dermatitis	A	J	M
	Contact Dermatitis	A	J	M
	Eczema (dyshidrosis)	A	J	M
	Herpes Simplex Virus		A	M
	Herpes Zoster	A	J	M
	Impetigo		A	M
	Smallpox	A	J	M
	Varicella (chickenpox)	A	J	M

EYES, EARS, NOSE, AND THROAT				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Red Eye	Blepharitis	A	J	M
	Chalazion		A	M
	Chemical Burn		A	M
	Conjunctivitis, Allergic	A	J	M
	Conjunctivitis, Infectious	A	J	M
	Corneal Abrasion	A	J	M
	Foreign Body		A	M
	Glaucoma		A	M
	Hordeolum	A	J	M
	HypHEMA	A	J	M
	Pinguecula		A	M
	Pterygium		A	M
	Retinal Detachment		A	M
	Subconjunctival Hemorrhage	A	J	M
Uveitis		A	M	
Earache	Barotrauma		A	M
	Cerumen Impaction	A	J	M
	Eustachian Tube Dysfunction	A	J	M
	Mastoiditis		A	M
	Otitis Externa	A	J	M
	Otitis Media	A	J	M
	Perforation	A	J	M
	Serous Otitis Media	A	J	M

EYES, EARS, NOSE, AND THROAT, Continued				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Earache, continued	Temporomandibular Joint Syndrome		A	M
Stuffy Nose	Allergic Rhinitis	A	J	M
	Common Cold	A	J	M
	Epistaxis	A	J	M
	Sinusitis	A	J	M
Sore Throat	Aphthous Ulcer	A	J	M
	Epiglottitis		A	M
	Herpes Simplex Virus		A	M
	Laryngitis		A	M
	Mononucleosis		A	M
	Peritonsillar Abscess		A	M
	Pharyngitis, Bacterial	A	J	M
	Pharyngitis, Viral	A	J	M
	Salivary Stone		A	M

CARDIOVASCULAR				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Cardiac Chest Pain	Acute Coronary Syndrome (ACS)	A	J	M
	Angina Pectoris	A	J	M
	Pericarditis		A	M
Non-Cardiac Chest Pain	<i>Anxiety (see Mental Health—Feeling Down or Worried)</i>		A	M
	Costochondritis	A	J	M
	Gastroesophageal Reflux Disease (GERD—see <i>Respiratory—Chronic Cough</i>)	A	J	M
	Pleuritis	A	J	M
Syncope	Arrhythmia		A	M
	Orthostatic Hypotension		A	M
	Seizure (<i>see Neurological—Altered Mental Status</i>)		A	M
Vascular	Deep Vein Thrombosis		A	M
	Raynaud's Disease		A	M
	Varicose Veins		A	M

RESPIRATORY				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Acute Cough	Bronchitis, Mycoplasma		A	M
	Bronchitis, Viral	A	J	M
	Influenza	A	J	M
	Pneumonia, Bacterial	A	J	M
	Pneumonia, Mycoplasma	A	J	M
	Pneumonia, Viral	A	J	M
Chronic Cough	Chronic Obstructive Pulmonary Disease		A	M
	Gastroesophageal Reflux Disease	A	J	M
	Tuberculosis	A	J	M
Difficult Breathing	Anaphylaxis	A	J	M
	Asthma	A	J	M
	Pneumothorax, Spontaneous		A	M

GASTROINTESTINAL				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Abdominal pain	Appendicitis	A	J	M
	Cholecystitis		A	M
	Constipation (symptom)	A	J	M
	Diarrhea (symptom)	A	J	M
	Diverticulitis		A	M
	Food Poisoning	A	J	M
	Gastroenteritis, Acute (viral)	A	J	M
	Gastroesophageal Reflux Disease	A	J	M
	Hepatitis		A	M
	Hernia, Abdominal		A	M
	Irritable Bowel Syndrome		A	M
	Pancreatitis, Acute		A	M
	Peptic Ulcer Disease		A	M
Abdominal Pain – Female	Ectopic Pregnancy	A		M
	Endometriosis		A	M
	Ovarian Cyst		A	M
Rectal Pain/Bleeding	Colorectal Cancer		A	M
	Hemorrhoid		A	M
	Pilonidal Cyst (abscess)		A	M
	Ulcerative Colitis		A	M

GENITOURINARY				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Female Complaint	Bacterial Vaginosis		A	M
	Bartholin's Cyst		A	M
	Candidiasis, Vulvovaginal	A	J	M
	Urinary Tract Infection	A	J	M
Male Complaint	Epididymitis	A	J	M
	Hydrocele, Acute		A	M
	Inguinal Hernia	A	J	M
	Prostatitis, Acute	A	J	M
	Testicular Torsion	A	J	M
	Urinary Tract Infection (UTI)	A	J	M
Hematuria	Varicocele		A	M
	Glomerulonephritis		A	M
	Pyelonephritis	A	J	M
Sexually Transmitted Disease	Renal Calculi	A	J	M
	Chancroid	A	J	M
	Chlamydia	A	J	M
	Condyloma Acuminata		A	M
	Gonorrhea	A	J	M
	Herpes Simplex Virus	A	J	M
	Human Immunodeficiency Virus (HIV)	A	J	M
	Lymphogranuloma Venereum		A	M
	Pediculosis		A	M
	Syphilis	A	J	M
Trichomoniasis		A	M	

GYNECOLOGICAL				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Menses	Dysfunctional Uterine Bleeding		A	M
	Dysmenorrhea	A	J	M

MUSCULOSKELETAL				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Neck pain	Cervical Muscle Strain	A	J	M
	Herniated Cervical Disk (HNP)		A	M
Shoulder pain	Bicipital Tendon Rupture, Proximal		A	M
	Bicipital Tendonitis	A	J	M
	Impingement Syndrome		A	M
	Rotator Cuff Tear		A	M
	Subacromial Bursitis	A	J	M
Elbow pain	Bursitis, Olecranon	A	J	M
	Epicondylitis	A	J	M
Wrist pain	Carpal Tunnel Syndrome	A	J	M
	Ganglion Cyst		A	M
	Scaphoid Wrist Fracture	A	J	M
Finger pain	Paronychia		A	M
Continued next page				

MUSCULOSKELETAL, Continued				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Lower Back Pain	Mechanical Muscular Strain	A	J	M
	Neurological, Herniated Disk	A	J	M
	Prostatitis (see GU– male)		A	M
	Pyelonephritis (see GU– hematuria)	A	J	M
	Renal Calculi (see GU– hematuria)	A	J	M
Knee Pain	Bursitis, Patellar	A	A	M
	Collateral Ligament Tear		A	M
	Cruciate Ligament Tear		A	M
	Meniscal Tear		A	M
	Patellofemoral Syndrome		A	M
	Popliteal Cyst		A	M
Ankle Pain	Achilles Tendon Rupture		A	M
	Ankle Sprain	A	J	M
Foot Pain	Fifth Metatarsal Fracture	A	J	M
	Heel Spur		A	M
	Plantar Fasciitis		A	M
Toe Pain	Ingrown nail		A	M
Leg Pain	Shin splints	A	J	M

NEUROLOGICAL				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Altered Mental Status	Alcohol Abuse	A	J	M
	Cerebrovascular Accident (CVA)		A	M
	Seizure	A	J	M
Emergent Headache	Hemorrhage, Subarachnoid		A	M
	Hypertension Emergency		A	M
	Meningitis	A	J	M
Non-Emergent Headache	Cluster Headache		A	M
	Sinusitis	A	J	M
	Tension Headache	A	J	M
	Vascular Headache		A	M
Vertigo	Labyrinthitis		A	M
	Meniere's Disease		A	M
	Motion Sickness		A	M
	Vertigo, Benign Positional		A	M
Facial Neuropathy	Bell's Palsy		A	M
	Cerebrovascular Accident		A	M
	Trigeminal neuralgia		A	M

MENTAL HEALTH				
CHIEF COMPLAINT	CONDITION	HS3 Post 'A' School	HS2	IDHS 'C' School
Feeling Down or Worried	Adjustment Disorder		A	M
	Anxiety		A	M
	Depression		A	M
	Suicidal Ideation		A	M

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CHIEF COMPLAINT: ERYTHEMA

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Anthrax (cutaneous) Caused by <i>Bacillus anthracis</i> and is transmitted to humans by infected animals; has also been used for hostile purposes as a bio- logical warfare agent.</p>	<ul style="list-style-type: none"> Begins as a localized, painless, pruritic, red papule 1-6 days after exposure May have fever, malaise, myalgia, headache, nausea, vomiting 	<ul style="list-style-type: none"> Progressive enlargement with marked erythema, edema, vesicles, central ulceration, and black pustules Exposure Hx important 	<ul style="list-style-type: none"> Same as s/s Assess localized lymphadenopathy 	<ul style="list-style-type: none"> Culture lesion Chest radiograph and specific tests as indicated 	<p>Antibiotic: Ciprofloxacin 500 mg po bid for 60 days</p>	<ul style="list-style-type: none"> CONTACT MO and Flight Surgeon Notify Command - <i>Disease Alert Report</i> Be familiar with the AVIP www.anthrax.osd.mil
<p>Cellulitis Acute, diffuse bacterial infection of dermis and subcutaneous tissue</p>	<ul style="list-style-type: none"> Regional erythema May have fever and malaise 	Indurated patch that is painful and warm to touch	<ul style="list-style-type: none"> Localized red (rubor) Tender (dolor) Warm (calor) Marked nonpitting swelling (tumor) Assess regional lymphadenopathy 	<ul style="list-style-type: none"> Culture lesion CBC Mark borders of induration to follow progression 	<p>Antibiotic:</p> <ul style="list-style-type: none"> <i>Mild:</i> Penicillin VK, or erythromycin (E-mycin) <i>Severe:</i> Ceftriaxone (Rocephin) IM Augmentin, if a bite 	<ul style="list-style-type: none"> F/U every 24 hours until resolved IF not resolved in 7 days or severe, contact MO
<p>Drug Reaction Most common adverse reaction to drugs is a skin rash</p>	Generalized, confluent, pruritic maculopapular rash	<ul style="list-style-type: none"> Hx medication use Onset may be delayed by 1 week; R/O anaphylaxis and bacterial pharyngitis 	<ul style="list-style-type: none"> Bright pink/red confluent maculopapular patch(es) Complete HEENT, CV & respiratory exams 	<ul style="list-style-type: none"> CBC if secondary infection suspected Rapid strep and/or throat culture if <i>Streptococcus</i> suspected 	<p>Antihistamine: Hydroxyzine (Atarax) or diphenhydramine (Benadryl)</p> <ul style="list-style-type: none"> Discontinue drug causing eruption 	<ul style="list-style-type: none"> CONTACT MO if no improvement in 24 hours Complete VAERS Report if vaccine reaction

CHIEF COMPLAINT: ERYTHEMA (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Furuncle Pus-filled mass caused by <i>staphylococcus aureus</i> or MRSA</p>	<ul style="list-style-type: none"> Localized erythema Fever is rare 	<p>Papule or nodule, firm or fluctuant; painful and warm to touch</p>	<ul style="list-style-type: none"> Localized red (rubor) Tender (dolor) Warm (calor) Papule or nodule (tumor) Assess regional lymphadenopathy 	<ul style="list-style-type: none"> Culture lesion CBC. Patient contacts may also be contaminated with MRSA 	<p>Antibiotic: TMP/SMX (Septra DS) (covers both <i>staph. aureus</i> and MRSA)</p> <ul style="list-style-type: none"> Incise and drain if fluctuant lesion Large wound may require Iodoform packing – repack daily or PRN 	<ul style="list-style-type: none"> F/U Every 24 hours until resolved If NOT resolved in 7 days or severe, contact MO
<p>Urticaria 'Hives' usually are a result of an adverse drug or food reaction; though there are other causes, they usually are unknown.</p>	<p>Generalized, confluent, pruritic maculopapular rash</p>	<ul style="list-style-type: none"> Recent history of ingestion of drug or food associated with generalized rash Ask about over-the-counter or herb use Aspirin (salicylate) is most common cause 	<ul style="list-style-type: none"> General distribution of wheals or hives in patches Respiratory distress 	<p>Usually none indicated</p>	<p>Antihistamine: Hydroxyzine (Atarax) or diphenhydramine (Benadryl)</p> <ul style="list-style-type: none"> Avoid cause Respiratory distress will need emergent treatment (see anaphylaxis) 	<p>F/U PRN. Chronic conditions refer to MO</p>

CHIEF COMPLAINT: ERYTHEMA (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Viral Exanthemas Measles, mumps, and rubella are contagious viral diseases</p>	<ul style="list-style-type: none"> • Generalized or regional erythemic maculopapular rash • May have fever, malaise, myalgia, headache and lymphadenopathy 	<p>Measles</p> <ul style="list-style-type: none"> • Coryza • Cough • Conjunctivitis • Koplik's Spots (white) on bucal mucosa • Rash spreads from face to trunk and extremities <p>Mumps</p> <ul style="list-style-type: none"> • Parotid gland pain and swelling, 15% with meningeal signs • Maculopapular rash less common <p>Rubella</p> <ul style="list-style-type: none"> • Childhood disease • Petechiae of soft palate • Rosy red oval or round macules • Rash spreads rapidly from face to trunk and extremities; fades in 24 to 48 hours 	<ul style="list-style-type: none"> • Skin exam: as described by history • Assess regional lymphadenopathy • Complete HEENT, CV and respiratory exams 	<ul style="list-style-type: none"> • CBC • R/O Mononucleosis 	<p>Antipyretic: Acetaminophen</p> <ul style="list-style-type: none"> • Otherwise, symptomatic Tx • Ensure MMR vaccination is up-to-date 	<p>If not improved in 7 days, consult with MO PRN</p>

CHIEF COMPLAINT: GROWTHS

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Molluscum Contagiosum</p> <ul style="list-style-type: none"> Contagious viral disease In children it is transmitted from fomites In adults it is transmitted from fomites, but primarily sexually or intimate contact 	Individual or grouped papules	Usually an incidental and asymptomatic finding by the patient	<ul style="list-style-type: none"> Dome-shaped, pearly white to flesh colored small lesions on trunk, extremities, or groin The lesions are firm and centrally umbilicated 	<ul style="list-style-type: none"> Biopsy may be indicated if unable to differentiate from basal cell carcinoma (BCC) BCC usually have telangiectasia and usually found on face 	<ul style="list-style-type: none"> Self limiting in most cases Cryotherapy or cantharidin application may be indicated Good hygiene Condom use if genital 	F/U PRN
<p>Wart, common Verruca vulgaris, verruca plantaris (sole of foot); caused by direct contact; human papilloma virus</p>	Individual papule (also see genital warts)	<ul style="list-style-type: none"> Smooth flesh colored papules that become dome-shaped, gray-brown growths with black dots No skin lines through lesion as corns do 	“Cauliflower” flesh-colored papules that become dome-shaped growths	Usually nothing indicated	<ul style="list-style-type: none"> Self limiting in most cases Cryotherapy or salicylic acid patch 	<ul style="list-style-type: none"> F/U PRN. Therapy may require repeated application every two weeks

CHIEF COMPLAINT: INFLAMMATORY

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Acne Vulgaris Inflammatory disorder of the pilosebaceous glands.	Few or multiple papules, pustules or nodules on face, chest or back	Closed comedones and/or open comedones	Non-inflamed comedones to inflammatory papules, pustules, nodules, and cysts on face, chest and/or back	Usually none indicated	Topical: Benzyl peroxide gel <ul style="list-style-type: none"> Apply after washing with mild soap and water twice per day 	<ul style="list-style-type: none"> F/U PRN Chronic conditions refer to MO
Insect Bite/Sting (non-venomous) Insect bites/stings inoculate poisons, invade tissue, and transmit disease. Here we discuss irritative bites only.	Irritative bites: localized inflamed papule	<ul style="list-style-type: none"> Other varied reactions may be localized, toxic systemic, or allergic systemic Consider related conditions like allergy, Lyme Disease, West Nile Virus, Malaria, etc. 	<ul style="list-style-type: none"> Irritative bites: local erythema, edema, and pain Complete thorough skin exam and review of systems 	Usually none indicated unless related conditions suspected	<ul style="list-style-type: none"> Symptomatic treatment Related conditions like allergy, Lyme Disease, West Nile Virus, Malaria, etc will require specific treatments 	<ul style="list-style-type: none"> F/U PRN Chronic conditions refer to MO
Miliaria Sweat flow is obstructed (prickly heat) by humidity (or extreme cold).	Regionalized papules and pruritus	“Heat or prickly rash”	Multiple discrete, small, red, inflamed papules mostly on trunk and back	Usually none indicated	Topical: Hydrocortisone 1% lotion to affected area. Cool environment	F/U PRN
Pseudofolliculitis Barbae Inflammatory response to an ingrown hair.	Papules on beard area	Difficulty shaving; “razor bumps”	Beard area has multiple yellow or grayish inflamed pustules surrounded by red base with hair in middle or ingrown	Usually none indicated	Topical: Benzyl peroxide gel If associated with beard, massage beard area gently in a circular motion with a warm, moist, soapy soft washcloth or facial scrub pad; give a limited (days) “no shaving” chit.	F/U PRN

CHIEF COMPLAINT: INFLAMMATORY (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Scabies Mite infestation from close contact with infected individual or linen/clothing.	Papules and pruritus	"Itch/scratch" that may interrupt sleep	Small, inflamed papules of linear "burrows" most common on groin, genitals, fingers/toes webbing	Usually none indicated	Topical: <ul style="list-style-type: none"> • Permethrins lotion or shampoo (Elimite/Nix) • Also treat shipboard or home contacts and wash associated clothing and linen 	F/U PRN

CHIEF COMPLAINT: SCALY

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Candidiasis (oral) 'Thrush' is a fungal infection of the oral epithelium caused by antibiotics, steroids, or immunosuppression (AIDS).	White intra-oral plaque that is easily scraped off	<ul style="list-style-type: none"> • History of antibiotic or oral topical steroids (like asthma treatment) or HIV infection • Pasty 'cottage cheese' taste 	White curd-like patches that appear like 'cottage cheese'	<ul style="list-style-type: none"> • Potassium hydroxide (KOH preparation) microscopic eval • Investigate cause if unknown 	Topical antifungal: Clotrimazole troches OR Oral Antifungal: Fluconazole	F/U if not improved in 14 days
Pityriasis Rosea Self-limiting skin disorder of unknown cause (may be viral).	Delicate, salmon-colored round or oval patches of fine white flakes	<ul style="list-style-type: none"> • Onset with "heralds patch" 2-10 mm pink/tan oval patch frequently misdiagnosed as ringworm. • Pruritus 	"Heralds patch" with salmon-colored round to oval patches with delicate flaking; over trunk and occasionally extremities; "Christmas tree" rash pattern on back.	Usually none indicated	Reassurance – self-limiting, resolves in two weeks to two months	F/U PRN
Psoriasis Chronic, recurring skin disease of the epidermis; of unknown cause (may be genetic).	Marked, silvery, flaking patches or plaques	Gradual onset exacerbated by stress and sunlight; nail pitting	Silvery pink scaly patches or plaques, classically on scalp, elbows and knees	Usually none indicated	<ul style="list-style-type: none"> • High-potency topical steroids have some effect • Refer to MO 	Refer to MO

CHIEF COMPLAINT: SCALY (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Seborrheic Dermatitis Chronic "dandruff" condition affecting mostly hairy regions.	Regional greasy scaling patches or plaques	<ul style="list-style-type: none"> • Chronic • Waxing and waning Sx 	Superficial, greasy, flaky patch on scalp, eyebrows, face, chest, and groin	<ul style="list-style-type: none"> • Usually none indicated • May have fungal component 	Topical: Selenium sulfide shampoo (Selsun Blue) every day for 2 weeks	F/U PRN. Consider <u>low</u> -potency topical steroid cream; hydrocortisone 1% if unimproved
Fungal						
Tinea Capitis Fungal infection of scalp.	Scaly patch on scalp	<ul style="list-style-type: none"> • Alopecia • Pruritis of scalp 	Round scaly patches with alopecia	Potassium hydroxide (KOH) preparation microscopic evaluation	Oral antifungal: Refer to MO	Refer to MO
Tinea Corporis Fungal infection of face, trunk, or extremities.	Scaly patch on body	<ul style="list-style-type: none"> • "Ringworm" • Pruritis of affected area 	Annular, erythematous, scaly patch with central clearing	Potassium hydroxide (KOH) preparation microscopic evaluation	Antifungal: Clotrimazole 1% cream	F/U PRN
Tinea Cruris Fungal infection of groin.	Scaly patch on groin	<ul style="list-style-type: none"> • "Jock itch" • Pruritis of groin 	Sharply demarcated patch or plaque with elevated, scaly border (occasionally vesicular border)	Potassium hydroxide (KOH) preparation microscopic evaluation	Antifungal: Clotrimazole 1% cream Loose-fitting under-clothes may help	<ul style="list-style-type: none"> • F/U PRN. • Consider <i>bacterial erythrasma</i> if not improving
Tinea Pedis Fungal infection of foot.	Scaly patch on feet	<ul style="list-style-type: none"> • "Athletes foot" • Pruritis of foot/feet 	Diffuse, not well- demarcated scaly patches on sole or toe webs	Potassium hydroxide (KOH) preparation microscopic evaluation	Antifungal: Clotrimazole 1% cream and/or tolnaftate 1% powder, solution, cream Keep area dry, wear clean and dry socks	F/U PRN
Tinea Unguium Fungal infection of nail.	Scaly nails	"Onychomycosis"	Nail exam: subungual scaly debris with yellowish nail	Potassium hydroxide (KOH) preparation microscopic evaluation	Oral antifungal: Refer to MO	Refer to MO
Tinea Versicolor Fungal infection of the skin.	Scaly patch on body	<ul style="list-style-type: none"> • Fine hypopigmented small patches, usually multiple on trunk • Mild pruritis of affected area 	White, tan or pink patches with fine flaking border	Potassium hydroxide (KOH) preparation microscopic evaluation Woods' Lamp	Topical: Selenium sulfide shampoo (Selsun Blue) every day for 2 weeks.	F/U PRN

CHIEF COMPLAINT: VESICULAR

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Eczematous						
Atopic Dermatitis Recurrent eruptions associated with history of hay fever, asthma, dry skin or eczema.	<ul style="list-style-type: none"> • Papulovesicular patch • Pruritis is prominent symptom 	<ul style="list-style-type: none"> • Chronic history of same • Scratching or oozing and crusting may occur 	Lichenified vesicular patches with classic distribution of flexural area of extremities	Usually none indicated	Topical: Hydrocortisone 1% cream Antihistamine: Hydroxyzine (Atarax) or diphenhydramine (Benadryl) for itch	F/U if not improved in 7 days
Contact Dermatitis Cutaneous reaction to irritant like chemical, product, metal, latex, clothing, soap, plant, etc.	<ul style="list-style-type: none"> • Papulovesicular patch • Severe pruritis. 	Acute history of contact to exogenous plant, chemical or metal; common offending agents include poison ivy/oak/sumac	Wet, papulovesicular patch with geometric outline and sharp margins	Usually none indicated	Oral Steroid: Prednisone (tapered dose) Antihistamine: Hydroxyzine (Atarax) or diphenhydramine (Benadryl) for itch	F/U if not improved in 7 days
Eczematous Dermatitis or Dyshidrosis Recurrent eruptions affecting the hands and feet.	<ul style="list-style-type: none"> • Papulovesicular patch • Mild pruritis 	Acute or chronic associated with excessive sweating, related to stress or irritation by nickel, chromate or cobalt	Papulovesicular patches on hands or feet soles (Some shoes have metal that are causative agent)	Usually none indicated	Topical: Hydrocortisone 1% cream	F/U PRN; usually chronic; may develop secondary bacterial infection
Infectious						
Herpes Simplex Virus Recurrent, incurable, contagious viral disease. (see oral and genital)	Localized, grouped, uniform lesion	<ul style="list-style-type: none"> • Acute or chronic. Primary infection; fever, malaise, headache, regional adenopathy. • Recurrent lesions with prodrome of fever or local warmth, burning, usually just prior to eruption 	<ul style="list-style-type: none"> • Grouped "grape-like" cluster of uniform vesicles that quickly become papules that rupture & weep • May be found on any body location • Usually recurs in same location 	Tzanck Smear or HSV antibody titers	Antiviral: <ul style="list-style-type: none"> • Acyclovir (Zovirax) for best results, take with first onset of Sx • Good hygiene • Patient education on transmission. Condom use if genital 	IF not resolved in 14 days, contact MO for advice Disease Alert Report required IF primary genital infection

CHIEF COMPLAINT: VESICULAR (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Infectious (cont)						
<p>Herpes Zoster “Shingles” is a latent cutaneous varicella virus infection involving a single dermatome. It is not infectious, though it may cause primary varicella if not immune.</p>	Localized, unilateral, linear, dermatomal lesion	Acute prodrome of knife-like pain, pruritis prior to eruption; lesion lasting weeks to months with predominant complaint of pain	Groups of vesicles on an erythematous base situated unilaterally along a dermatomal (nerve) distribution	Usually none indicated	<p>Antiviral: Acyclovir (Zovirax)</p> <p>Analgesic: Acetaminophen OR ibuprofen OR acetaminophen with codeine (narcotic) given short duration or as advised by MO</p> <p>Lesion lasting weeks to months</p>	Contact MO for advice
<p>Impetigo Superficial contagious skin infection caused by <i>Staphylococcus aureus</i>, Group A beta-hemolytic streptococci or <i>Streptococcus Pyogenes</i></p>	Localized crusted lesion	<ul style="list-style-type: none"> • Acute • History of minor trauma to area may be associated with disruption leading to weeping lesion that becomes crusted 	“Honey”-crusted lesion with red base, usually on face, that may have multiple new lesions surrounding	Culture wound on the advice of MO	<p>Antibiotic: Dicloxacillin or cephalexin (Keflex)</p> <p>Good hygiene</p>	F/U if not improved in 7 days
<p>Smallpox Highly contagious and deadly orthopox virus. It has been eradicated through aggressive immunization programs, though has the potential for use in bioterrorism.</p>	Prodrome - regional maculopapular rash	<ul style="list-style-type: none"> • Acute onset with oropharyngeal, facial, & arm lesions spreading to trunk & legs • Fever, headache, abdominal pain, vomiting, backache, & extreme malaise 	After 1-2 days, cutaneous lesions become vesicular, then pustular; unlike varicella, all lesions are in the same stage of development on a given body part. After 8-9 days all lesions become crusted.	Viral culture – notify laboratory of smallpox suspicion; highly contagious	Treatment is generally supportive, with antibiotics for secondary bacterial infections. Antivirals have never been used clinically.	<ul style="list-style-type: none"> • CONTACT MO and Flight Surgeon • Notify Command - Disease Alert Report • Be familiar with the SVP. http://www.smallpox.army.mil/

CHIEF COMPLAINT: VESICULAR (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Infectious (cont)						
<p>Varicella “Chickenpox” is a highly contagious viral disease, spread by respiratory droplets or direct contact.</p>	<p>Generalized macules that quickly develop to papules, rupture & crust</p>	<ul style="list-style-type: none"> • Acute prodrome of chills, fever, malaise, headache, sore throat, anorexia, dry cough • Lesions first develop on trunk, then to head and extremities • Classic “crops” of lesions with new papules develop simultaneously with ruptured crusted lesions • Pruritis 	<p>“Crops” of vesicles described as “dewdrop on a rose petal” in varying stages of development from macules to papules to vesicles to crusted lesions; first on trunk, then head and extremities</p>	<p>CBC otherwise usually nothing indicated</p>	<p>Symptomatic treatment; Self-limiting though a course of acyclovir may shorten duration Antiviral: Acyclovir (Zovirax) Bed rest</p>	<p>CONTACT MO for advice</p> <ul style="list-style-type: none"> • Infectious from 48 hours before rash to when all lesions crusted over • <i>Disease Alert Report</i> required • Heals without scar

CHIEF COMPLAINT: RED EYE OR PAIN

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Blepharitis Inflammation of the eyelid by either seborrhea or staphylococcal cause.</p>	<ul style="list-style-type: none"> Erythema of the eyelid margin Itchy, watery, burning sensation 	<p>Seborrheic Blepharitis: Dry flakes and oily secretion on the lid margins</p> <p>Staphylococcal Blepharitis: Ulcerations at base of eyelashes and photophobia</p>	<ul style="list-style-type: none"> Complete eye exam Erythema of lid margin that may be ulcerated if staphylococcal infection 	Usually none indicated	<ul style="list-style-type: none"> Clean eyelid margin with baby shampoo (also see seborrhea dermatitis) For staphylococcal: Topical ophthalmic: Gentamycin OR erythromycin solution/ointment No contact lens use until resolved 	F/U if not resolved in 14 days
<p>Chalazion Non-infectious meibomian gland occlusion causing swelling.</p>	<ul style="list-style-type: none"> Non-tender erythemic papule of the eyelid Itchy, watery, burning sensation 	Mild foreign body sensation but usually painless	<ul style="list-style-type: none"> Complete eye exam Swelling behind the lid margin 	Usually none indicated	<ul style="list-style-type: none"> Warm compress to promote drainage 5-10 minutes tid No contact lens use until resolved No contact lens use until resolved 	F/U if not resolved in 14 days
<p>Chemical Burn to eye Self explanatory.</p>	<ul style="list-style-type: none"> Erythema of the affected part of the eye Itchy, watery, burning sensation 	Determine causative agent	<ul style="list-style-type: none"> Complete eye exam Generalized erythema of affected area Assess for corneal abrasion with fluorescein stain—epithelial defect shows brilliant green with fluorescent staining 	<ul style="list-style-type: none"> Usually none indicated Fluorescein staining to determine ulceration or abrasion 	<ul style="list-style-type: none"> Immediate irrigation with copious normal saline for at least 10 minutes. Hold eyelid open. If alkali burn, irrigate for at least 40 minutes and during transport if possible <p><u>MEDEVAC</u></p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p>Emergency transport to emergency department or ophthalmologist <u>must</u> be considered</p>

CHIEF COMPLAINT: RED EYE OR PAIN (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Conjunctivitis, Allergic Inflammation of the conjunctiva.</p>	<ul style="list-style-type: none"> Erythema of the eyelid Bilateral Itchy, watery, burning sensation 	<ul style="list-style-type: none"> History of allergies, Rhinorrhea, itchy, watery eyes Seasonal environmental conditions present 	<ul style="list-style-type: none"> Complete eye exam Different Palpebral conjunctiva with cobblestone-like swelling 	Usually none indicated	<p>Topical ophthalmic: liquid tears</p> <p>Oral Antihistamine: Diphenhydramine (Benadryl), loratadine (Claritin), or Fexofenadine (Allegra)</p> <ul style="list-style-type: none"> Treat underlying allergic symptoms No contact lens use until resolved 	F/U if not resolved in 14 days
<p>Conjunctivitis, Infectious Contagious viral or bacterial infection of the conjunctiva.</p> <p>“Pink eye” refers to bacterial infection.</p>	<ul style="list-style-type: none"> Erythema of the eyelid Itchy, watery, burning sensation 	<ul style="list-style-type: none"> Bacterial - may have history of inoculation or family member with “pink eye,” purulent discharge with morning crusting of lid margin Viral – may have associated viral symptoms with watery discharge 	<ul style="list-style-type: none"> Complete eye exam Injected conjunctiva and margin edema Bacterial – crusted discharge may or may not be present Viral - may have preauricular adenopathy 	Usually none indicated	<p>Topical ophthalmic:</p> <ul style="list-style-type: none"> Bacterial infection - Gentamicin OR erythromycin solution/ointment Viral infection – liquid tears Good hygiene No contact lens use until resolved 	F/U if not resolved in 7 days
<p>Corneal Abrasion Breakdown in the epithelial barrier due to an abrasive injury or contact lenses. Most common eye injury.</p>	Foreign body sensation, tearing	<ul style="list-style-type: none"> History of trauma or contact lens irritation Severe pain and photophobia 	<ul style="list-style-type: none"> Complete eye exam Consider tetracaine 0.5% ophthalmic solution to help examine eye Epithelial defect shows brilliant green with fluorescein staining 	Fluorescein staining to confirm abrasion	<p>Irrigation with normal saline for at least 10 minutes</p> <p>Topical ophthalmic: Gentamicin OR erythromycin solution/ointment</p> <ul style="list-style-type: none"> No contact lens use until resolved 	<ul style="list-style-type: none"> Usually resolves in 24 hours If not resolved in 24 hours consult MO

CHIEF COMPLAINT: RED EYE OR PAIN (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Foreign Body on eye Self explanatory</p>	Foreign body sensation, tearing	<ul style="list-style-type: none"> History of trauma Mild to severe pain Photophobia Foreign body sensation Tearing 	<ul style="list-style-type: none"> Complete eye exam Consider tetracaine 0.5% ophthalmic solution to help examine eye Foreign body may be imbedded and sometimes difficult to find & may or may not cause abrasion Epithelial defect shows brilliant green with fluorescein staining 	Fluorescein staining to determine abrasion	<ul style="list-style-type: none"> Attempt to visualize foreign body and carefully remove using cotton-tip moist with normal saline Irrigation with normal saline for at least 10 minutes Topical ophthalmic: Entamicin OR erythromycin solution/ointment No contact lens use until resolved 	<ul style="list-style-type: none"> IF/U if not resolved in 24 hours Reinforce eye protection use
<p>Glaucoma Closed-angle glaucoma is an acute decreased outflow of aqueous humor through pupil due to an anatomically narrow anterior chamber increasing intraocular pressure. (open-angle is a slow progressive disease)</p>	<ul style="list-style-type: none"> Injected conjunctiva and ocular pain May have eyelid edema 	<ul style="list-style-type: none"> Acute blurred vision Frontal headache Lacrimation “Halos” around lights Possible nausea & vomiting 	<ul style="list-style-type: none"> Complete eye exam Increased intraocular pressure (IOP) to 50-65 mmHg. IOP in uveitis is generally 35-45 mmHg 	<ul style="list-style-type: none"> Tonometry If no tonometry, red, painful eye with visual halos is ‘warning’ sign 	<p>Emergency treatment is <u>required</u> as the optic nerve may become compressed by high intraocular pressure</p> <ul style="list-style-type: none"> No contact lens use until resolved 	<p><u>CONTACT</u> MO or Duty Flight Surgeon <u>MEDEVAC</u></p>

CHIEF COMPLAINT: RED EYE OR PAIN (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Hordeolum Infection or inflammation of eyelid hair follicle internal or external (aka sty)</p>	<ul style="list-style-type: none"> • Tender erythemic papule on eyelid margin • Itchy, watery, burning sensation 	<p>Sudden onset of localized tenderness on eyelid margin</p>	<ul style="list-style-type: none"> • Complete eye exam • Erythemic papule on eyelid margin • Bacterial infection usually has discharge in area 	<p>Usually none indicated</p>	<ul style="list-style-type: none"> • Warm compress to promote drainage 5-10 minutes tid • No contact lens use • Bacterial infection: gentamicin or erythromycin solution/ointment • No contact lens use until resolved 	<p>F/U if not resolved in 7 days</p>
<p>HypHEMA Blood in the anterior chamber</p>	<p>May or may not have erythema of the eyelid</p>	<ul style="list-style-type: none"> • History of trauma or spontaneous presentation • Dull ache & decreased vision 	<ul style="list-style-type: none"> • Complete eye exam • Blood in anterior chamber, decreased visual acuity, intraocular pressure may rise 	<p>Tonometry</p>	<p>Think: concern for increased intraocular pressure Bed rest for 3-5 days</p> <ul style="list-style-type: none"> • No contact lens use until resolved 	<p>CONTACT MO or Duty Flight Surgeon</p>
<p>Pinguecula Benign 'yellowish' colored lesion on bulbar conjunctiva caused by irritation</p>	<ul style="list-style-type: none"> • Perceived as unsightly • Asymptomatic 	<p>Eye irritation and patient concern</p>	<ul style="list-style-type: none"> • Complete eye exam • Triangular, fleshy papule over sclera/bulbar conjunctiva 	<p>Usually none indicated</p>	<p>Reassurance</p> <ul style="list-style-type: none"> • No contact lens use until resolved 	<ul style="list-style-type: none"> • F/U PRN • Consult with MO if in doubt
<p>Pterygium Benign 'yellowish' colored lesion encroaching onto the cornea caused by irritation</p>	<ul style="list-style-type: none"> • Perceived as unsightly • Asymptomatic 	<p>Eye irritation, visual changes, & patient concern</p>	<ul style="list-style-type: none"> • Complete eye exam • Triangular, fleshy growth of bulbar conjunctiva onto the cornea; nasal side 	<p>Usually none indicated</p>	<p>Reassurance</p> <ul style="list-style-type: none"> • No contact lens use until resolved 	<ul style="list-style-type: none"> • F/U PRN • Consult with MO if in doubt. Refer to optometrist if change in acuity.

CHIEF COMPLAINT: RED EYE OR PAIN (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Retinal Detachment Self-explanatory. The cause can be trauma or retinal tear common in highly myopic [good near-sight (minus lens)] individuals</p>	Decrease or loss of vision	<ul style="list-style-type: none"> History of visual flashes of lights or sparks May be described as a “curtain falling” or cloudy or smoky in front of their eye 	<ul style="list-style-type: none"> Complete eye exam Detached retina appears gray with white folds during ophthalmoscope exam 	<ul style="list-style-type: none"> Ophthalmoscope Tonometry 	<ul style="list-style-type: none"> Patch as directed Emergency treatment is <u>required</u> No contact lens use until resolved 	<p><u>CONTACT MO</u> or Duty Flight Surgeon <u>MEDEVAC</u></p>
<p>Subconjunctival Hemorrhage Blood under the conjunctiva</p>	May or may not have erythema of the eyelid	<ul style="list-style-type: none"> Asymptomatic. History of venous pressure from straining 	<ul style="list-style-type: none"> Complete eye exam Blood under the conjunctiva may spill over into the lower lid margin 	Tonometry	<ul style="list-style-type: none"> No treatment is necessary short of treatment to associated minor trauma if any. Treat underlying illness if present No contact lens use until resolved 	F/U if not improved in 14 days
<p>Uveitis Acute inflammation of the uveal tract (iris, ciliary body and choroids), increasing intraocular pressure</p>	Injected conjunctiva & ocular pain	<ul style="list-style-type: none"> Acute blurred vision, deep ache & photophobia May have history of trauma or inflammatory condition 	<ul style="list-style-type: none"> Complete eye exam Dilated pupil, injected flare along limbus border Increased intraocular pressure to 35-45 mmHg 	<ul style="list-style-type: none"> Tonometry If no tonometry, <i>red, painful eye with photophobia is 'warning' sign.</i> 	<p>Emergency treatment is <u>required</u> as the optic nerve may become compressed by high intraocular pressure</p> <ul style="list-style-type: none"> No contact lens use until resolved 	<p><u>CONTACT MO</u> or Flight Surgeon <u>MEDEVAC</u></p>

CHIEF COMPLAINT: EARACHE

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Barotrauma Ear pain or damage caused by rapid change in pressure	Ear pain	<ul style="list-style-type: none"> History of trauma or rapid pressure change Acute hearing loss 	<ul style="list-style-type: none"> Conductive hearing loss R/O TM perforation 	<ul style="list-style-type: none"> Weber or Rinne Test Whisper test or Audiogram 	<ul style="list-style-type: none"> Self-limiting Decongestant or Valsalva maneuver may be helpful 	F/U if not improved in 7 days
Cerumen Impaction Cerumen is a natural lubricant for the ear canal; accumulation of cerumen can cause obstruction, thus hearing loss, tinnitus, and infection.	<ul style="list-style-type: none"> Ear pain and/or hearing loss May be asymptomatic 	<ul style="list-style-type: none"> Bilateral or unilateral itchy sensation in ear canal Chronic Q-tip use in ear canal causes cerumen production leading to impaction 	TM not visible with irritated appearing external canal	Usually none indicated	Emulsifying Agent: Debrox <ul style="list-style-type: none"> Ear irrigation with warm sterile water 	F/U if not improved in 7 day
Eustachian Tube Dysfunction ET equalized pressure in the middle ear. Viral symptoms and allergies may block tube with swelling.	Ear pain and/or hearing loss	Popping sensation in ear	Normal TM	Tympanometry. (normal peak though may be diminished)	Decongestant: Pseudoephedrine	F/U if not improved in 7 days
Mastoiditis Infective process of the mastoid air cells	Ear pain	<ul style="list-style-type: none"> History of recurrent or inadequate treatment of otitis media Feverish feeling 	<ul style="list-style-type: none"> Fever, bulging purulent & erythemic TM Postauricular edema and tenderness 	CBC & mastoid radiographs	Antibiotics: Ceftriaxone IV (Rocephen) (consult with MO prior to administering drug) Emergency treatment is <u>required</u>	<u>CONTACT</u> MO or Duty Flight Surgeon <u>MEDEVAC</u>

CHIEF COMPLAINT: EARACHE (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Otitis Externa Infection of the external auditory canal	Ear pain	<ul style="list-style-type: none"> • May have history of swimming • Itchy sensation in ear canal • May have otorrhea 	<ul style="list-style-type: none"> • Tenderness with pinna 'tug' • Edema and erythema of external canal • Normal TM 	Usually none indicated	Topical: Corticosteroid	F/U if not improved in 7 days; R/O <i>Pseudomonas</i> infection with persistent symptoms
Otitis Media Infection of the middle ear	Ear pain	<ul style="list-style-type: none"> • History of viral symptoms or Eustachian tube dysfunction • May have nasal discharge, otorrhea, fever or dizziness 	TM inflamed, non-mobile, bulging with decreased light reflex	Tympanometry	Antibiotics: Amoxicillin (Amoxil), or erythromycin (Emycin)	F/U if not improved in 7 days
Perforation of Tympanic Membrane Self-explanatory	Ear pain and hearing loss	<ul style="list-style-type: none"> • History of trauma, barotrauma, or insertion of object into ear canal • Bleeding from canal, hearing loss, tinnitus 	TM perforated. Blood may be present in canal	<ul style="list-style-type: none"> • Tympanometry • Audiogram before and after treatment 	<ul style="list-style-type: none"> • No specific treatment • Keep ear dry with ear plugs in shower • No swimming 	F/U if not improved in 7 days
Serous Otitis Media Effusion of serous fluid in middle ear	Ear Pain	<ul style="list-style-type: none"> • History of viral or allergy symptoms or Eustachian tube dysfunction • Popping sensation in ears 	TM is relatively normal with fluid line or fluid bubble visible	Tympanometry	Decongestant: Pseudoephedrine	F/U if not improved in 7 days
Temporomandibular Joint (TMJ) Syndrome Pain in the TMJ that may be referred to the ear; commonly caused by grinding of teeth	Ear or TMJ pain	<ul style="list-style-type: none"> • Popping sensation in TMJ or ears • Headache 	<ul style="list-style-type: none"> • Normal ear exam • May have tenderness and crepitus of TMJ with range of motion test or mastication 	Usually none indicated	<ul style="list-style-type: none"> • Stress reduction may be helpful • Referral to dental clinic 	F/U PR

CHIEF COMPLAINT: STUFFY NOSE

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Allergic Rhinitis Allergic response to airborne allergens affecting the nose and eyes</p>	<ul style="list-style-type: none"> Nasal congestion Seasonal allergies common in the spring where perennial allergies may last all year 	<ul style="list-style-type: none"> Watery, itchy eyes and nose, sneezing, clear nasal discharge Postnasal drip may cause cough 	<ul style="list-style-type: none"> Pale, boggy turbinates, conjunctiva injection May have dark circles under eyes 	<ul style="list-style-type: none"> Usually none indicated CBC (eosinophilia) CT of sinus if Sx persist 	<p>Antihistamine: loratadine (Claritin), or fexofenadine (Allegra)</p>	F/U PRN
<p>Common Cold Viral upper respiratory infection occurring anytime during the year. (influenza is usually in winter months)</p>	Nasal congestion.	<ul style="list-style-type: none"> General malaise and low-grade fever Rhinorrhea, sore throat, and cough Influenza has high fever with more acute & severe Sx 	<ul style="list-style-type: none"> Possible fever Nasal turbinate edema and erythema with clear/white discharge Injected conjunctiva and throat Clear lungs 	Usually none indicated	<p>Self limiting. Analgesic: Acetaminophen or ibuprofen</p> <p>Decongestant: Pseudoephedrine or combined with antihistamine</p>	F/U if not improved in 7 days
<p>Epistaxis (Nosebleed):</p> <ul style="list-style-type: none"> Anterior: Kiesselbach's plexus Posterior: posterior half of roof of nasal cavity May be idiopathic, traumatic or medical cause 	Stuffy nose	<ul style="list-style-type: none"> Bloody nose May have history of aspirin or NSAID use or trauma 	Bleeding from the nostril(s) and/or clot	<p>Usually none indicated</p> <ul style="list-style-type: none"> CBC CT of sinus if Sx persist 	<p>Anterior epistaxis: Pinch nostrils for several minutes. Vasoconstrictor like Afrin may help.</p> <p>Posterior epistaxis: Pack nostril with Vaseline-coated gauze</p>	Refer for emergency intervention if unsuccessful immediate treatment

CHIEF COMPLAINT: STUFFY NOSE (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Sinusitis Inflammation <u>or</u> infection of mucous membranes of paranasal sinus</p>	Nasal congestion	<ul style="list-style-type: none"> • Sinus pressure, facial pain or headache • May have yellow - green nasal discharge, maxillary toothache, fever or malaise 	<ul style="list-style-type: none"> • Turbinates are erythemic and swollen • Face pain worse when bending over (tilt test), sinus tenderness with percussion • May be unable to transilluminate sinuses 	<ul style="list-style-type: none"> • Usually none indicated • CT of sinus if Sx persist 	<ul style="list-style-type: none"> • Reserve antibiotics for patients that fail a 7 day course of decongestants and analgesics • Antibiotic: Amoxicillin-clavulanate (Augmentin) or Septra DS 	F/U if not improved in 7 days or increased fever or headache

CHIEF COMPLAINT: SORE MOUTH/THROAT

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Aphthous Ulcer Mouth ulceration on buccal mucosa referred to as “canker sore.” Cause is idiopathic though may be related to stress or other more serious condition if recurrent.</p>	Mouth sore	Painful ulcers	White circular lesions surrounded by an erythematous margin	Usually none indicated	<ul style="list-style-type: none"> • OTC benzocaine preparations like Anbesol and Oragel • Reassurance 	<ul style="list-style-type: none"> • F/U PRN • Refer to MO if recurrent
<p>Epiglottitis Inflammation <u>and</u> infection of the epiglottis. More common in children.</p>	Sore throat	Fever, dysphagia, drooling, muffled voice, and may hold tripod position (head forward and tongue out)	<ul style="list-style-type: none"> • Inspiratory stridor, cervical adenopathy • Throat most likely appears normal • Do NOT use tongue blade to visualize throat 	<ul style="list-style-type: none"> • Blood culture • Chest radiograph • Throat culture conducted ONLY in emergency room with tracheostomy kit available 	<p>Antibiotics: Ceftriaxone IV (Rocephen) (consult with MO prior to administering drug)</p> <p>Emergency treatment is <u>required</u></p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon <u>MEDEVAC</u></p>
<p>Herpes Simplex Virus Incurable, contagious, recurrent viral disease. HSV1 generally associated with oral symptoms and HSV2 genital symptoms though may be mixed and not distinguishable clinically. Referred to as “fever blister.” Recurrence may be associated with sunlight, illness, or emotional stress.</p>	Mouth sore	<ul style="list-style-type: none"> • May have prodrome of localized pain, warmth, burning usually just prior to irruption • Occasional tender adenopathy • Headache, myalgia, or fever • Primary infection may be worst of Sx 	<ul style="list-style-type: none"> • Primary infection: grouped “grape-like” cluster of uniform vesicles on erythematous base; lesions erode and crust, last 2 to 6 weeks • Recurrent Infection: same as above though dome shaped lesions rupture and crust lasting about 8 days 	Tzanck Smear or HSV antibody titers	<p>Antiviral: Acyclovir (Zovirax) For best results, take with first onset of Sx</p> <ul style="list-style-type: none"> • Patient education on transmission • Condom use if genital 	<ul style="list-style-type: none"> • IF not resolved in 14 days contact MO for advice • Disease Alert Report required IF primary genital infection only

CHIEF COMPLAINT: SORE MOUTH/THROAT (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Laryngitis Inflammation of the mucosa of the larynx or vocal cords may be associated with excessive voice use or virus</p>	Sore throat	<ul style="list-style-type: none"> • Voice hoarseness main feature • If viral, fever, malaise, difficult swallowing, regional lymphadenopathy may be present 	Exam may be normal or have slight pharyngeal erythema	Usually none indicated	<ul style="list-style-type: none"> • Supportive care • Strict voice rest for a few days or until resolving 	F/U if not improved in 7 days
<p>Mononucleosis Contagious infection caused by the Epstein-Barr virus. Spread by person to person oropharyngeal route</p>	Gradual onset of sore throat, fatigue and malaise	<ul style="list-style-type: none"> • Headache, fever, malaise, fatigue • Sx generally lasting longer than 2 weeks (a normal course for common viral syndromes) • May have generalized maculopapular rash 	<ul style="list-style-type: none"> • Appears ill and is febrile • Palatal petechiae is key feature with white membrane on tonsils, posterior cervical adenopathy, hepatic or splenic enlargement 	<ul style="list-style-type: none"> • Rapid Strep test (30% with mono also have strep throat) • Mono Spot CBC • Consider EBV, LFT and throat culture 	<ul style="list-style-type: none"> • Supportive care. Recovery may take weeks. Maintain healthy diet and rest • Avoid 'contact' sports • Good hygiene 	<ul style="list-style-type: none"> • Consult MO or Duty Flight Surgeon • Follow up if not improved in 30 days
<p>Peritonsillar Abscess Bacterial cellulites of peritonsillar area. Initiates in tonsil and spreads to surrounding soft tissue.</p>	Severe sore throat and difficulty swallowing	<p>Fever with marked trismus (difficulty opening mouth)</p> <p>Virtually always unilateral and "hot potato voice"</p>	<ul style="list-style-type: none"> • Appears ill and is febrile • Pharyngeal erythema, tonsil displaced medially with unilateral neck swelling 	CT of neck or ultrasound can confirm diagnosis	<p>Antibiotic: Penicillin IV or ceftriaxone IV (Rocephen) (consult with MO prior to administering drug)</p> <p>Emergency treatment is <u>required</u>. (Incision & drainage of abscess completed in emergency room)</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p><u>MEDEVAC</u></p>

CHIEF COMPLAINT: SORE MOUTH/THROAT (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Pharyngitis, Bacterial</p> <p>Infection of throat by group A beta-hemolytic streptococci; other organisms can cause bacterial infection, but they are not discussed here. Also referred to as tonsillopharyngitis</p>	Severe sore throat	<ul style="list-style-type: none"> • Acute onset • Describes halitosis, fever, difficulty swallowing, chills, malaise & headache • Usually NO common cold symptoms or cough 	<ul style="list-style-type: none"> • May appear ill and is febrile • Triad: pharyngeal erythema (beefy red), tonsillar exudate, cervical adenopathy 	<ul style="list-style-type: none"> • Rapid Strep • Throat culture if rapid strep negative 	<p>Antibiotic:</p> <p>Penicillin VK</p> <ul style="list-style-type: none"> • Saline gargle • New toothbrush • Good hygiene • Family may have same Sx – consider testing/treatment 	<ul style="list-style-type: none"> • F/U if not improved in 7 days • Tonsillar hypertrophy may be present and concern for airway obstruction
<p>Pharyngitis, Viral</p> <p>Viral infection of the throat (also see mono-nucleosis)</p>	Acute onset of sore throat and malaise	<ul style="list-style-type: none"> • Feverish, difficulty swallowing, chills, malaise, and headache • Coryza and common cold symptoms usually suggest viral, not bacterial infection 	<ul style="list-style-type: none"> • Fever • Rhinorrhea • Viral conjunctivitis • Pharyngeal erythema • Nonproductive cough 	Rapid Strep	<ul style="list-style-type: none"> • Supportive care • Saline gargle • Good hygiene 	F/U if not improved in 7-14 days
<p>Salivary Stone</p> <p>Calcium salts accumulate in salivary glands causing parotid, submandibular or sublingual duct obstruction.</p>	Swelling and pain of the salivary gland	Localized pain is key feature mostly after eating	The stone may be felt by palpation of the duct/gland in the mouth	If stone is not apparent on exam, give patient lemon juice, hard candy (something to stimulate saliva). Reproduction of Sx is diagnostic.	<ul style="list-style-type: none"> • Manual manipulation (massage) of duct/gland may help stone extraction • Antibiotics indicated if associated bacterial infection present 	<ul style="list-style-type: none"> • F/U if not improved in 7 days • Watch for secondary infection

CHIEF COMPLAINT: CHEST PAIN						
CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Cardiac						
<p>Acute Coronary Syndrome</p> <p>Acute obstruction of coronary artery. Ranges from unstable angina pectoris (cardiac chest pain at rest) to myocardial infarction (necrosis of heart muscle) to sudden death.</p> <p>Known as Acute Myocardial Infarction (MI)</p>	<ul style="list-style-type: none"> • Acute onset of chest pain • Patient may focus on denial of cardiac relation to cardiac condition 	<p>O – acute</p> <p>P – rest may make better, activity/stress makes worse</p> <p>Q – dull, tight, pressing, not usually sharp pain</p> <p>R – substernal ache, radiating to back or shoulders</p> <p>S – severe to vague</p> <p>T – <u>angina at rest lasts longer than 20 minutes.</u></p> <p>Shortness of breath, nausea, diaphoresis, & weakness may be associated</p>	<ul style="list-style-type: none"> • Appears anxious, diaphoretic, pallor, dyspnea • Assess vitals, jugular vein distention, third-fourth heart sound, adventitious lung sounds, extremity edema 	<ul style="list-style-type: none"> • ECG may have non ST-segment changes. ST-segment elevation and/or Q-waves is suggestive of MI • Troponin-I - Normally, troponin levels are very low; even slight elevations can indicate some degree of damage to the heart • Creatinine kinase (CK) or CK-MB 	<p><u>I</u>V – Normal Saline</p> <p><u>M</u>orphine</p> <p><u>O</u>xygen</p> <p><u>N</u>itroglycerin</p> <p><u>A</u>spirin</p> <ul style="list-style-type: none"> • Comfortable rest • Emergency treatment is <u>required</u> 	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p><u>MEDEVAC</u></p>
<p>Angina Pectoris</p> <p>“Chest pain” caused by diminished oxygen supply to heart muscle by ischemia or narrowing of the coronary arteries.</p> <p><i>Stable angina</i> is exercise induced.</p> <p><i>Unstable angina</i> also occurs at rest.</p> <p><i>Prinzmetal’s angina</i> may occur at rest; caused by coronary artery spasms, not ischemia.</p>	<ul style="list-style-type: none"> • Acute onset of chest pain • Denial of cardiac relation may be patient focus 	<p>O – acute</p> <p>P – rest may make better, activity/stress makes worse</p> <p>Q – dull, tight, pressing, not usually sharp pain</p> <p>R – substernal ache, radiating to back or shoulders</p> <p>S – severe to vague</p> <p>T – see definition</p> <p>Shortness of breath, nausea, diaphoresis, & weakness may be associated</p>	<ul style="list-style-type: none"> • Appears anxious, diaphoretic, pallor, dyspnea • Assess vitals, jugular vein distention, third-fourth heart sound, adventitious lung sounds, extremity edema 	<ul style="list-style-type: none"> • No test is diagnostic for angina • ECG is indicated though may be normal. Unstable angina may have ST segment changes. 	<p><u>I</u>V – Normal Saline</p> <p><u>M</u>orphine</p> <p><u>O</u>xygen</p> <p><u>N</u>itroglycerin</p> <p><u>A</u>spirin</p> <ul style="list-style-type: none"> • Comfortable rest • Emergency treatment is <u>required</u> 	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p><u>MEDEVAC</u></p>

CHIEF COMPLAINT: CHEST PAIN (continued)						
CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Cardiac (continued)						
Pericarditis Inflammation of the pericardium (fibrous sac surrounding the heart)	Acute onset of chest pain	O – acute P – relieved by leaning forward and sitting up Q – dull, tight, pressing R – substernal ache, radiating to back or shoulders S – severe to vague T – may have recent viral syndrome Shortness of breath, nausea, diaphoresis, & weakness may be associated	<ul style="list-style-type: none"> Appears anxious, diaphoretic, pallor, dyspnea Assess vitals, febrile, “friction rub” heart sound, adventitious lung sounds 	<ul style="list-style-type: none"> ECG may have ST-segment “concave” elevation in most leads creating a “smile face” CBC and Chest radiograph 	Analgesics: <ul style="list-style-type: none"> Aspirin or ibuprofen Oxygen PRN Comfortable rest. Emergency treatment may be necessary 	CONTACT MO or Duty Flight Surgeon. <ul style="list-style-type: none"> Consider MEDEVAC as MI cannot be ruled out
Non-Cardiac						
Anxiety Excessive worry, fear, nervousness, and hypervigilance. May be associated with adjustment disorder or generalized.	Chest pain may be associated with stress or panic attack	Physical complaints prompt patient to seek medical attention; worry, insomnia, muscle tension, headache, fatigue, GI upset.	<ul style="list-style-type: none"> Appears anxious, diaphoretic, pallor, dyspnea Mental health interview Assess vitals and R/O cardiac involvement 	<ul style="list-style-type: none"> ECG is normal Objective Anxiety Questionnaire. (Beck's) 	<i>Acute Tx:</i> Antianxiety: hydroxyzine (Atarax) OR diazepam (Valium) <i>Chronic Tx:</i> Refer to MO	CONTACT MO or Duty Flight Surgeon IF doubt
Costochondritis “Tietze’s disease” is an inflammation of the rib cartilage/ligament/muscles.	Chest pain is exacerbated by cough or deep breathing	History of physical exertion or trauma to chest or ribs	Direct palpable chest wall tenderness of costochondral ligament/muscle	ECG is normal	Analgesics: Acetaminophen or ibuprofen Reassurance	CONTACT MO or Duty Flight Surgeon IF doubt

CHIEF COMPLAINT: CHEST PAIN (continued)						
CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Non-Cardiac (continued)						
<p>Gastroesophageal Reflux Disease Irritation caused by reflux of gastric secretions into the esophagus (i.e. GERD). Excessive use of tobacco, alcohol, & caffeinated products can be contributing factors</p>	Chest pain and nausea may be associated with meal, exercise, or patient resting supine	<ul style="list-style-type: none"> • Epigastric “heartburn” • Regurgitation causing bitter taste • Symptoms relieved by sitting up or antacids • May have nagging cough 	<ul style="list-style-type: none"> • May have normal exam findings • Assess for epigastric tenderness 	<ul style="list-style-type: none"> • ECG is normal • Antigen/antibody for H. pylori 	<p><i>Acute Tx:</i> H2 Inhibitor: Ranitidine (Zantac) <i>For chronic Tx or H. pylori refer to MO</i></p>	CONTACT MO or Duty Flight Surgeon IF doubt
<p>Pleuritis Viral infection causing inflammation of the pleurae sac surrounding the lungs</p>	Chest pain	<ul style="list-style-type: none"> • Marked sharp stabbing pain with respiration • May have recent viral syndrome 	<ul style="list-style-type: none"> • Febrile • Friction fremitus with respiratory sounds 	<ul style="list-style-type: none"> • ECG is normal • Chest radiographs 	<p>Analgesics: Aspirin or ibuprofen</p>	<ul style="list-style-type: none"> • F/U if not improved in 7 days • Consult with MO PRN

CHIEF COMPLAINT: SYNCOPE						
CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Arrhythmia</p> <p>Rhythm is just that; regular, coordinated electrical impulses. Arrhythmia is loss of heart rhythm, either a regular or irregular abnormality.</p>	<p>Transient, sudden loss of consciousness that resolves spontaneously</p>	<ul style="list-style-type: none"> • May have history of arrhythmia and fainting • Palpitations and lightheadedness may precede syncope • Age usually greater than 50 	<ul style="list-style-type: none"> • Appears anxious, diaphoretic, pallor, dyspnea or normal • Complete physical examination 	<ul style="list-style-type: none"> • Orthostatic blood pressure • ECG is indicated but may be normal at time of exam 	<ul style="list-style-type: none"> • Refer to MO • Evaluate urgency of case 	<p>CONTACT MO or Duty Flight Surgeon IF doubt or abnormal ECG</p>
<p>Orthostatic Hypotension</p> <p>Benign failure of normal compensation for blood pressure drop reducing blood flow to brain due to dehydration</p> <p><i>Vasovagal syncope</i> has similar end result with different mechanism of action</p>	<p>Transient, sudden loss of consciousness that resolves spontaneously</p>	<ul style="list-style-type: none"> • Brought on by dehydration secondary to vomiting, diarrhea, bleeding, diuretic medication, emotional stress, warm environment • Palpitations and lightheadedness may precede syncope 	<ul style="list-style-type: none"> • Appears anxious, diaphoretic, pallor, dyspnea or normal • Complete physical examination 	<ul style="list-style-type: none"> • Orthostatic blood pressure • ECG is indicated but may be normal at time of exam • Electrolyte imbalance can cause ECG changes 	<p>IV – NS or oral fluid replenishment</p>	<p>CONTACT MO or Duty Flight Surgeon IF doubt or abnormal ECG</p>

CHIEF COMPLAINT: SYNCOPE (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Seizure Paroxysmal hyper excitation of the neurons in the brain; epilepsy is chronic recurrent seizures</p>	Compromised motor activity	<ul style="list-style-type: none"> • <u>Partial Seizure</u> – no loss of consciousness, though simple muscle contractions, paresthesias, loss of bowel & bladder • <u>Petit Mal Seizure</u> – sudden stopping of motor function with blank stare • <u>Grand Mal Seizure</u> – loss of consciousness, tonic-clonic muscle contractions, loss of bowel & bladder; postictal period 	Between seizures physical exam is normal though may have bruising or trauma to tongue just after	<ul style="list-style-type: none"> • CBC • Chemical Panel • Urinalysis • Drug & alcohol screening • CT scan or MRI 	<ul style="list-style-type: none"> • During seizure, maintain airway and prevent injury • Refer to MO <u>Seizure > 10 minutes needs emergency intervention!</u> 	Consult with MO or Flight Surgeon

CHIEF COMPLAINT: VASCULAR SYMPTOMS

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Deep Vein Thrombosis Blood clot(s) in the calf or femoral veins resulting in inflammation (e.g., DVT)</p>	Leg pain	Limb pain and swelling	Calf tenderness swelling with increased diameter (note difference between unaffected calf)	Positive Homan's sign	<ul style="list-style-type: none"> Support hose Refer to MO Evaluate urgency of case 	CONTACT MO or Duty Flight Surgeon
<p>Raynaud's Disease Vasospasm of the vessels of the digits in response to cold or stress</p>	Hand pain	<ul style="list-style-type: none"> Fingertips turn mottled white and red then cyanotic Tobacco use exacerbates Sx 	<ul style="list-style-type: none"> Normal examination between attacks Cold challenge test will reproduce Sx 	Cold challenge test	Caution patient about cold exposure and to stop tobacco use	Refer to MO
<p>Varicose Veins Superficial veins with incompetent valves cause dilation of veins</p>	Burning sensation and unsightly discoloration at site	Patient concern mostly about appearance though extensive varicosities have constant dull ache	Dilated, tortuous veins of the medial anterior ankle, calf or thigh	Usually nothing indicated	Avoid prolonged standing, and use support hose PRN	Refer to MO PRN

CHIEF COMPLAINT: COUGH

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Acute						
Bronchitis, Mycoplasma Inflammatory condition of the tracheobronchial tree caused by mycoplasma pneumoniae (non-bacterial)	Non-productive, recurrent, barking cough early, then becomes productive	<ul style="list-style-type: none"> Severe cough with purulent sputum late Sx persist for > 2 weeks Fever, fatigue, and possible hemoptysis 	<ul style="list-style-type: none"> Low-grade fever Lung sounds: coarse rhonchi and possibly rales 	Chest radiograph	Cough suppression with expectorant: Robitussin DM Antibiotic: Erythromycin (E-Mycin) or Bactrim DS Bed rest	F/U if not improved in 7 days
Bronchitis, Viral Inflammatory condition of the tracheobronchial tree caused by virus	Non-productive, recurrent, barking cough	<ul style="list-style-type: none"> Scant white to clear sputum May or may not have fever Sx usually 7-10 days Common in smokers 	Lung sounds: coarse rhonchi and possibly rales	Chest radiograph	Cough suppression with expectorant: Robitussin DM	F/U if not improved in 7 days
Influenza "Flu" is a viral infection that affects the nasopharynx, conjunctiva, and respiratory tract, usually in winter months. (common cold occurs anytime during the year)	Non-productive acute cough, usually worse at night	Abrupt onset of nonproductive cough with high fever, malaise, headache, Rhinorrhea, sore throat, & conjunctivitis (Common cold has low-grade fever with less severe Sx and may not be seasonal)	<ul style="list-style-type: none"> High fever Nasal turbinate edema & erythema with clear/white discharge Injected conjunctive and throat. Clear lungs. 	Chest radiograph	Analgesic: Acetaminophen or ibuprophen Cough suppression with expectorant: Robitussin DM <ul style="list-style-type: none"> Self limiting Annual influenza vaccine 	F/U if not improved in 7 days

CHIEF COMPLAINT: COUGH (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Acute (continued)						
<p>Pneumonia, Bacterial “Community acquired” (outside hospital/nursing home) bacterial infection of the lung</p> <p><i>Streptococcus pneumoniae</i></p>	<ul style="list-style-type: none"> Productive, severe cough with copious purulent sputum Usually worse at night 	<ul style="list-style-type: none"> High fever Dark, thick, rusty sputum Tachypnea, shaking chills, tachycardia, malaise, confusion 	<ul style="list-style-type: none"> Appears ill Febrile > 100F/37.8C Pulse > 100 Lung sounds: rales and whispered pectoriloquy Assess bronchophony & egophony 	<ul style="list-style-type: none"> Chest radiograph with lobar consolidation Pulse Ox CBC <p>Note: Repeat chest x-ray in 4-6 weeks</p>	<p>Antibiotic: Ceftriaxone (Rocephin) <u>Plus</u> azithromycin (Zithromax)</p> <p>Analgesic: Acetaminophen or ibuprofen</p> <p>Cough suppression with expectorant: Robitussin DM or with codeine</p> <ul style="list-style-type: none"> Consider oxygen and IV – NS Bed rest 	<p>CONTACT MO or Duty Flight Surgeon</p>
<p>Pneumonia, Mycoplasma Atypical pneumonia, “walking pneumonia” is an infection of the lung more common in the summer months and in young adults.</p> <p><i>Mycoplasma pneumoniae</i></p>	<p>Non-productive, dry cough</p>	<ul style="list-style-type: none"> Mild symptoms, sore throat, low-grade fever, sore throat & malaise Headache usually always present 	<ul style="list-style-type: none"> May appear ill Erythematous throat, fluid-line or bubbles behind TM Lung sound: pleural friction rub 	<ul style="list-style-type: none"> Chest radiograph with bilateral pleural effusion Pulse Ox Consider Rapid Strep & Mono Spot if sore throat severe 	<p>Antibiotic: Azithromycin (Zithromax) <u>or</u> erythromycin (E-Mycin)</p> <p>Analgesic: Acetaminophen or ibuprofen</p> <p>Cough suppression with expectorant: Robitussin DM or with codeine</p> <p>Bed rest</p>	<p>F/U if not improved in 7 days</p>

CHIEF COMPLAINT: COUGH (continued)						
CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Acute (continued)						
Pneumonia, Viral Viral infection of the lungs with recent history of common cold or influenza	Productive, mild cough	<ul style="list-style-type: none"> Severe cough with white to clear sputum Fever & fatigue Recent history of upper respiratory viral illness 	<ul style="list-style-type: none"> Fever Tachycardia Usually has cervical adenopathy Lung sounds: rales or pleural friction rub 	<ul style="list-style-type: none"> Chest radiograph with peribronchial thickening and bilateral spars infiltrate Pulse Ox 	Analgesic: Acetaminophen or ibuprophen Cough suppression with expectorant: Robitussin DM. Bed rest	F/U if not improved in 7 days
Chronic						
Chronic Obstructive Pulmonary Disease Permanent dilation and destruction of the alveolar ducts and bronchi caused by chronic lung irritation seen in ages > 40 (occupational, cigarette smoking, or alpha1-antitrypsin deficiency)	Chronic coughing with scant sputum	<ul style="list-style-type: none"> Weight loss & dyspnea History of recurrent bronchial infections 	<ul style="list-style-type: none"> Respiratory effort and use of accessory muscles, barrel chest, pursed lip breathing Clubbing of fingers Change in weight 	<ul style="list-style-type: none"> Pulse Ox Peak flow before and after treatment 	Bronchodilator: Nebulized albuterol Oxygen NC	CONTACT MO or Duty Flight Surgeon if doubt

CHIEF COMPLAINT: COUGH (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Chronic (continued)						
<p>Gastroesophageal Reflux Disease (GERD) Irritation caused by reflux of gastric secretions into the esophagus</p>	<p>Chronic, mild nagging cough and nausea</p>	<ul style="list-style-type: none"> Epigastric 'heartburn' Regurgitation causing bitter taste Symptoms relieved by sitting up or antacids May have chest pain 	<ul style="list-style-type: none"> May have normal exam findings Assess for epigastric tenderness Complete HEENT, CV, Respiratory, & GI Exam 	<ul style="list-style-type: none"> Antigen/antibody for H. pylori ECG is normal 	<p><i>Acute Tx:</i> H2 Inhibitor: Ranitidine (Zantac)</p> <ul style="list-style-type: none"> For chronic Tx or H. pylori refer to MO 	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF doubt</p>
<p>Tuberculosis "TB" is primarily a lung infection caused by inhalation of tubercle bacilli from close contact with actively infected person</p>	<p>Chronic cough</p>	<ul style="list-style-type: none"> Productive yellow/green sputum that progresses Prominent features are chronic "not feeling well" with drenching night sweats Hemoptysis is late Sx History of close contact with infected person 	<p>Lung sounds: rales in upper lobes with whispered pectoriloquy</p>	<ul style="list-style-type: none"> PPD (PPD converter does not necessarily mean active disease (may be past exposure), though all with active disease are positive) CBC Sputum culture with acid-fast smear x 3 (culture takes 3-6 wks) Chest radiograph: multi-nodule infiltrate in apical lobe and hilar adenopathy 	<ul style="list-style-type: none"> Multi drug therapy is required Direct observation therapy recommended Consult with MO. 	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p>

CHIEF COMPLAINT: DIFFICULT BREATHING

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Anaphylaxis Immune hyper-sensitivity reaction to an antigen (insect, food, medication)</p> <p>IgE mediated</p>	Acute labored tachypnea, cough, and wheeze	<ul style="list-style-type: none"> History of exposure May have Urticaria and angioedema of the face with cyanosis 	<ul style="list-style-type: none"> Obvious distress requiring <u>immediate</u> care ABCs first Lung sounds: rhonchi and wheeze Vitals: hypotension Complete HEENT, CV, respiratory, skin exam 	<ul style="list-style-type: none"> Pulse Ox Peak Flow before and after Tx 	<p>Bronchodilator: Epinephrine 1:1000 0.3 to 0.5 mg IM and Nebulized albuterol; oxygen, IV – NS</p> <p>Antihistamine: Diphenhydramine (Benadryl)</p> <p>Oral steroid: Prednisone may be indicated to prevent recurrence</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <ul style="list-style-type: none"> IF reaction to vaccine, complete VAERS Report
<p>Asthma Disorder of the tracheobronchial tree with reversible airway obstruction (bronchospasm with inflammatory process)</p>	Acute labored tachypnea, cough, and wheeze	<ul style="list-style-type: none"> History of asthma Prolonged expiratory wheeze brought on by exposure trigger May have cyanosis 	<ul style="list-style-type: none"> Obvious distress requiring <u>immediate</u> care ABCs first Lung sounds: expiratory wheeze 	<ul style="list-style-type: none"> Pulse Ox Peak Flow before and after Tx 	<p>Bronchodilator: Epinephrine 1:1000 0.3 to 0.5 mg IM and Nebulized albuterol; oxygen, IV – NS</p> <p>Oral steroid: Prednisone may be indicated to prevent recurrence</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p>
<p>Pneumothorax, Spontaneous Sudden collapse of lung most common in young, tall, thin men (primary) or persons who smoke (secondary)</p>	<ul style="list-style-type: none"> Acute labored tachypnea, cough, and wheeze Sx may be subtle 	<ul style="list-style-type: none"> History of smoking, vigorous exercises Sharp chest discomfort that is worse with breathing 	<ul style="list-style-type: none"> Asymmetrical chest movements and decreased lung sounds Just listening to the lungs makes the Dx 	<ul style="list-style-type: none"> Pulse Ox Chest radiograph 	<ul style="list-style-type: none"> Oxygen Emergency treatment is <u>required</u> 	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p><u>MEDEVAC</u></p>

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CHIEF COMPLAINT: ABDOMINAL PAIN						
CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Appendicitis Acute inflammation of the vermiform appendix	Nausea, vomiting, constipation & fever	<ul style="list-style-type: none"> • Early, colicky to constant pain in epigastrium or periumbilical; RLQ later • Vomiting <u>after</u> pain & pain worse with movement 	<ul style="list-style-type: none"> • RLQ involuntary guarding • RLQ rebound tenderness; pain may be referred (Rovsing's sign) • Pain with psoas/obturator maneuver (Psoas – Obturator sign) 	<ul style="list-style-type: none"> • CBC • UA 	<ul style="list-style-type: none"> • Prompt referral to ER or direct hospital admission • Emergency treatment is <u>required</u> 	<u>CONTACT</u> MO or Duty Flight Surgeon <u>MEDEVAC</u>
Cholecystitis Acute inflammation of the gallbladder	Nausea, vomiting, loose stool, and fever	<ul style="list-style-type: none"> • Colicky to constant pain at RUQ to inferior angle of right scapula • Brought on by fatty foods. More common in females • May have dark urine, light stool, and/or jaundice 	RUQ tender with deep palpation during inspiration (Murphy's Sign)	<ul style="list-style-type: none"> • CBC • UA • LFT • Gallbladder ultrasound 	Prompt referral to ER or direct hospital admission	<u>CONTACT</u> MO or Duty Flight Surgeon <u>MEDEVAC</u>
Constipation (symptom) Difficulty passing stool or diminished frequency of defecation. May be symptom of other conditions	Nausea	<ul style="list-style-type: none"> • Diffuse cramps • Difficulty expelling feces; less frequent defecation than normal for patient 	<ul style="list-style-type: none"> • Abdomen bloated and tender • Hyperactive bowel sounds 	<ul style="list-style-type: none"> • Labs directed towards cause • MO may recommend rectal exam for occult blood detection 	Stool softener: Docusate sodium (Colase) <ul style="list-style-type: none"> • Increase water intake • Increase dietary fiber AFTER relief of Sx 	<ul style="list-style-type: none"> • F/U if not improved in 24 hours • Consult with MO PRN

CHIEF COMPLAINT: ABDOMINAL PAIN (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Diarrhea (symptom)</p> <p>Acute diarrhea is abnormal and increased frequency and liquid stool consistency.</p> <p>May be symptom of other conditions. Symptoms lasting > 2 weeks = chronic diarrhea.</p>	Nausea, vomiting, fever	<ul style="list-style-type: none"> Diffuse cramps Abnormal and increased frequency and liquid stool consistency 	<ul style="list-style-type: none"> Diffuse, abdominal tender May have poor skin turgor indicating dehydration 	<ul style="list-style-type: none"> CBC UA Stool culture and ova/parasite may be indicated MO may recommend rectal exam for occult blood detection 	<p>Antidiarrheal: Loperamide (Immodium) Antibiotics may be indicated</p> <ul style="list-style-type: none"> Increase water intake; consider IV normal saline if dehydrated NO solids x 24 hours then BRATS diet x 24 hours Consider cause 	F/U if not improved in 72 hours or chronic symptoms, CONTACT MO and or Duty Flight Surgeon.
<p>Diverticulitis</p> <p>Inflamed diverticula (outpouchings of the mucosa through the muscular wall of the intestine)</p>	Nausea, vomiting, fever, anorexia, and constipation or diarrhea	Intermittent chronic pain, usually LLQ	LLQ tenderness, tympanic sound on percussion	<ul style="list-style-type: none"> CBC UA MO may recommend rectal exam for occult blood detection 	<p>Bowel spasm relief: Dicyclomine (Bentyl) Antibiotic: Metronidazole (Flagyl) PLUS ciprofloxacin (Cipro)</p>	CONTACT MO or Duty Flight Surgeon
<p>Food Poisoning</p> <p>Bacterial cause from contaminated food</p>	<ul style="list-style-type: none"> Nausea Vomiting Fever Diarrhea 	<ul style="list-style-type: none"> Onset of nausea, vomiting & diarrhea within 12–24 hours of eating Diffuse cramps 	<ul style="list-style-type: none"> Diffuse abdominal tender May have poor skin turgor indicating dehydration 	<ul style="list-style-type: none"> CBC Stool culture may be indicated MO may recommend rectal exam for occult blood detection 	<p>Antibiotic: Ciprofloxacin (Cipro)</p> <ul style="list-style-type: none"> Increase water intake; consider IV normal saline if dehydrated NO solids x 24 hours then BRATS diet x 24 hours 	F/U if not improved in 24 hours

CHIEF COMPLAINT: ABDOMINAL PAIN (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Gastroenteritis, Acute</p> <p>Viral cause of vomiting and diarrhea. Irritants like medications and alcohol can cause nausea and vomiting referred to as gastritis.</p>	<ul style="list-style-type: none"> Nausea Vomiting Malaise Fever Diarrhea 	<ul style="list-style-type: none"> Onset of nausea, vomiting and diarrhea within 48-72 hours of feeling ill Diffuse cramps Nausea, better after vomiting or bowel movement 	May have normal exam	CBC	<ul style="list-style-type: none"> Increase water intake NO solids x 24 hours then BRATS diet x 24 hours 	F/U if not improved in 24 hours
<p>Gastroesophageal Reflux Disease (GERD)</p> <p>Irritation caused by reflux of gastric secretions into the esophagus</p>	Nausea	<ul style="list-style-type: none"> Epigastric 'heartburn' Regurgitation causing bitter taste. Symptoms relieved by sitting up or antacids. May have nagging cough 	<ul style="list-style-type: none"> May have normal exam findings. Assess for epigastric tenderness Complete HEENT, CV, Respiratory, & GI Exam 	<ul style="list-style-type: none"> Antigen/antibody for H. pylori ECG to R/O "cardiac chest pain" 	<p><i>Acute Tx:</i></p> <p>H2 Inhibitor: Ranitidine (Zantac)</p> <p><i>For chronic Tx or H. pylori refer to MO</i></p>	CONTACT MO or Duty Flight Surgeon IF doubt
<p>Hepatitis</p> <p>Viral hepatitis is an inflammatory disease of the liver caused by a distinct group of viruses (HAV and HBV are discussed here)</p>	<ul style="list-style-type: none"> Fever Jaundice Anorexia Nausea Malaise Myalgia 	<ul style="list-style-type: none"> HAV – may be infectious 2 wks before Sx and 1 wk after. Caused by contaminated food and water HBV - may be infectious for 6 wks before Sx and unpredictable after. Caused by sexual contact or blood products 	<ul style="list-style-type: none"> Jaundice skin and sclera RUQ tenderness with splenic and/or liver enlargement 	<ul style="list-style-type: none"> CBC LFT Serologic marker for specific type of hepatitis 	<p>HAV – Immune globulin. Also Tx intimate contacts</p> <p>HBV – Hepatitis B immune globulin and start HB vaccine in unvaccinated and booster in vaccinated. Also Tx sexual contacts</p> <p>CG member should be vaccinated with both HA and HB vaccines</p>	CONTACT MO or Duty Flight Surgeon

CHIEF COMPLAINT: ABDOMINAL PAIN (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Hernia, Abdominal An abnormal opening or weakness in the abdominal muscular wall allowing protrusion of abdominal viscus (Inguinal hernia – see GU conditions)</p>	<p>May be asymptomatic or have mild pain</p>	<ul style="list-style-type: none"> • If reducible or irreducible: may complain of a soft bulge at the site • If strangulated: colicky abdominal pain, nausea and vomiting, abdominal distention 	<ul style="list-style-type: none"> • Visual exam noting size and suppleness of the mass • Reducible = able to push mass in • Irreducible = unable to push mass in • Strangulated = irreducible, discolored, painful; <u>do not</u> reduce 	<p>None indicated</p>	<p>Gently reduce hernia if possible, and if not considered strangulated</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF in doubt</p> <p><u>If strangulated hernia, MEDEVAC</u></p>
<p>Irritable Bowel Syndrome Chronic abdominal pain, with altered diarrhea/constipation and gaseousness in the absence of detectable pathology</p>	<ul style="list-style-type: none"> • Nausea • Vomiting • Diarrhea or constipation • Gas 	<ul style="list-style-type: none"> • Predominate alternating diarrhea and constipation without blood in stool • Possible stressors in life • no weight loss 	<p>May have vague abdominal tenderness > left</p>	<ul style="list-style-type: none"> • CBC • ESR • Stool culture, hemocult, ova and parasites • MO may recommend rectal exam for occult blood detection 	<p>Bowel spasm relief: Dicyclomine (Bentyl) Treat for constipation or diarrhea</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF in doubt</p>
<p>Pancreatitis, Acute Inflammation of the pancreas caused by trauma, virus, cysts, drugs (steroids, sulfa, NSAID), duct obstruction, alcohol</p>	<ul style="list-style-type: none"> • Nausea • Vomiting • Fever • Jaundice • Dark urine 	<ul style="list-style-type: none"> • Sudden, severe epigastric pain radiating to mid-back • Hypotension 	<ul style="list-style-type: none"> • Bluish flank (Gray Turner's sign) • Bluish periumbilical (Cullen's sign) • Mild jaundiced • Crackles in lungs • Epigastric tenderness • Frothy dark urine 	<ul style="list-style-type: none"> • Complete blood chemistry test • CBC • UA • Ultrasound or CT 	<ul style="list-style-type: none"> • IV – NS Analgesics PRN: Acetaminophen or ibuprofen • Otherwise NPO as directed by MO. 	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p><u>MEDEVAC</u></p>

CHIEF COMPLAINT: ABDOMINAL PAIN (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Peptic Ulcer Disease Erosion of gastric mucosa. Duodenal > gastric</p>	<ul style="list-style-type: none"> • Nausea • Vomiting • Melena • Abdominal cramping 	<ul style="list-style-type: none"> • Duodenal Ulcer: nocturnal pain, heartburn, better with food/antacids • Gastric Ulcer: heartburn or back pain, worse w/ food 	<p>Epigastric tenderness though exam may be unremarkable</p>	<ul style="list-style-type: none"> • CBC • MO may recommend rectal exam for occult blood detection 	<p><i>Acute Tx:</i> H2 Inhibitor: Ranitidine (Zantac)</p> <p><i>Chronic Tx:</i> Refer to MO</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF in doubt</p>

CHIEF COMPLAINT: ABDOMINAL PAIN Female Specific

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Ectopic Pregnancy Implantation of fertile egg in fallopian tube, cervix, or ovary</p>	<ul style="list-style-type: none"> • Nausea • Vomiting (morning sickness) • Mild or severe unilateral pelvic or referred pain 	<ul style="list-style-type: none"> • Amenorrhea or abnormal uterine bleeding • Determine last menses and menses history; sexual contact 	<ul style="list-style-type: none"> • Unilateral lower quadrant or pelvic tenderness exacerbated by movement • Shock (cool, clammy, pallor, hypotension, tachycardia) 	HCG <u>Positive</u> when patient is pregnant (R/O pregnancy in all females with abdominal pain or abnormal uterine bleeding)	<ul style="list-style-type: none"> • IV – NS • Otherwise NPO as directed by MO • Emergency treatment is required 	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p><u>MEDEVAC</u></p>
<p>Endometriosis Abnormal growth of endometrial tissue outside the uterus</p>	<ul style="list-style-type: none"> • Nausea • Vomiting • Mild or severe pelvic or referred pain 	<ul style="list-style-type: none"> • Dyspareunia • Dysmenorrhea • Determine last menses and menses history; sexual contact. 	Vague to diffuse abdominal or pelvic tenderness	HCG Negative (R/O pregnancy in all females with abdominal pain or abnormal uterine bleeding)	<p>Analgesics PRN: Acetaminophen, ibuprofen or combination of both (Tylenol 1000 mg PLUS Motrin 800 mg)</p>	This is a chronic condition requiring referral to MO for work-up and Tx
<p>Ovarian Cyst Associated with or without ovulation, a cyst may cause dysmenorrhea or rupture releasing blood/fluid and severe pain.</p> <p><i>Note: Mittelschmerz is a self-limiting mid-cycle pelvic pain associated with ovulation.</i></p>	<ul style="list-style-type: none"> • Nausea • Vomiting • Mild or severe pelvic or referred pain 	<ul style="list-style-type: none"> • Dysmenorrhea • Determine last menses and menses history; sexual contact. 	<ul style="list-style-type: none"> • Unilateral lower quadrant or pelvic tenderness; exacerbated by movement • Abdominal rigidity = possible surgical case 	HCG Negative (R/O pregnancy in all females with abdominal pain or abnormal uterine bleeding)	<p>Goal is to determine urgency of case. If non-emergent case: Analgesics PRN: Acetaminophen, ibuprofen or combination of both (Tylenol 1000 mg PLUS Motrin 800 mg)</p> <p>Otherwise:</p> <ul style="list-style-type: none"> • IV – NS • NPO as directed by MO • Transport 	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p>Emergent case = <u>MEDEVAC</u></p>

CHIEF COMPLAINT: RECTAL PAIN/BLEEDING						
CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Colorectal Cancer Malignant tumor of the colon, rectum, or anus</p>	Fatigue associated with anemia and blood mixed into stool	<ul style="list-style-type: none"> • Alternating diarrhea and constipation with blood in stool • Stool may be narrow or ribbon-like 	Abdominal tenderness or mass on right or left side	<ul style="list-style-type: none"> • CBC • MO may recommend rectal exam for occult blood detection 	<p>Take home point: persistent rectal bleeding may be colorectal cancer and MUST be referred to the MO</p>	CONTACT MO or Duty Flight Surgeon IF in doubt
<p>Hemorrhoid Varicosities (congested veins) in the rectum or anus</p>	Bright red blood, not necessarily in stool	<ul style="list-style-type: none"> • May be internal or external • Anal pain, burning, itching 	<ul style="list-style-type: none"> • Hemorrhoid or blood may or may not be visible • Enlarged, thrombosed hemorrhoids are extremely painful, firm, bluish 	<ul style="list-style-type: none"> • CBC • MO may recommend rectal exam for occult blood detection 	<p>Stool softener: Docusate sodium (Colase)</p> <p>Topical: Hydrocortisone ointment (Anusol HC)</p>	F/U if not improved in 72 hours, CONTACT MO and or Duty Flight Surgeon
<p>Pilonidal Cyst (abscess) Acute abscess or chronic draining sinus tract in the sacrococcygeal area. May involve bacterial infection. Coccyx pain, not rectal pain.</p>	Sacrococcygeal (superior to anus) drainage or scant bleeding	<ul style="list-style-type: none"> • Lesion is abscess, though location is unique to disease • Lesion may have or does contain hair 	<ul style="list-style-type: none"> • Mid-line swelling with or without pit or sinus tract • May have signs of infections: Localized red (rubor), tender (dolor), warm (calor), swelling (tumor) 	None, unless wound culture is indicated	<p>The treatment of choice is incision & drainage. Large wound may require iodiform packing – repack daily</p> <p>Antibiotics only indicated in signs of infection or positive culture</p>	F/U every 24 hours until resolved. IF not resolved in 7 days or severe, CONTACT MO
<p>Ulcerative Colitis Inflammation of colon/rectum, similar to Crohn's disease though UC spreads in a continuous fashion, where Crohn's has patchy inflammation</p>	<ul style="list-style-type: none"> • Bloody diarrhea • Anemia • Fever • Arthralgia • Tenesmus 	<ul style="list-style-type: none"> • Urgent and frequent bowel movements • Regular lower abdominal cramps • Weight loss 	<ul style="list-style-type: none"> • Complete GI exam noting abdominal tenderness on palpation to lower abdomen • Orthostatic hypotension 	<ul style="list-style-type: none"> • CBC • Hemoccult • MO may recommend rectal exam for occult blood detection 	Refer to MO	CONTACT MO or Duty Flight Surgeon IF in doubt

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CHIEF COMPLAINT: SEXUALLY TRANSMITTED DISEASE						
CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Chancroid Contagious bacterial infection of genitals caused by <i>Haemophilus ducreyi</i></p>	Ulceration on genitals	<ul style="list-style-type: none"> Sexual history usually has multiple partners; travel to developing country <u>Painful</u> ulceration on genitals with inguinal adenopathy that may progress to abscess (bubo) 	<ul style="list-style-type: none"> The HS/IDHS conducts visual GU exam with chaperone Tender ulcerated genital lesion with inguinal adenopathy that may have abscess development Female pelvic exam by MO may be indicated 	STD Screening PRN: (test for <i>H. ducreyi</i> not available in US) <ul style="list-style-type: none"> HIV RPR (syphilis) Chlamydia Gonorrhea HSV antibody Pap smear (HPV) 	<p>Antibiotic: Ceftriaxone (Rocephin) IM or erythromycin (E-mycin)</p> <ul style="list-style-type: none"> Tx for partner(s) also Encourage condom use 	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF doubt</p> <p>Disease Alert Report</p>
<p>Chlamydia Trachomatis Contagious intracellular parasite. Most common STD.</p>	Scant white to clear urethral or vaginal discharge	<ul style="list-style-type: none"> Possible history of sexual contact Females may be asymptomatic 	<ul style="list-style-type: none"> The HS/IDHS conducts visual GU exam with chaperone Discharge may not be visible Female pelvic exam by MO may be indicated 	STD Screening PRN: <ul style="list-style-type: none"> HIV RPR (syphilis) Chlamydia Gonorrhea HSV antibody Pap Smear (HPV) 	<p>Antibiotic: Doxycycline or Azithromycin</p> <p>Tx for partner(s) also</p> <p>Encourage condom use</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF doubt</p> <p>Disease Alert Report</p>
<p>Condyloma Acuminata Contagious viral infection of the genitals/anus caused by human papilloma virus</p>	Wart-like growth on genitals or anus	<ul style="list-style-type: none"> Possible history of sexual contact Pruritus Dysuria 	<ul style="list-style-type: none"> The HS/IDHS conducts visual GU exam with chaperone Cauliflower-like clusters of papules on genitals or anus Female pelvic exam by MO may be indicated 	STD Screening PRN: <ul style="list-style-type: none"> HIV RPR (syphilis) Chlamydia Gonorrhea HSV antibody Pap Smear (HPV) 	<ul style="list-style-type: none"> Refer to MO Encourage condom use 	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF doubt</p> <p>Disease Alert Report</p>

CHIEF COMPLAINT: SEXUALLY TRANSMITTED DISEASE (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Gonorrhea Contagious bacterial infection caused by <i>Neisseria gonorrhoeae</i> (gram-negative diplococcus)</p>	Purulent urethral or vaginal discharge	<ul style="list-style-type: none"> • Possible history of sexual contact • Males with severe pyuria and dysuria • Female with moderated vaginal pruritus and burning 	<ul style="list-style-type: none"> • The HS/IDHS conducts visual GU exam with chaperone • Discharge apparent on genitals and underwear or sheets • Female pelvic exam by MO may be indicated 	<p>STD Screening PRN:</p> <ul style="list-style-type: none"> • HIV • RPR (syphilis) • Chlamydia • Gonorrhea • HSV antibody • Pap Smear (HPV) 	<p>Antibiotic: Ceftriaxone (Rocephin) IM Tx for partner(s) also Encourage condom use</p>	<p>CONTACT MO or Duty Flight Surgeon IF doubt</p> <p>Disease Alert Report</p>
<p>Herpes Simplex Virus Recurrent, incurable, contagious viral disease (see oral and skin)</p>	Localized, grouped, uniform lesion on genitals. (may be found on other body parts)	<ul style="list-style-type: none"> • Possible history of sexual contact • Acute or chronic • Primary infection; fever, malaise, headache, regional adenopathy • Recurrent lesions with prodrome of fever or local warmth, burning, usually just prior to eruption 	<ul style="list-style-type: none"> • The HS/IDHS conducts visual GU exam with chaperone • Grouped “grape-like” cluster of uniform vesicles quickly become papules that rupture and weep and may be found on any body location • Usually recurs in same location • Female pelvic exam by MO may be indicated 	<p>STD Screening PRN:</p> <ul style="list-style-type: none"> • HIV • RPR (syphilis) • Chlamydia • Gonorrhea • HSV antibody • Pap Smear (HPV) • Tzanck Smear 	<p>Antiviral: Acyclovir (Zovirax) (for best results, take with first onset of Sx)</p> <ul style="list-style-type: none"> • Good hygiene; patient education on transmission • Condom use if genital 	<ul style="list-style-type: none"> • F/U if not resolved in 14 days, contact MO for advice • Disease Alert Report required IF primary genital infection only

CHIEF COMPLAINT: SEXUALLY TRANSMITTED DISEASE (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Human Immunodeficiency Virus (HIV)</p> <p>Retrovirus that infects/kills CD4 lymphocytes resulting in patient prone to opportunistic infections and malignancies leading to acquired Immunodeficiency syndrome (AIDS)</p>	<p>Flu-like or mononucleosis-like complaint</p>	<ul style="list-style-type: none"> Sexual, drug, and blood transfusion history helpful May be asymptomatic or early fever, myalgia, headache, malaise, and rash Initial Sx may be mild and self-limiting As disease progresses, general lymphadenopathy chronic diarrhea, weight loss, and recurrent night sweats develop. 	<ul style="list-style-type: none"> Head to toe physical if suspected <p>Note the following:</p> <ul style="list-style-type: none"> Vitals Weight Hx Oral thrush or ulcers Lymphadenopathy Lung crackles Cardiac murmur/gallop Hepatomegaly Splenomegaly Skin lesions Female pelvic exam by MO may be indicated 	<p>STD Screening PRN:</p> <ul style="list-style-type: none"> HIV RPR (syphilis) Chlamydia Gonorrhea HSV antibody Pap Smear (HPV) CBC If HIV ELISA is positive, confirm with Western Blot 	<ul style="list-style-type: none"> Refer to MO Counsel on lifestyle changes Immunize: pneumonia, influenza, tetanus booster, hepatitis A and B vaccines 	<p>CONTACT MO or Duty Flight Surgeon IF doubt</p> <ul style="list-style-type: none"> Disease Alert Report Notify Health Department for patient contact investigation
<p>Lymphogranuloma Venerum</p> <p>Systemic, contagious intracellular parasite affecting the inguinal lymph nodes. (virulent <i>Chlamydia trachomatis</i>)</p>	<ul style="list-style-type: none"> <i>Primary Stage:</i> Painless papules, on external genitalia <i>Secondary:</i> inguinal node enlargement is hallmark. 	<ul style="list-style-type: none"> Fever Foreign travel to Africa, South America, Haiti, Jamaica, East Asia, and Indonesia with history of sexual contact Travel history is key to diagnosis Rare in U.S. 	<ul style="list-style-type: none"> The HS/IDHS conducts visual GU exam with chaperone Possible papules on external genitalia or <u>unilateral</u> tender inguinal node enlargement – may drain Female pelvic exam by MO may be indicated 	<p>STD Screening PRN:</p> <ul style="list-style-type: none"> HIV RPR (syphilis) Chlamydia Gonorrhea HSV antibody Pap Smear (HPV) CBC 	<p>Antibiotics:</p> <p>Doxycycline</p> <p>Encourage condom use</p>	<p>CONTACT MO or Duty Flight Surgeon IF doubt</p> <p>Disease Alert Report</p>

CHIEF COMPLAINT: SEXUALLY TRANSMITTED DISEASE (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Pediculosis Infestation of the scalp (capitis), body (corporis), or pubic area (pubis) by parasite (lice/crab/louse)</p>	<p>Acute onset of intense pruritis in affected hair areas</p>	<ul style="list-style-type: none"> • Possible history of sexual contact with infestation exposure • “Itch/scratch” interrupts sleep 	<ul style="list-style-type: none"> • Complete skin exam and visual GU exam with chaperonee • Papules, erythema, in hair areas of groin or scalp; nits or egg capsules that appear as whitish structures on hair filaments 	<ul style="list-style-type: none"> • None usually indicated • STD screening may be indicated PRN 	<p>Topical: Permethrin lotion or shampoo (Elimite/Nix) Also treat shipboard or home contacts and wash associated clothing and linen</p>	<ul style="list-style-type: none"> • F/U PRN • Eggs not destroyed may hatch with a second infestation in 2 weeks
<p>Syphilis Contagious spirochete disease caused by <i>Treponema pallidum</i>. The clinical stages of syphilis, if untreated, are primary, secondary, latent, and tertiary.</p>	<p>Primary <u>painless</u> ulceration on genitals may be subtle</p>	<ul style="list-style-type: none"> • Possible history of sexual contact • Onset 1-2 weeks after exposure; primary lesion self-limiting in 7-10 days; secondary lesion is generalized rash • Fever, malaise • Tertiary syphilis involves latent neurologic symptoms 	<ul style="list-style-type: none"> • Primary non-tender ulcerated (button-like) genital lesion, inguinal adenopathy; secondary lesion is generalized non-tender • Erythematous macular rash that <u>also involves soles and palms</u> • Tertiary syphilis involves latent neurologic symptoms • Female pelvic exam by MO may be indicated 	<p>STD Screening PRN:</p> <ul style="list-style-type: none"> • HIV • RPR (syphilis) • Chlamydia • Gonorrhea • HSV antibody • Pap Smear (HPV) • If Rapid Plasma Reagin (RPR) is positive, confirm with fluorescent treponemal antibody absorption (FTA-ABS). 	<p>Antibiotic:</p> <ul style="list-style-type: none"> • Penicillin G benzathine IM 2.4 mil units OR Doxycycline 100 mg bid x 14 days (for patients allergic to penicillin in primary and secondary infection) • Encourage condom use 	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF doubt.</p> <p>Disease Alert Report</p>

CHIEF COMPLAINT: SEXUALLY TRANSMITTED DISEASE (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Trichomoniasis Contagious flagellated protozoa infection caused by <i>Trichomonas vaginalis</i>. Though referred to as vaginalis, may be found in males as well as females.</p>	<p>Mild urethral or vaginal pruritus</p>	<ul style="list-style-type: none"> Sexual history usually reveals multiple partners Females with vaginal discharge and “rancid” odor Males may have dysuria and discharge, but may be asymptomatic 	<ul style="list-style-type: none"> The HS/IDHS conducts a visual GU exam with chaperone Females with copious yellow to green vaginal frothy discharge with rancid odor. Males may have mild urethral discharge. Female pelvic exam by MO may be indicated Cherry red cervix 	<p>Urinalysis:</p> <ul style="list-style-type: none"> Wet mount – motile organisms Vaginal pH > 6.0 (normal around 4.0) <p>STD Screening PRN:</p> <ul style="list-style-type: none"> HIV RPR (syphilis) Chlamydia Gonorrhea HSV antibody Pap Smear (HPV) 	<p>Antibiotic: Metronidazole (Flagyl) Encourage condom use</p>	<p>CONTACT MO or Duty Flight Surgeon IF doubt</p>

CHIEF COMPLAINT: MALE COMPLAINT

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Epididymitis</p> <ul style="list-style-type: none"> • Infection or inflammation of the epididymis • Common causes are coliform bacteria and ductal obstruction • For young males (<35 yo) consider <i>N. gonorrhoeae</i> or <i>Chlamydia trachomatis</i> 	<p>Testicular pain and/or scrotal swelling</p>	<ul style="list-style-type: none"> • Possible fever • Consider STD if patient is under 35 y/o 	<ul style="list-style-type: none"> • The HS/IDHS conducts a visual GU exam with chaperone • Testicular tenderness more superior/posterior and <u>elevation of testicle may decrease pain</u> (Prehn's sign) • May have scrotal edema and erythema 	<ul style="list-style-type: none"> • Urinalysis – may have pyuria • If suspected, complete STD screening for Chlamydia and Gonorrhea 	<p>Antibiotics: Septra DS if NOT an STD</p> <ul style="list-style-type: none"> • <i>For gonorrhea:</i> Ceftriaxone (Rocephin) IM • <i>For chlamydia:</i> Doxycycline or Azithromycin 	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF doubt</p> <ul style="list-style-type: none"> • Disease Alert Report if STD
<p>Hydrocele, Acute Fluid accumulation in the serous lining covering the testicle and epididymis (tunica vaginalis)</p>	<p>Testicular pain and/or scrotal swelling</p>	<ul style="list-style-type: none"> • Scrotum may feel heavy • May have fluctuation in the size of the scrotum 	<ul style="list-style-type: none"> • The HS/IDHS conducts a visual GU exam with chaperone • Swelling of the scrotum 	<p>Transillumination- light passes through the hydrocele causing a red glow (IF light does not pass through solid, firm mass = tumors = carcinoma until proven other-wise)</p>	<p>If mass clearly transilluminates, reassure patient, though may not be self-limiting & referral to MO is indicated.</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF doubt</p>
<p>Inguinal Hernia An abnormal opening or weakness in the abdominal muscular wall allowing protrusion of abdominal viscus (hernia, abdominal – see GI conditions)</p>	<p>May be asymptomatic or have mild pain</p>	<ul style="list-style-type: none"> • If reducible or irreducible: May complain of a soft bulge at the site • If strangulated: colicky abdominal pain, nausea and vomiting, abdominal distention 	<ul style="list-style-type: none"> • The HS/IDHS conducts a visual GU exam with chaperone • Reducible = able to push mass in • Irreducible = unable to push mass in • Strangulated = Irreducible, discolored, painful; <u>do not</u> reduce 	<p>None indicated</p>	<p>If not considered strangulated, gently reduce hernia</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF doubt <u>If strangulated hernia, MEDEVAC</u></p>

CHIEF COMPLAINT: MALE COMPLAINT (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Prostatitis, Acute Infection or inflammation of the prostate gland. Usually caused by ascending urethral infection of coli form bacteria or non-bacterial chronic cause.</p>	Lower back and perineal pain	<ul style="list-style-type: none"> Urinary frequency, urgency minor feature Nocturia may be present 	<ul style="list-style-type: none"> The HS/IDHS conducts a visual GU exam with chaperone Digital rectal exam by MO is indicated = tender, boggy prostate (IF prostate hard with nodules or mass = tumor = carcinoma until proven otherwise) 	<ul style="list-style-type: none"> Urinalysis – may have leukocytes Subtle symptoms with lower back pain (also see renal calculi) in the absence of STD Sx, provide direction for Tx Prostate Specific Antigen (PSA) 	<p>Antibiotic: Ciprofloxacin (Cipro) or Septra DS Treat for 30 days</p>	F/U if not improving in 14 days
<p>Testicular Torsion The twisting of the testis and spermatic cord resulting in acute ischemia of testis</p>	Testicular pain and/or scrotal swelling	<ul style="list-style-type: none"> History of trauma or excessive physical activity just before symptoms Nausea and/or vomiting 	<ul style="list-style-type: none"> The HS/IDHS conducts a visual GU exam with chaperone Scrotum enlarged, red, edematous Testis may appear high in scrotum with tenderness <u>Elevating scrotum increases pain</u> Cremasteric reflex absent 	<ul style="list-style-type: none"> Urinalysis – normal Do not delay emergency Tx for urinalysis if high suspicion 	<ul style="list-style-type: none"> Emergency treatment is <u>required</u> Torsion usually rotates inward. For de-torsion, the testis is rotated outward. More than one rotation may be needed. Pain reduction guides progress. 	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p><u>MEDEVAC</u></p> <p>If de-torsion fails, emergency surgery is required to save testis. Salvage drops to 20% in 6-8 hrs and near 0% in 12 hrs.</p>

CHIEF COMPLAINT: MALE COMPLAINT (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Urinary Tract Infection (UTI) Infection of the urinary tract or bladder. Uncommon in males. Cause may be ascending infection of coliform bacteria or STD.</p>	Dysuria; urinary frequency and urgency.	<ul style="list-style-type: none"> Consider causes that introduce coli form bacteria as urinary infection Suprapubic discomfort 	<ul style="list-style-type: none"> The HS/IDHS conducts a visual GU exam with chaperone. CVA tenderness usually not present Digital rectal exam by MO is indicated if need to R/O prostatitis. 	<ul style="list-style-type: none"> Urinalysis - may have leukocyte and nitrites If suspected, complete STD screening PRN, considering Chlamydia or Gonorrhea 	<p>Antibiotic: Septra DS or ciprofloxacin (Cipro)</p>	F/U if not improved in 7 days
<p>Varicocele A collection of large veins, usually on the left scrotum, caused by venous valve dilation.</p>	Testicular pain and/or scrotal swelling	Feeling of heaviness in the testicle(s)	<ul style="list-style-type: none"> The HS/IDHS conducts a visual GU exam with chaperone Visible swelling or palpable “bag of worms” in scrotum 	Urinalysis – normal	<p>Analgesic: Ibuprofen or acetaminophen for discomfort PRN.</p> <p>Athletic support for scrotum</p>	May require referral to MO IF doubt

CHIEF COMPLAINT: FEMALE COMPLAINT						
CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Bacterial Vaginosis A bacterial infection of the vagina and/or vulva commonly caused by <i>Gardnerella vaginalis</i>. Not STD.</p>	<ul style="list-style-type: none"> Mild vaginal Pruritis Dysuria Dyspareunia 	<ul style="list-style-type: none"> History of vaginal/vulva irritation A grayish to clear discharge with unique "fishy" vaginal odor 	<ul style="list-style-type: none"> The HS/IDHS conducts a visual GU exam with chaperone Female pelvic exam by MO may be indicated 	<p>Urinalysis</p> <ul style="list-style-type: none"> Wet mount – clue cell KOH 'whiff test' with amine/fishy odor 	<p>Antibiotic: Metronidazole (Flagyl)</p>	<p>CONTACT MO or Duty Flight Surgeon IF doubt</p>
<p>Bartholin's Cyst Mucus-filled glandular cyst of the Bartholin's gland occurring on either side of the vaginal opening; cause unknown, though may be due to vaginal irritation. Not STD.</p>	<ul style="list-style-type: none"> Mild vaginal pruritis Dysuria Dyspareunia 	<ul style="list-style-type: none"> Usually starts asymptomatic, as cyst grows larger it become very painful with sitting If untreated, may develop into an abscess 	<ul style="list-style-type: none"> The HS/IDHS conducts a visual GU exam with chaperone Lump or mass at the introitus <p>Note: any drainage or signs of infection = abscess.</p>	<ul style="list-style-type: none"> Urinalysis – normal Dx made with physical examination <p>DDX:</p> <ul style="list-style-type: none"> <i>Skene's Duct Cyst</i> – duct obstruction at distal urethra <i>Vulvar Inclusion Cyst</i> – duct obstruction at sebaceous gland of epidermis 	<p>Warm compresses to area is mainstay of Tx</p> <p>Analgesic: Ibuprofen or acetaminophen for discomfort PRN.</p> <p>If the cyst becomes abscess consider antibiotics; Cephalexin (Keflex)</p>	<p>CONTACT MO or Duty Flight Surgeon IF doubt</p>
<p>Candidiasis, Vulvo-vaginal Yeast-like fungal infection of the vulva or vagina. Caused by <i>Candida albicans</i>. Not STD.</p>	<p>Vulvar-vaginal pruritis</p>	<ul style="list-style-type: none"> White, malodorous discharge Patient may relay that symptoms similar to past yeast infections 	<ul style="list-style-type: none"> The HS/IDHS conducts a visual GU exam with chaperone Cheesy discharge with white plaques on erythematous base 	<ul style="list-style-type: none"> Urinalysis – normal KOH prep with pseudohyphae and budding spores 	<p>Antifungal: Clotrimazole 1% vaginal cream or floxuridine (Diflucan)</p>	<p>F/U if not improved in 7 days</p>

CHIEF COMPLAINT: FEMALE COMPLAINT (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Urinary Tract Infection (UTI) Infection of the urinary tract or bladder. Cause may be ascending infection of coli form bacteria or STD</p>	Dysuria; urinary frequency and urgency	<ul style="list-style-type: none"> Suprapubic discomfort Patient may relay that symptoms similar to past infections 	<ul style="list-style-type: none"> The HS/IDHS conducts a visual GU exam with chaperonee CVA tenderness usually not present 	<ul style="list-style-type: none"> Urinalysis - may have leukocyte and nitrites If suspected, STD screening PRN, considering Chlamydia or Gonorrhea 	<p>Antibiotic: Septra DS or ciprofloxacin (Cipro)</p>	F/U if not improved in 7 days

CHIEF COMPLAINT: HEMATURIA

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Glomerulonephritis, Acute Inflammation of the glomeruli of the kidney. More common in young adults.</p>	Hematuria	<ul style="list-style-type: none"> History of recent streptococcal infection or other infection Oliguria, edema, and weight gain 	<ul style="list-style-type: none"> Complete physical exam May have hypertension 	<ul style="list-style-type: none"> Urinalysis – Blood and protein (no leukocytes or nitrites) CBC Renal Function Test 	<p>CONTACT MO or Duty Flight Surgeon for directions.</p>	F/U with MO for proper work-up
<p>Pyelonephritis, Acute Bacterial infection of the kidney; may lead to bacteremia, progressing to septic shock and death if untreated</p>	Hematuria	<ul style="list-style-type: none"> Fever Flank pain Shaking chills Urinary urgency Frequency Dysuria Malaise, Myalgia Anorexia Nausea Vomiting Diarrhea Headache Suprapubic pain 	<ul style="list-style-type: none"> Complete physical examination Febrile Tachycardia CVA tenderness 	<ul style="list-style-type: none"> Urinalysis – Blood and protein PLUS leukocytes, & nitrites Urine culture - >100,000 CFU/ml. CBC Renal ultrasound or spiral CT 	<p>Antibiotic: Septra DS or ciprofloxacin (Cipro)</p> <p>Analgesic: Acetaminophen (NSAIDS metabolized in kidney)</p> <p>Increase fluids, SIQ x 72 hours</p>	<p>CONTACT MO or Duty Flight Surgeon</p> <p>F/U if no improvement in <u>24 hrs</u>; consider hospitalization and MEDEVAC</p>

CHIEF COMPLAINT: HEMATURIA, (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Renal Calculi “Kidney stones” are crystallized minerals, commonly calcium or uric acid that forms in the urinary tract system.</p>	<p>Hematuria, though may just present as flank pain</p>	<ul style="list-style-type: none"> • May have history of kidney stones, family history of kidney stones • Pain originates in flank though may radiate to groin/testicles/supra-pubic or labia • May have diaphoresis, tachycardia, nausea, vomiting 	<ul style="list-style-type: none"> • Patient appears anxious and unable to sit; paces the floor. • May have CVA tenderness though no fever unless kidney infection also present 	<ul style="list-style-type: none"> • Urinalysis – Blood and acidic (<7pH) or alkalytic (>7pH). Normal urine pH is around 7.0 • Spiral CT of kidneys 	<p>Analgesic: Ketorolac (Toradol) or morphine IM/IV</p> <p>Oral Analgesic: Tramadol (Ultram) Tx nausea PRN.</p> <p>IV – NS</p> <p>‘Catch’ urine to find stone</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p>MEDEVAC PRN</p>

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CHIEF COMPLAINT: MENSES COMPLAINT

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Dysfunctional Uterine Bleeding</p> <p>This is abnormal uterine bleeding caused by hormone imbalance.</p> <p><i>Other causes</i> of abnormal uterine bleeding include anovulation; pregnancy-related, malignancies, infection, masses, tumors, or cysts.</p>	<p>Lower abdominal pain and cramping with dysfunctional uterine bleeding.</p>	<p>Dysfunctional uterine bleeding is more frequent than typical menses; > 7 days of heavy menses OR less than 21 days apart OR irregular bleeding between menses.</p> <p>Ask about “possibility of pregnancy”</p>	<ul style="list-style-type: none"> The HS/IDHS conduct an abdominal exam History alone may elicit tentative diagnosis of dysfunctional uterine bleeding Refer to MO for pelvic exam 	<ul style="list-style-type: none"> HCG <u>Negative</u> (R/O pregnancy in all females with abdominal pain or uterine bleeding) If HCG is positive, patient is pregnant. Consider ectopic pregnancy or threatened abortion which are emergent conditions. CBC Urinalysis, and other tests PRN 	<p>Oral Contraceptive Pill:</p> <p>Take tid for 3 days, then once daily for three months to prevent recurrence. Consult with MO prior to treatment</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p>
<p>Dysmenorrhea, Primary</p> <p>Primary: cramps, lower abdominal pain that occurs before or during menses caused by excess prostaglandin release. <i>Secondary dysmenorrhea</i> has pathologic cause.</p>	<p>“Crampy” lower abdominal pain</p>	<p>Pain is intermittent or constant and may be associated with moodiness, fatigue, headache, bloating and nausea.</p>	<ul style="list-style-type: none"> The HS/IDHS conduct an abdominal exam History alone may elicit diagnosis Refer to MO for pelvic exam 	<ul style="list-style-type: none"> CBC Urinalysis Dysmenorrhea workup: wet mount, pap, cultures, ultrasound 	<p>Analgesic:</p> <ul style="list-style-type: none"> Ibuprofen 800 mg tid. May <u>add</u> acetaminophen 1000 mg tid for severe discomfort 	<p><u>CONTACT</u> MO or Duty Flight Surgeon IF doubt</p>

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CHIEF COMPLAINT: NECK PAIN

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Cervical Muscle Strain</p> <p>A 'strain' can refer to muscle and ligamentous injury, though here, generally, strain refers to muscle injury. The term strain and sprain are often interchangeable.</p>	<p>Pain along trapezius and/or sternocleidomastoid muscles</p>	<p>O – trauma or spontaneous P – extreme movement or spasm makes worse Q – dull ache R – nonradicular S – mild to moderate T – constant</p> <p>Tension headache may be associated</p>	<p>Insp: symmetrical w/o atrophy/deformity/dicolor Palp: tenderness at paraspinous and trapezius muscle ROM: active - limited; passive - full Stability: yes Motor: 5/5 strengths Sense: normal No bony tenderness</p>	<p>Radiograph indicated if trauma</p>	<p>Analgesic/NSAID: Ibuprofen</p> <ul style="list-style-type: none"> • Ice initially, then moist heat • Rest • May last 1-2 weeks • ROM exercises when acute pain subsides 	<p>F/U if not improved in 14 days</p>
<p>Herniated Cervical Disk</p> <p>Rupture of the inter-vertebral disc with protrusion of the nucleus pulposus in the spinal canal.</p> <p>HNP = Herniated Nucleus Pulposus</p>	<p>Neck pain may be prominent, though may present as deltoid or hand numbness also.</p>	<p>O – acute trauma or past trauma P – worse w/ extension; better w/ rest Q – dull to sharp ache R – radiculopathy in deltoid or hand S – mild to moderate T – intermittent</p> <p>Tension headache may be associated.</p>	<p>Insp: symmetrical w/o atrophy/deformity/dicolor Palp: tenderness at cervical disk (C5/6/7) ROM: active - limited; passive - limited Stability: stable Motor: 3/5 strengths (neck and grip) Sense: distal sensation in hand may diminish Distraction Test less pain; Compression Test more pain</p>	<ul style="list-style-type: none"> • Radiograph indicated if trauma • MRI to confirm HNP 	<p>Analgesic/NSAID: Ibuprofen</p> <ul style="list-style-type: none"> • Moist heat • Bed Rest for 1-2 days • ROM exercises when acute pain subsides • Chronic problem • If not improving, refer to MO 	<p>F/U if not improved in 14 days</p> <p>If in doubt, CONTACT the MO</p>

CHIEF COMPLAINT: SHOULDER PAIN						
CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Bicipital Tendon Rupture, Proximal</p> <p>The tendon rupture is more common in older adults and often associated with chronic shoulder pathology.</p>	Involves proximal bicipital tendon, though may be generalized pain	<p>O – acute trauma or force on muscle P – worse w/ onset; better over time Q – sudden sharp ache R – nonradicular S – mild to moderate T – worse w/ onset</p> <p>Often a result of a trivial event</p>	<p>Insp: asymmetrical with bulge deformity distally & may have ecchymosis Palp: early tenderness proximally, then no pain ROM: active - full; passive - full Stability: stable Motor: 5/5 strengths Sense: normal</p> <p>The bulge can be accentuated by contraction of biceps</p>	Radiograph indicated if trauma	<p>Analgesic/NSAID: Ibuprofen</p> <ul style="list-style-type: none"> Progressive ROM exercises Nonsurgical treatment is effective Distal rupture may require surgical intervention 	CONTACT MO or Duty Fight Surgeon for advice
<p>Bicipital Tendonitis</p> <p>Inflammation of the tendon caused by repetitive movement or trauma</p>	Involves anterior bicipital groove, though may be generalized pain	<p>O – overuse P – worse w/ use; better w/ rest Q – dull ache R – nonradicular S – mild to moderate T – intermittent or constant</p> <p>Often concurrent with subacromial bursitis</p>	<p>Insp: symmetrical w/o atrophy/deformity/discolor Palp: tenderness over bicipital groove. ROM: active - full; passive - full Stability: pain, weakness with Yergason's Test Motor: 4/5 strengths Sense: normal</p>	Usually nothing indicated	<p>Analgesic/NSAID: Ibuprofen</p> <p>No overhead reach for 3-4 days, consider sling to prevent reach</p>	F/U if not improved in 14 days

CHIEF COMPLAINT: SHOULDER PAIN (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Impingement Syndrome</p> <p>A chronic inflammation causing fibrosis of the tendon or an anatomical tilting of the acromion process</p>	<p>Chronic generalized shoulder pain exacerbated by overhead reach</p>	<p>O – chronic overuse or past trauma P – worse w/ overhead lifting or ball throwing; better w/ rest Q – dull ache R – nonradicular S – mild to moderate T – intermittent or constant</p> <p>Past history of rotator or acromion joint trauma</p>	<p>Insp: symmetrical w/o atrophy/deformity/discolor Palp: tenderness over the glenohumeral joint ROM: active - limited; passive - limited Stability: pain, weakness w/ abduction > 90 degree Motor: 4/5 strengths Sense: normal</p> <p>Chronic cases may result in atrophy of rotator cuff muscles</p>	<p>Failed conservative treatment requires referral to orthopedic surgeon. MRI is indicated then.</p>	<p>Analgesic/NSAID: Ibuprofen</p> <ul style="list-style-type: none"> • Codman Exercises • Avoid overhead reaching • If not improving, refer to MO; steroid injections may be indicated 	<p>F/U if not improved in 14 days</p>
<p>Rotator Cuff Tear</p> <p>Four muscles compose the rotator cuff. The supraspinatus is most often involved in a tear. Cause of tear may be acute injury, though commonly it is related to old, degenerative injury.</p>	<p>Chronic pain associated with specific past injury; acute presentation is also possible</p>	<p>O – chronic w/ past trauma or night pain P – worse w/ overhead lifting or ball throwing; better w/ rest Q – dull ache R – nonradicular S – mild to moderate T – intermittent or constant</p> <p>Past history of rotator or acromion joint trauma</p>	<p>Insp: symmetrical w/o atrophy/deformity/discolor Palp: tenderness over the glenohumeral joint ROM: active - limited; passive - full Stability: pain, weakness w/ Drop Arm Test Motor: 3/5 strengths Sense: normal</p> <p>Chronic cases may result in atrophy of rotator cuff muscles.</p>	<p>Failed conservative treatment requires referral to orthopedic surgeon. MRI is indicated then.</p>	<p>Analgesic/NSAID: Ibuprofen</p> <ul style="list-style-type: none"> • Codman Exercises • Avoid overhead reaching • If not improving, refer to MO; steroid injections may be indicated 	<p>F/U if not improved in 14 days</p>

CHIEF COMPLAINT: SHOULDER PAIN (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Subacromial Bursitis</p> <p>Inflammation of the bursae, the fluid-filled sac of the acromion process</p>	<p>Involves anterior aspect of lateral shoulder, though may be generalized pain</p>	<p>O – acute trauma or overuse</p> <p>P – worse w/ use; better w/ rest</p> <p>Q – dull ache</p> <p>R – nonradicular</p> <p>S – mild to moderate</p> <p>T – intermittent or constant</p> <p>Often concurrent with bicipital tendonitis</p>	<p>Insp: symmetrical w/o atrophy/deformity/discolor</p> <p>Palp: tenderness at anterior/inferior acromion</p> <p>ROM: active - limited; passive - full</p> <p>Stability: yes</p> <p>Motor: 5/5 strengths</p> <p>Sense: distal sensation in hand may diminish.</p> <p>Arm maximally flexed for palpation</p>	<p>Radiograph indicated if trauma</p>	<p>Analgesic/NSAID:</p> <p>Ibuprofen</p> <ul style="list-style-type: none"> • Codman Exercises • If not improving, refer to MO; steroid injections may be indicated 	<p>F/U if not improved in 14 days</p>

CHIEF COMPLAINT: ELBOW PAIN

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Bursitis, Olecranon Inflammation of the bursae, the fluid-filled sac of the olecranon process</p>	<p>Acute pain on dorsal aspect with dramatic swelling is the most common presentation</p>	<p>O – acute swelling (trauma) is most common. Infection may also be acute (cellulitis). P – worse w/ attempt to put on shirt; better w/ rest Q – dull ache R – nonradicular S – mild to moderate T – intermittent or constant</p> <p>Gradual swelling is due to chronic inflammation</p>	<p>Insp: asymmetrical w/o atrophy/dicolor. Dramatic fluctuant swelling. Palp: tenderness over the dorsal olecranon ROM: active - limited; passive - full Stability: stable Motor: 4/5 strengths Sense: normal</p> <p>See cellulitis -if infection suspected</p>	<ul style="list-style-type: none"> Usually nothing indicated Radiograph indicated if trauma Aspiration of fluid may be both therapeutic and diagnostic. Fluid should be analyzed and cultured. 	<p>Analgesic: Ibuprofen</p> <ul style="list-style-type: none"> RICE Self-limiting Reassurance 	<p>F/U if not improved in 7 days or signs of infection</p>
<p>Epicondylitis, Medial/Lateral A chronic irritation (not inflammation) causing fibrosis of the muscles/tendon just distal to the epicondyle</p>	<p>Gradual elbow pain. Lateral epicondylitis is most common.</p>	<p>O – gradual pain with history of overuse P – worse w/ wrist extension or rotation; better w/ rest Q – dull ache R – nonradicular S – mild to moderate T – intermittent or constant</p> <p>Lateral more common than medial symptoms</p>	<p>Insp: symmetrical w/o atrophy/deformity/dicolor Palp: tenderness just distal to epicondyle ROM: active – full; passive – full; Lateral = pain with wrist extension Stability: stable Motor: 4/5 strengths Sense: normal</p> <p>Medial = pain with wrist flexion</p>	<p>Usually nothing indicated</p>	<p>Analgesic: Acetaminophen or ibuprofen</p> <ul style="list-style-type: none"> ROM Exercises and isometric squeezing of rubber ball If not improving, refer to MO; steroid injections may be indicated 	<p>F/U if not improved in 14 days</p>

CHIEF COMPLAINT: WRIST PAIN						
CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Carpal Tunnel Syndrome</p> <p>Compression of the median nerve due to repetitive movement of the wrist (for example, typing)</p>	Vague, gradual or acute ache in wrist or hand	<p>O – vague pain with history of overuse</p> <p>P – worse w/ sleep & repetitive action; better w/ rest</p> <p>Q – dull ache</p> <p>R – radicular referral to thenar, thumb, index and middle fingers</p> <p>S – mild to moderate</p> <p>T – intermittent</p>	<p>Insp: asymmetrical w/ thenar atrophy w/o deformity/dicolor</p> <p>Palp: tenderness and radiation; Positive Tinel's and Phalen's Tests</p> <p>ROM: active – full; passive – full</p> <p>Stability: stable</p> <p>Motor: 3/5 strengths</p> <p>Sense: decreased sensation to thenar, thumb, index, and middle fingers</p>	Radiograph indicated if trauma	<p>Analgesic:</p> <p>Ibuprofen</p> <ul style="list-style-type: none"> • Modify repetitive movement activities • Night splint help prevent full flexion of wrist during sleep 	F/U if not improved in 30 days or worse, refer to MO
<p>Ganglion Cyst</p> <p>Cystic structure that arises from the capsule of the joint synovial sheath and contains thick, clear, mucinous fluid</p>	Painful, localized mass on dorsal or volar surface of wrist	<p>O – gradual with or without pain, may have history of overuse</p> <p>P – worse w/ activities of frequent movement; better w/ rest</p> <p>Q – dull ache</p> <p>R – non-radicular unless median nerve involved</p> <p>S – mild to moderate</p> <p>T – intermittent</p>	<p>Insp: asymmetrical w/o atrophy/dicolor. Lump on dorsal or volar aspect</p> <p>Palp: tenderness over fluctuant mass</p> <p>ROM: active – full; passive – full</p> <p>Stability: stable</p> <p>Motor: 5/5 strengths</p> <p>Sense: normal unless median nerve involved</p>	Usually nothing indicated	<ul style="list-style-type: none"> • Reassurance is usually adequate • If activities of daily living (picking up paper/glass) are compromised, refer to MO for possible aspiration of mass 	F/I if not improved in 30 days or worse, refer to MO

CHIEF COMPLAINT: WRIST PAIN (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Scaphoid Wrist Fracture</p> <p>Most common fx of the wrist caused by fall on outstretched hand. Important because of frequency and Scaphoid only has proximal blood supply. Untreated fracture can lead to osteonecrosis.</p>	<p>Acute wrist pain after trauma</p>	<p>O – acute associated with trauma</p> <p>P – worse w/ gripping; better w/ rest</p> <p>Q – dull ache</p> <p>R – nonradicular</p> <p>S – mild to moderate</p> <p>T – intermittent</p>	<p>Insp: asymmetrical w/o atrophy/deformity/dicolor</p> <p>Palp: tenderness at (snuffbox) dorsal Scaphoid bone</p> <p>ROM: active – limited; passive – full</p> <p>Stability: stable</p> <p>Motor: 3/5 strengths</p> <p>Sense: normal</p>	<ul style="list-style-type: none"> • Radiograph indicated if trauma • Fracture may not be visible on initial radiographs and must be repeated if pain persists beyond 2-3 weeks 	<p>Analgesic: Acetaminophen with codeine for 7 days (short term).</p> <ul style="list-style-type: none"> • When in doubt, treat as fracture. Short arm splint and immobilize thumb (thumb spica cast). • Contact MO 	<p>CONTACT MO or Duty Flight Surgeon</p>

CHIEF COMPLAINT: FINGER PAIN

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Paronychia Infection of the tissue around fingernail. (called a "Felon" if fingertip involved). <i>Staphylococcus aureus</i> is the most common cause.</p>	<p>Acute pain at distal phalanx along edge of nail</p>	<p>O – acute w/ history of trauma vague pain. P – worse w/ palpation to lesion; better w/ rest Q – dull ache R – nonradicular S – moderate to sever T – constant</p>	<p>Insp: asymmetrical w/ localized red (rubor), tender (dolor), warm (calor), fluctuant swelling (tumor) along lateral edge on nail. Palp: very tender ROM: active – full; passive – full Stability: stable Motor: 4/5 strengths Sense: intact</p>	<p>Culture if unsure or suspect MRSA</p>	<p>Antibiotic: Cephalexin (Keflex)</p> <p>I and D as directed by MO</p>	<p>Follow up every 24 hours until resolved.</p> <p>If not resolved in 7 days; <u>CONTACT</u> MO</p>

CHIEF COMPLAINT: LOWER BACK PAIN

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Mechanical Muscular Strain</p> <p>Lower back pain secondary to paravertebral spinal muscle strain caused by physical activity or poor fitness. Chronic symptoms can be related to psychosocial issues.</p>	Acute and focused lower back pain	<p>O – acute w/ history of physical strain. The strain and cause may be as trivial as leaning forward to tie shoe.</p> <p>P – worse w/ activity; better w/ rest</p> <p>Q – dull ache</p> <p>R – nonradicular. May involve buttocks.</p> <p>S – moderate to severe</p> <p>T – constant</p>	<p>Insp: symmetrical w/o atrophy/deformity/dicolor</p> <p>Palp: tenderness at sacroiliac region. May have muscle spasms.</p> <p>ROM: active – limited; passive – full</p> <p>Stability: stable</p> <p>Motor: 5/5 strengths</p> <p>Sense: intact with negative Straight Leg Raise</p>	<p>Usually nothing indicated.</p> <p>Note: The motor and sensory function can help distinguish muscular strain from neurological involvement with herniated disk. See lower back pain; Neurological, Herniated Disk</p>	<p>Analgesic: Ibuprofen</p> <p>Muscle spasms give: diazepam, (Valium) 1-2 days</p> <ul style="list-style-type: none"> Limit activities that aggravate Sx with return to normal activity plan and psychosocial intervention if indicated Home exercise concentrating on abdominal muscle tone 	F/U if not improved in 14 days
<p>Neurological, Herniated Disk (L4 – L5 – S1)</p> <p>Rupture of the inter-vertebral disc with protrusion of the nucleus pulposus in the spinal canal. HNP = Herniated Nucleus Pulposus.</p>	Acute or insidious radiation of lower back pain	<p>O – acute physical strain or insidious</p> <p>P – worse w/ sitting, standing, cough; better supine with knees bent</p> <p>Q – dull to sharp ache</p> <p>R – unilateral radiculopathy to anterior thigh and below knee</p> <p>S – moderate to severe</p> <p>T – intermittent or constant</p> <p>Patient may have incontinence or loss of rectal tone.</p>	<p>Insp: symmetrical w/o atrophy/deformity/dicolor</p> <p>Palp: tenderness at lumbar disk (L4/5-S1))</p> <p>ROM: active - limited; passive - limited</p> <p>Stability: yes</p> <p>Motor: 3/5 strengths (big toe dorsiflexion diminished w/ L5 rupture 67%)</p> <p>Sense: dermatome – L4 = big toe, L5 = plantar/anter, S1 = little toe sensation diminished. Positive Straight Leg Raise</p>	<p>MRI to confirm HNP <u>only</u> if symptoms persist longer than 4 weeks <u>or</u> if significant neurological deficit</p> <p>Note: the toe-walk and heel-walk will help localize HNP. Weak toe walk indicates S1 involvement 28% and a weak heel walk is L4 involvement 5%</p>	<p>Analgesic: Acetaminophen with codeine for no longer than 7 days.</p> <ul style="list-style-type: none"> Limit activities that aggravate Sx for 3-4 weeks Physical therapy 	F/U if not improved in 7 days; CONTACT MO

CHIEF COMPLAINT: KNEE PAIN

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Bursitis, Patellar Inflammation of the bursae (fluid-filled sac), caused by repetitive kneeling. There are several bursa of the knee that may be involved.</p>	<p>Knee pain with direct pressure or after prolonged sitting or kneeling</p>	<p>O – may or may not present as pain. May just be swelling. P – worse after sitting or kneeling; better w/ activity Q – dull ache R – nonradicular S – mild to moderate T – intermittent</p> <p>The patient will be feverish if infected.</p>	<p>Insp: w/o atrophy/ discolor. Swelling may be evident Palp: tenderness over bursae ROM: active – full; passive – full Stability: stable Motor: 5/5 strengths Sense: normal</p> <p>An infected bursae will show signs of infection.</p>	<p>Usually nothing indicated</p> <p>Note: infected (septic) and gouty knees will present as a swollen, painful knee in the <u>absence</u> of trauma and will require MO consultation for diagnostic approach.</p>	<p>Analgesic: Ibuprofen No kneeling for 7-10 days</p>	<p>If not improved in 14 days or signs of infection or gouty, refer to MO.</p>
<p>Collateral Ligament Tear (Lateral/Medial) The medial ligament is most commonly injured and related to valgus force as in a football clipping injury.</p>	<p>Acute knee pain without initial swelling</p>	<p>O – acute pain without initial swelling P – worse w/ ambulation; better after swelling reduces Q – sharp ache R – nonradicular S – severe T – constant; ambulation limitation may be 24-48 hrs after swelling progresses</p>	<p>Insp: slight swelling with possible ecchymosis Palp: tender over ligament ROM: active – limited; passive – limited Stability: instable, positive valgus/varus stress test Motor: 4/5 strengths Sense: normal</p>	<p>Radiograph indicated to rule out fracture</p> <p>Note: Unlike the lateral, the medial collateral ligament attaches to the meniscus and injury to either can affect the other.</p>	<p>Analgesic: Ibuprofen</p> <ul style="list-style-type: none"> • RICE and crutches • Immobilize for 2-3 days, then regular, gentle ROM exercises • Usually <u>non-surgical</u>. ROM exercises and strengthening are important to recovery 	<p>If not improved in 14 days; consult with MO</p>

CHIEF COMPLAINT: KNEE PAIN (continued)						
CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Cruciate Ligament Tear (Anter./Posterior)</p> <p>The anterior cruciate ligament is the prime knee stabilizer and more likely to be injured. A tear results from a twisting or hyper-extension of the knee joint.</p>	<p>Acute and severe knee pain and swelling associated with trauma</p>	<p>O – sudden pain may be associated with an audible pop</p> <p>P – worse w/ ambulation; better after swelling reduces</p> <p>Q – sharp ache</p> <p>R – nonradicular</p> <p>S – severe</p> <p>T – constant</p> <p>Pain develops over 24 hrs as swelling worsens</p>	<p>Insp: marked swelling with possible ecchymosis</p> <p>Palp: tender knee</p> <p>ROM: active – limited; passive – limited</p> <p>Stability: instable; positive Drawer Sign</p> <p>Motor: 2/5 strengths</p> <p>Sense: normal</p> <p>Initially, knee may be too swollen to examine</p>	<ul style="list-style-type: none"> • Radiograph indicated to rule out fracture • MRI, although quite sensitive to detecting tears, rarely are necessary unless diagnosis is allusive or surgery is indicated 	<p>Analgesic: Ibuprofen</p> <ul style="list-style-type: none"> • RICE and crutches • Immobilize for 2-3 days, then regular, gentle ROM exercises • If not corrected by surgery, ROM exercises and strengthening are important to recovery 	<p>Consult with the MO</p>
<p>Meniscal Tear (Lateral/Medial)</p> <p>The menisci are fibrocartilaginous pads that act as shock absorbers. Significant twisting can injure the meniscus, though in older patients, minimal or no trauma can cause injury.</p>	<p>Acute trauma may result in a 'locking sensation' with flexion</p>	<p>O – Insidious, even with trauma. No initial swelling</p> <p>P – worse w/ locking sensation or squatting; better with rest</p> <p>Q – sharp ache</p> <p>R – nonradicular</p> <p>S – mild</p> <p>T - intermittent</p>	<p>Insp: may have slight swelling otherwise normal</p> <p>Palp: tender along joint line</p> <p>ROM: active – limited; passive – limited</p> <p>Stability: stable, positive McMurray test with painful click</p> <p>Motor: 4/5 strengths</p> <p>Sense: normal</p>	<ul style="list-style-type: none"> • Radiograph indicated to rule out fracture • Diagnosis may be allusive and MRI is quite sensitive to detecting tears 	<p>Analgesic: Ibuprofen</p> <ul style="list-style-type: none"> • RICE and crutches • Immobilize for 2-3 days, then regular, gentle ROM exercises • Surgery may be indicated 	<p>If not improved in 14 days; consult with MO</p>

CHIEF COMPLAINT: KNEE PAIN (continued)						
CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Patellofemoral Syndrome</p> <p>Vague pain associated with running or climbing stairs, usually in younger patients. Cause can be articular surface irregularities or patellar malalignment.</p>	<p>Diffuse knee pain with running and may have crepitus with squatting</p>	<p>O – insidious</p> <p>P – worse w/ prolonged sitting or running; better with rest</p> <p>Q – dull ache</p> <p>R – nonradicular</p> <p>S – mild</p> <p>T - intermittent</p>	<p>Insp: symmetrical w/o atrophy/deformity/ discolor</p> <p>Palp: nontender, though crepitus with movement</p> <p>ROM: active – full; passive – full</p> <p>Stability: Stable. Positive Patellar Grind test</p> <p>Motor: 5/5 strengths</p> <p>Sense: normal</p>	<ul style="list-style-type: none"> • Usually nothing indicated • Q-angle measurement can be helpful to determining malalignment. 	<p>Analgesic:</p> <p>Ibuprofen</p> <p>Continue activity but change to low impact or swimming until resolved</p>	<p>F/U if not improved in 2-3 months</p>
<p>Popliteal Cyst</p> <p>A “Baker cyst” is a cystic structure that arises from the capsule of the joint synovial sheath associated with arthritis or degeneration of the meniscus</p>	<p>Cyst may be painless and present as <u>swelling</u> behind the knee</p>	<p>O – gradual and may be painless w/ just patient complaint of swelling behind the knee</p> <p>P – worse if cyst ruptures; better after swelling reduces</p> <p>Q – dull ache</p> <p>R – nonradicular</p> <p>S – slight to mild</p> <p>T – intermittent</p>	<p>Insp: asymmetrical w/ swelling in popliteal fossa w/o atrophy or discoloration.</p> <p>Palp: tender or nontender popliteal mass.</p> <p>ROM: active – full; passive – full</p> <p>Stability: stable though may have positive McMurray if meniscus is cause</p> <p>Motor: 5/5 strengths</p> <p>Sense: normal</p>	<p>Transillumination, or shining a light through the cyst, can demonstrate that the mass is filled with fluid</p>	<ul style="list-style-type: none"> • Observation unless the cyst becomes large and painful • NSAIDs for minor discomfort • Treatment is directed at the cause. Refer to MO PRN 	<p>F/U PRN</p>

CHIEF COMPLAINT: ANKLE PAIN						
CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Achilles Tendon Rupture</p> <p>Usually the tendon ruptures just proximal to calcaneus, and more common in middle-aged men who play quick, stop-and-go sports.</p>	<p>Sudden, severe calf pain</p>	<p>O – sudden w/audible ‘pop’ and pain may resolve quickly</p> <p>P – worse w/ambulation; better with rest</p> <p>Q – sudden sharp then dull ache</p> <p>R – nonradicular</p> <p>S – moderate to severe</p> <p>T – constant</p>	<p>Insp: asymmetrical w/ calf swelling and ecchymosis</p> <p>Palp: tender</p> <p>ROM: active – limited; passive – limited</p> <p>Stability: unstable w/ positive Thompson test (no plantar flexion w/ calf squeeze)</p> <p>Motor: 1/5 strengths</p> <p>Sense: normal</p>	<p>Usually nothing indicated.</p>	<p>Analgesic:</p> <p>Ibuprofen PRN</p> <ul style="list-style-type: none"> Initially RICE Immediate referral to MO required There are surgical and non-surgical approaches requiring an orthopedic evaluation 	<p>CONTACT MO or Duty Flight Surgeon</p> <p>MEDEVAC</p>
<p>Ankle Sprain</p> <p>Most common ankle ligament sprain is the lateral anterior talofibular ligament (ATFL) caused by an inversion injury.</p> <p>The rare aversion injury involves the medial deltoid ligaments.</p>	<ul style="list-style-type: none"> Acute ankle pain associated with trauma Ability to ambulate and weight-bear helps determine severity 	<p>O – sudden and swelling may not be immediate</p> <p>P – worse w/ambulation; better with rest</p> <p>Q – sudden sharp then dull ache</p> <p>R – nonradicular</p> <p>S – moderate to severe</p> <p>T – constant</p>	<p>Insp: asymmetrical w/ swelling and ecchymosis</p> <p>Palp: tender at ATFL</p> <p>Tenderness at base of 5th metatarsal may indicate fracture.</p> <p>ROM: active – limited; passive – limited</p> <p>Stability: unstable w/ positive Drawers sign</p> <p>Motor: 3/5 strengths</p> <p>Sense: normal</p>	<p>Radiograph indicated to rule out fracture if patient unable to weight-bear, or if there is marked swelling.</p>	<p>Analgesic:</p> <p>Ibuprofen</p> <ul style="list-style-type: none"> RICE and crutches Immobilize for 2-3 days, then regular, gentle ROM exercises Severe sprains may require a cast or orthopedic boot for 2-3 weeks 	<p>If not improved in 14 days; consult with MO</p>

CHIEF COMPLAINT: FOOT PAIN

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>5TH Metatarsal Fracture</p> <p>The fifth metatarsal is at the base of the small toe, and the proximal end, where the fracture occurs, is in the mid-portion of the foot.</p> <p>These fractures occur after forced inversion with the foot and ankle in plantar flexion, causing the tendon to pull off a piece of the bone.</p>	<p>Patients who sustain a fracture have pain over this middle/outside area of their foot</p>	<p>O – trauma (after an inversion injury)</p> <p>P – walking and prolonged standing aggravate the symptoms</p> <p>Q – sudden sharp then dull ache</p> <p>R – nonradicular</p> <p>S – moderate to severe</p> <p>T – constant, aggravated by prolonged standing, walking or activity</p>	<p>Insp: ecchymosis and swelling at the site</p> <p>Palp: tenderness at the base of the fifth metatarsal. Full evaluation of the distal fibula and lateral ligamentous structures must be included in the assessment.</p> <p>Stability: stable</p> <p>Motor: 5/5 strengths</p> <p>Sense: normal</p>	<ul style="list-style-type: none"> • Radiographs are indicated with initial evaluation • Weight-bearing radiographs indicated if treatment unsuccessful 	<p>Analgesic:</p> <p>Ibuprofen</p> <ul style="list-style-type: none"> • Options include elastic wrapping, ankle splints and low-profile walking boots or casts • Weight bearing is allowed as tolerated • Treatment should be continued until symptoms abate-usually within six weeks 	<p>F/U if not improving in 6 weeks</p>
<p>Heel Spur</p> <p>Soft, bendable deposits of calcium that are the result of tension and inflammation in the plantar fascia attachment to the heel.</p>	<p>Dull ache that is felt most of the time with episodes of a sharp pain in the center of the heel or on the inside margin of the heel.</p>	<p>O – first ambulation</p> <p>P – worse w/ fist ambulation; better with time, though returns over course of day</p> <p>Q – sudden sharp then dull ache</p> <p>R – nonradicular</p> <p>S – moderate to severe</p> <p>T – constant, aggravated by prolonged standing</p>	<p>Insp: symmetrical w/o atrophy/deformity/dicolor</p> <p>Palp: tender at calcaneal tuberosity</p> <p>ROM: active – full; passive – full</p> <p>Stability: stable</p> <p>Motor: 5/5 strengths</p> <p>Sense: normal</p>	<ul style="list-style-type: none"> • Radiographs not indicated with initial evaluation • Weight-bearing radiographs indicated if treatment unsuccessful 	<p>Analgesic:</p> <p>Ibuprofen</p> <ul style="list-style-type: none"> • Heel cushion or donut • Avoid high impact exercise or work 	<p>F/U if not improving in 3-6 months</p>

CHIEF COMPLAINT: FOOT PAIN (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Plantar Fasciitis Degenerative tear of fascial origin from the calcaneus. This may be associated with a heel spur.</p>	<ul style="list-style-type: none"> Acute or Chronic arch pain Usually no trauma; worse on first ambulation and gradually gets better throughout day 	<p>O – first ambulation P – worse w/ first ambulation; better with time throughout day Q – dull ache R – nonradicular S – moderate to severe T – constant</p>	<p>Insp: symmetrical w/o atrophy/deformity/dicolor Palp: tender at <u>medial</u> calcaneal tuberosity and distally along plantar fascia ROM: active – full; passive – full Stability: stable Motor: 5/5 strengths Sense: normal</p>	<ul style="list-style-type: none"> Radiographs not indicated with initial evaluation Weight-bearing radiographs indicated if treatment unsuccessful 	<p>Analgesic: Ibuprofen Heel cup (raise heel slightly to decrease strain on plantar fascia) or OTC orthotic insert</p>	<p>F/U if not improved in 3-6 months</p>

CHIEF COMPLAINT: TOE PAIN

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Ingrown Toenail The toenail abnormally grows into nail bed and may involve infection of the tissue around toenail. <i>Staphylococcus aureus</i> is the most common organism involved</p>	Acute pain at distal phalanx along edge on nail	<p>O – Insidious P - worse w/ palpation to lesion; better w/ rest Q – dull ache R – nonradicular S – moderate to severe T – constant</p>	<p>Insp: asymmetrical w/ localized red (rubor), tender (dolor), if infected will also be warm (calor), and swollen (tumor) along lateral edge on nail Palp: very tender ROM: active – full; passive – full Stability: stable Motor: 4/5 strengths Sense: normal</p>	Culture if unsure or suspect MRSA	<p>Soak the foot in warm water 4 times a day, preferably with Epsom salts. If infected: Antibiotic: Cephalexin (Keflex)</p> <ul style="list-style-type: none"> • Pain management, no boots • Partial toenail removal as directed by MO 	<p>Follow up every 24 hours until resolved</p> <p>IF not resolved in 7 days; <u>CONTACT MO</u></p>

CHIEF COMPLAINT: LEG PAIN

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Shin Splints A general name given to pain at the front of the lower leg related to inflammation of the periosteum of the tibia due to traction forces on the muscles attached. Caused by training too hard or running in ill-fitting or worn-out footwear.</p>	<p>Lower leg pain over inside of the shin</p>	<p>O – gradual onset P - worse with running; better w/o activity Q – dull ache R – nonradicular S – mild to moderate T – intermittent</p>	<p>Insp: w/o atrophy/ discolor, deformity. May have slight swelling. Palp: tenderness over anterior tibia (shin) ROM: active – full; passive – full Stability: stable Motor: 5/5 strengths Sense: normal</p>	<p>Usually nothing indicated Note: If symptoms appear persistent, radiographs may indicate stress fracture.</p>	<p>Analgesic: Ibuprofen Wear proper footwear and lessen the impact of training</p>	<p>F/U if not improved in 14 days; or refer to MO</p>

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CHIEF COMPLAINT: ALTERED MENTAL STATUS

(though any neurological condition can have AMS, the CC here is categorized by common presenting features)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Alcohol Intoxication Physically and/or psychologically reliant on alcohol. Alcohol abuse may be situational or chronic. Alcohol dependency is a chronic, life-time diagnosis.</p>	<ul style="list-style-type: none"> • Acute intoxication • Cognitive deficit 	<ul style="list-style-type: none"> • Sloppy speech, alcohol on breath • Nausea and vomiting • Headache • Happy, sad or angry affect <p>(Note: diabetic emergencies may appear as intoxication)</p>	<ul style="list-style-type: none"> • Appears intoxicated • The classic chronic alcoholic may appear with poor hygiene, spider angiomas on skin, 'red faced', 'pot' belly, thin extremities. <p>Ask: C = cut down need? A = annoyed by drink? G = guilty about drink? E = eye opener need?</p>	<p>Reasonable blood alcohol concentration (BAC) is <0.06%.</p> <p>(1 drink = 0.03% BAC: 12 oz of 4% beer, 1.5 oz of 40% shot, or 6 oz of 11% wine)</p> <p>Note: 5 drinks/2.5 hrs = 0.15 BAC = intoxication/delirium</p>	<p><i>Acute Tx:</i></p> <ul style="list-style-type: none"> • Time • Avoid stimulants like caffeine • Monitor • Severe cases may require MO consultation. <p><i>Chronic Tx:</i> Refer to MO</p>	<p>Refer to CDAR</p> <p>Note: MNM-0013 is: Maturity = Mod. Zero illegal drink Zero DUI 1 drink per hour 3 drinks per 24 hours Never leave drink unattended</p>
<p>Cerebrovascular Accident (CVA) Infarction or hemorrhage in the brain caused by ischemia, trauma or anticoagulation. Most common in age > 45.</p>	<p>Acute cognitive deficit</p>	<ul style="list-style-type: none"> • Slurred speech • Motor and sensory deficits • Headache may be gradual or sudden 	<ul style="list-style-type: none"> • Patient able to easily close both eyes but unable to completely smile. Facial weakness does not include forehead as it does in Bell's Palsy. • Complete physical examination including neurological 	<ul style="list-style-type: none"> • CBC • Blood chemistries • Blood glucose • RPR • Urinalysis • ECG • CT of head 	<p><i>Acute Tx:</i> Aspirin 650 mg bid</p> <p><i>Chronic Tx:</i> Refer to MO</p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon.</p> <p><u>MEDEVAC</u></p>

CHIEF COMPLAINT: ALTERED MENTAL STATUS

(though any neurological condition can have AMS, the Chief Complaint is categorized by common presenting features)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Seizure Paroxysmal hyperexcitation of the neurons in the brain. Epilepsy is chronic recurrent seizures.</p>	Compromised motor activity	<ul style="list-style-type: none"> • <u>Partial Seizure</u> – no loss of consciousness, though simple muscle contractions, paresthesias, loss of bowel & bladder • <u>Petit Mal Seizure</u> – sudden stopping of motor function with blank stare • <u>Grand Mal Seizure</u> – loss of consciousness, tonic-clonic muscle contractions, loss of bowel & bladder;. postictal period 	Between seizures, physical exam is normal, though may have bruising or trauma to tongue just after.	<ul style="list-style-type: none"> • CBC • Chemical Panel • Urinalysis • Drug & alcohol screening • CT scan or MRI 	<ul style="list-style-type: none"> • During seizure, maintain airway and prevent injury. • Refer to MO <p><u>Seizure > 10 minutes need emergency intervention!</u></p>	Consult with MO or Flight Surgeon

CHIEF COMPLAINT: HEADACHE						
CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Emergent						
<p>Hemorrhage, Subarachnoid</p> <p>Hemorrhage within the subarachnoid space of the brain caused by trauma or anticoagulation</p>	Acute cognitive deficit with sudden, severe headache	<ul style="list-style-type: none"> • Sudden, severe headache. Reports “worst headache of life” • Nausea, vomiting • Altered consciousness • May have visual and neurological deficiency 	<ul style="list-style-type: none"> • Appears with altered level of consciousness • Increased BP • Tachycardia • Complete physical examination including neurological 	<ul style="list-style-type: none"> • CBC • Blood chemistries • Blood glucose • RPR • Urinalysis • ECG • CT of head 	<ul style="list-style-type: none"> • Oxygen • IV- NS • Comfortable rest <p>Emergency treatment is <u>required</u></p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p><u>MEDEVAC</u></p>
<p>Hypertension Emergency</p> <p>Severe hyper-tension with potential to cause target organ damage (brain, cardio-vascular system, and kidneys)</p>	Normal mental status with headache	<ul style="list-style-type: none"> • May be asymptomatic or have a headache with blurred vision • Nausea and maybe vomiting 	<ul style="list-style-type: none"> • Marked increased BP with a diastolic of >120 (>210/>120) and bounding pulse • Fundoscopic = papilledema • Complete physical examination including neurological 	<ul style="list-style-type: none"> • CBC • Blood chemistries • Urinalysis • ECG • Spiral CT of kidneys 	<p>Antihypertensive: Nitroprusside IV; BP must be reduced within 1 hour</p> <p>Emergency treatment is <u>required</u></p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p><u>MEDEVAC</u></p>
<p>Meningitis</p> <p>Bacterial or viral infection/inflammation of the covering of the brain and spinal cord. Cause is mainly bacterial or viral. Cause must be identified because treatments are different.</p>	<ul style="list-style-type: none"> • Acute severe headache with a fever • May have cognitive deficit 	<ul style="list-style-type: none"> • Fever • Gradual or sudden headache with neck pain and stiffness • Photophobia • Occasional rash 	<ul style="list-style-type: none"> • Febrile • Nuchal rigidity on flexion only • Positive Kernig's or Brudzinski's sign • Fundoscopic = papilledema • Complete physical examination including neurological 	<ul style="list-style-type: none"> • CBC • Lumbar Puncture • CT of head 	<p><i>Acute Tx:</i></p> <p>Determine cause:</p> <ul style="list-style-type: none"> • If <u>bacterial</u>, IV antibiotics as directed • If <u>viral</u>, IV analgesics as directed <p>Emergency treatment is <u>required</u></p>	<p><u>CONTACT</u> MO or Duty Flight Surgeon</p> <p><u>MEDEVAC</u></p>

CHIEF COMPLAINT: HEADACHE (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Non-Emergent						
<p>Cluster Headache Excruciating unilateral periorbital or temporal pain typically in men. Cause unknown, though suggests hypothalamic disorder.</p>	<p>Normal mental status with sharp, boring headache</p>	<ul style="list-style-type: none"> • Rhinorrhea • Ipsilateral lacrimation • Unilateral headache centered around orbit and lasting 30-120 minutes in clusters over 4-12 weeks with 1-2 per day. 	<ul style="list-style-type: none"> • Appears un-rested, and in pain • Complete physical examination including neurological 	<ul style="list-style-type: none"> • Usually nothing indicated • If uncertain, CT or MRI of head 	<ul style="list-style-type: none"> • <i>Acute Tx:</i> Ergotamines (NOT with sulfa allergy): Sumatriptan SQ (Imitrex) or Midrin, oxygen, IV NS if dehydrated • <i>Chronic Tx</i> –refer to MO 	<p>F/U if not improved in 24 hrs refer to MO</p>
<p>Sinusitis Inflammation <u>or</u> infection of mucous membranes of paranasal sinus</p>	<ul style="list-style-type: none"> • Normal mental status with dull, functional headache • Nasal Congestion 	<ul style="list-style-type: none"> • Sinus pressure, facial pain or headache • May have yellow - green nasal discharge, maxillary toothache, fever or malaise. 	<ul style="list-style-type: none"> • Turbinates are erythematic and swollen • Face pain worse when bending over (tilt test), sinus tenderness with percussion • May be unable to transilluminate sinuses 	<ul style="list-style-type: none"> • Usually none indicated • CT of sinus if Sx persist 	<p>Antibiotic: Amoxicillin-clavulanate (Augmentin) or Septra DS</p> <ul style="list-style-type: none"> • Reserve antibiotics for patients that fail a 7 day course of decongestants and analgesics • If severe pain, treat sooner 	<p>F/U if not improved in 7 days or increased fever or headache</p>

CHIEF COMPLAINT: HEADACHE (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
Non-Emergent (continued)						
<p>Tension Headache Diffuse bilateral occipital or band-like pain usually associated with stress (episodic) and may be chronic in nature</p>	Normal mental status with dull, functional headache	Bilateral occipital or band-like head pain is most common, though may be a generalized pain.	<ul style="list-style-type: none"> • Normal physical finding • Complete physical examination including neurological 	<ul style="list-style-type: none"> • Usually nothing indicated • If uncertain, CT or MRI of head 	<p>Analgesics: Acetaminophen (Tylenol) or NSAIDS</p> <ul style="list-style-type: none"> • Stress reduction or evaluate workplace ergonomics 	F/U PRN
<p>Vascular Headache Migraine headache is a diffuse severe unilateral pain. Exact cause is unknown though a disturbance of cerebral blood flow precipitated by food, alcohol, BCP, menses, fatigue, excess sleep, hunger, stress or relief of stress is involved. 65% with positive family history of same.</p>	Normal mental status with severe, throbbing headache	<ul style="list-style-type: none"> • Unilateral headache, preceded by aura, gradually intense and throbbing • Associated nausea, vomiting, photophobia, blurred vision are very common 	<ul style="list-style-type: none"> • Appears un-rested, in pain and may have facial flushing during attack • Complete physical examination including neurological 	<ul style="list-style-type: none"> • Usually nothing indicated • If uncertain, CT or MRI of head 	<ul style="list-style-type: none"> • <i>Acute TX</i> Ergotamines (NOT with sulfa allergy): Sumatriptan SQ (Imitrex) or Midrin, oxygen, IV NS if dehydrated • <i>Chronic TX</i> –refer to MO 	F/U if not improved in 24 hrs refer to MO

CHIEF COMPLAINT: VERTIGO

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Benign Positional Vertigo</p> <p>Vertigo occurs with certain head positions. Cause associated with otoconial crystals that stimulate semicircular canal hair cells</p>	Vertigo with body position changes	<ul style="list-style-type: none"> • Vertigo associated with positional changes. Usually occurs when supine or acute change in body position. • May have recent HO viral infection 	<ul style="list-style-type: none"> • Dix-Hallpike Barany Maneuver positive (with + nystagmus) • Complete physical examination including neurological 	<ul style="list-style-type: none"> • Usually nothing indicated • CT or MRI if tumor is suspected 	<p>Antiemetics: Meclozine</p>	F/U if not improved in 24 hours
<p>Labyrinthitis</p> <p>Inflammation of the vestibular labyrinth of the inner ear</p>	Vertigo with nausea and vomiting	Gradual, severe vertigo with <u>b</u> ilateral tinnitus and associated nausea, and vomiting	<ul style="list-style-type: none"> • Dix-Hallpike Maneuver negative • Complete physical examination including neurological 	<ul style="list-style-type: none"> • Usually nothing indicated • CT or MRI if tumor is suspected 	<p>Antiemetics: meclozine</p> <ul style="list-style-type: none"> • Hydration for vomiting 	F/U if not improved in 24 hours
<p>Meniere's Disease</p> <p>Disease of the inner ear in which there is increased endolymph, which creates increased pressure in the inner ear</p>	Vertigo. symptoms may be vague	<ul style="list-style-type: none"> • Periodic, sudden, severe attacks of vertigo with <u>u</u>nilateral tinnitus <u>and</u> hearing loss • Occasional nausea, vomiting 	<ul style="list-style-type: none"> • Dix-Hallpike Maneuver negative • Complete physical examination including neurological 	<ul style="list-style-type: none"> • Diagnosis of exclusion may require rule out of other conditions • CT or MRI if tumor is suspected 	<p>Antiemetics: Meclozine</p>	F/U if not improved in 24 hrs refer to MO
<p>Motion Sickness</p> <p>Normal response to abnormal erratic or rhythmic motions.</p> <p>Chronic symptoms without relief of stimulus can be debilitating</p>	Vertigo or lightheadedness and nausea	Motion stimulus. Symptoms may include nausea, vomiting, yawning, salivation, and hyperventilation.	<ul style="list-style-type: none"> • Dix-Hallpike Maneuver negative • Complete physical examination including neurological 	Usually nothing indicated	<p>Antiemetics: Meclozine, preferably <u>p</u>rior to travel</p> <p>Hydration for vomiting</p>	F/U if not improved in 24 hours

CHIEF COMPLAINT: FACIAL NEUROPATHY

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Bell's Palsy Facial muscle weakness caused by inflammation of the seventh cranial nerve (facial nerve). Complete resolution within 6 weeks. Cause unknown though may be associated with herpes.</p>	<p>Facial flaccidity</p>	<ul style="list-style-type: none"> • Sudden onset of flaccidity of one side of the face • May have loss of hearing • May have history of or active herpes lesion on face 	<ul style="list-style-type: none"> • Patient <u>not</u> able to close affected eyelid • Unable to completely smile • Facial weakness includes forehead • Complete physical examination including neurological. 	<p>Usually nothing indicated</p>	<p>Keep affected eye moist with eye drops or ophthalmic ointment</p>	<p>CONTACT MO or Duty Flight Surgeon</p>
<p>Cerebrovascular Accident (CVA) Infarction or hemorrhage in the brain cause by ischemia, trauma or anticoagulation. Most common in age > 45.</p>	<ul style="list-style-type: none"> • Facial flaccidity • Acute cognitive deficit 	<ul style="list-style-type: none"> • Slurred speech, motor and sensory deficits • Headache may be gradual or sudden. 	<ul style="list-style-type: none"> • Patient able to <u>easily close both eyes</u> but unable to completely smile • Facial weakness does <u>not</u> include forehead as it does in Bell's Palsy • Complete physical examination including neurological 	<ul style="list-style-type: none"> • CBC • Blood chemistries • Blood glucose • RPR • Urinalysis • ECG • CT of head 	<ul style="list-style-type: none"> • <i>Acute TX:</i> Aspirin 650 mg bid • <i>Chronic Tx:</i> Refer to MO 	<p>CONTACT MO or Duty Flight Surgeon MEDEVAC</p>

CHIEF COMPLAINT: FACIAL NEUROPATHY (continued)

CONDITION & DEFINITION	COMMON FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Trigeminal Neuralgia</p> <p>“Tic douloureux’ is a syndrome of paroxysms of lancinating facial pain in the distribution of one or more division of the fifth (trigeminal) nerve. Caused by compression to the trigeminal nerve in 90% of cases. Rarely an aneurysm.</p>	<p>Facial pain in clusters</p>	<ul style="list-style-type: none"> • Pain burst for several seconds then remits • Attack brought on by mild trigger such as light touch or draft of air 	<p>Patient may present asymptomatic or have pain on one side of face with light touch</p>	<ul style="list-style-type: none"> • MRI for <u>all</u> patients to exclude mass lesions or central demyelination • Dental pathology may be cause—dental exam will help rule out 	<p>Carbamazepine (Tegretol) works in 75% of cases.</p>	<p>CONTACT MO or Duty Flight Surgeon</p>

CHIEF COMPLAINT: FEELING DOWN OR WORRIED

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Adjustment Disorder Transient, situational maladjustment due to special stress (significant life stressor)</p>	<p>Patient may present with somatic complaints caused by excessive worry or low mood</p>	<p>Patient usually presents with depressed mood associated with feelings of being in hopeless situation. Thoughts are often dominated by the problems that precipitate the episode.</p>	<ul style="list-style-type: none"> • May appear anxious or depressed: preoccupied by problems that precipitate the episode; military/sea life, homesick 	<ul style="list-style-type: none"> • R/O anxiety and depression • Anxiety Questionnaire and Depression Questionnaire 	<ul style="list-style-type: none"> • Self-limiting • Improvement when the stress is removed or adaptive coping mechanism employed 	<p>CONTACT MO and/or Duty Flight Surgeon IF doubt</p>
<p>Anxiety Excessive worry, fear, nervousness, & hyper vigilance. May be associated with adjustment disorder or generalized.</p>	<p>Patient may present with somatic complaints caused by excessive worry</p>	<ul style="list-style-type: none"> • Physical complaints prompt patient to seek medical attention; worry, insomnia, muscle tension, headache, fatigue, GI upset. • Chest pain may be associated with stress or panic attack. 	<ul style="list-style-type: none"> • Appears anxious, diaphoretic, pallor, dyspnea 	<ul style="list-style-type: none"> • If presenting with chest pain - ECG is normal • Anxiety Questionnaire 	<p><i>Acute Tx:</i> Antianxiety: Hydroxyzine (Atarax), or diazepam (Valium) <i>Chronic Tx:</i> Refer to MO</p>	<p>CONTACT MO and/or Duty Flight Surgeon IF doubt</p>
<p>Depression Abnormal emotional state; sadness, rejection, worthlessness, despair, and discouragement. May be associated with adjustment disorder or major depression.</p>	<p>Patient may present with somatic complaints caused by low mood</p>	<p>FIVE of the following criteria daily for TWO weeks:</p> <ul style="list-style-type: none"> • <u>S</u>leep more/less • <u>I</u>nterest down • <u>G</u>uilt dominant • <u>E</u>nergy down • <u>C</u>oncentration down • <u>A</u>ppetite more/less • <u>P</u>sychomotor loss • <u>L</u>ibido down • <u>S</u>uicidal ideation 	<ul style="list-style-type: none"> • Appears sad, unkempt, tearful, minimal eye contact, slow movements 	<p>Depression Questionnaire (SIGECAPS)</p>	<ul style="list-style-type: none"> • Listen • Encourage proper diet, daily exercise, pursuing pleasurable interest, minimal alcohol consumption; exercise is proven to reduce depression • Refer to MO • IF suicidal: refer to suicidal ideation 	<p>CONTACT MO and/or Duty Flight Surgeon IF doubt</p>

CHIEF COMPLAINT: FEELING DOWN OR WORRIED (continued)

CONDITION & DEFINITION	KEY FEATURES	DIFFERENTIATING SIGNS & SYMPTOMS	DIFFERENTIATING OBJECTIVE FINDINGS	COMMON DIAGNOSTIC TEST	TREATMENT	FOLLOW-UP
<p>Suicidal Ideation Self destructive thoughts or acts; three types:</p> <ul style="list-style-type: none"> • successful (death) • attempt • gesture <p>Thoughts & plans about suicide are ideation.</p>	<p>Patient may present with somatic complaints caused by excessive worry or low mood.</p>	<ul style="list-style-type: none"> • See anxiety and depression above • ASK: “Do you want to hurt yourself?” or “Do you have a plan to hurt yourself?” 	<ul style="list-style-type: none"> • May appear anxious or depressed. See anxiety and depression above • Mental Health Interview 	<p>Suicide Risk Questionnaire (SADPERSON)</p>	<ul style="list-style-type: none"> • Suicidal thoughts ALONE require immediate healthcare intervention • Obtain assistance • Establish a ‘No Harm Safety Plan’ 	<ul style="list-style-type: none"> • CONTACT MO and/or Duty Flight Surgeon • Follow unit SOP, i.e., suicide ideation policy • Contact command

ICD CODES, ABBREVIATED VERSION

CONDITION	CODE
Dermatological	
Erythema due to Anthrax	692.4
Erythema due to a Drug Reaction (internal)	693.0
Erythema due to a Drug Reaction (contact)	692.3
Erythema/Urticaria	708.9
Wart (common)	078.10
Acne Vulgaris	706.1
Tinea Corporis	110.5
Tinea Cruris	110.3
Tinea Pedis	110.4
Tinea Versicolor	111.0
Atopic Dermatitis	691.8
Contact Dermatitis	692.9
Eczema (dyshidrosis)	705.81
Herpes Zoster	053.9
Smallpox	050.9
Varicella (chickenpox)	052.9

ICD CODES, ABBREVIATED VERSION

HEENT	
Blepharitis	373.00
Allergic Conjunctivitis	372.05
Infectious Conjunctivitis	372.30
Corneal Abrasion	918.1
Subconjunctival Hemorrhage	372.72
Cerumen Impaction	380.4
Eustachian Tube Dysfunction	381.81
Otitis Externa	380.10
Otitis Media	382.9
Perforation (ear)	384.20
Serous Otitis Media	381.01
Allergic Rhinitis	477.9
Upper Respiratory Infection	465.9
Common Cold	460.0
Epistaxis	784.7
Sinusitis (Acute)	461.9
Viral Pharyngitis	462

ICD CODES, ABBREVIATED VERSION

Gastrointestinal	
Appendicitis	541
Constipation	564.00
Diarrhea	787.91
Food Poisoning	005.9
Acute Gastroenteritis (viral)	008.8
Gastroesophageal Reflux Disease (GERD)	530.81
Peptic Ulcer Disease	533.90
Ectopic Pregnancy	633.90
Genitourinary	
Vulvovaginal Candidiasis	112.1
Dysmenorrhea	625.3
Urinary Tract Infection (including cystitis)	599.0
Epididymitis	604.90
Inguinal Hernia	550.90
Acute Prostatitis	601.0
Testicular Torsion	608.20
Pyelonephritis	590.80
Renal Calculii	592.0

ICD CODES, ABBREVIATED VERSION

Genitourinary, continued	
Chancroid	009.0
Chlamydia	079.98
Gonorrhea	098.0
Herpes Simplex Virus II (HSV II)	054.9
Human Immunodeficiency Virus (HIV) (symptomatic)	042
Human Immunodeficiency Virus (HIV) asymptomatic)	V08
Pediculosis	132.9
Syphilis	097.9
Cardiovascular	
Acute Coronary Syndrome (ACS) (AMI)	411.1
Angina Pectoris	413.9
Costochondritis	733.6
Pleuritis	511.0
Respiratory	
Bronchitis, Viral	466.0
Bronchitis, Acute	466.0
Influenza	487.1
Pneumonia, Bacterial	482.9

ICD CODES, ABBREVIATED VERSION

Respiratory, continued	
Pneumonia, Mycoplasmal	483.0
Pneumonia, Viral	480.9
Tuberculosis	011.9
Anaphylaxis	995.0
Asthma	493.90
Musculoskeletal	
Neck - Cervical Muscle Strain	847.0
Herniated Cervical Disk – Neck	722.0
HNP – Herniated Nucleus Pulposus	722.2
Shoulder – Bicepital Tendon Rupture, Proximal	840.8
Shoulder – Biceptial Tendonitis	726.12
Shoulder – Subacromial Bursitis	726.19
Elbow – Epicondylitis, Media	726.31
Elbow – Epicondylitis, Lateral	726.32
Elbow – Epicondylitis, Olecranon	726.33
Wrist – Carpal Tunnel Syndrome	354.0
Wrist – Scaphoid Wrist Fracture	814.01
Lower back – Mechanical muscular strain	846.9

ICD CODES, ABBREVIATED VERSION

Musculoskeletal, continued	
Knee – Bursitis, Patellar	726.64
Ankle – Ankle sprain	845.00
Foot – Fifth Metatarsal Fracture	825.25
Leg – Shin splints	844.9
Neurological	
Alcohol Abuse	305.00
Cerebrovascular Accident (CVA)	434.91
Seizure	780.39
Emergent headache - Hemorrhage, Subarachnoid	430
Meningitis	322.9

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Listed medications are found on the Standardized Health Services Technician Formulary, Health Services Allowance List (Afloat), and the CG Nonprescription Medication Program.