TheCase.Report

PEARLS
GASTROENTERITIS

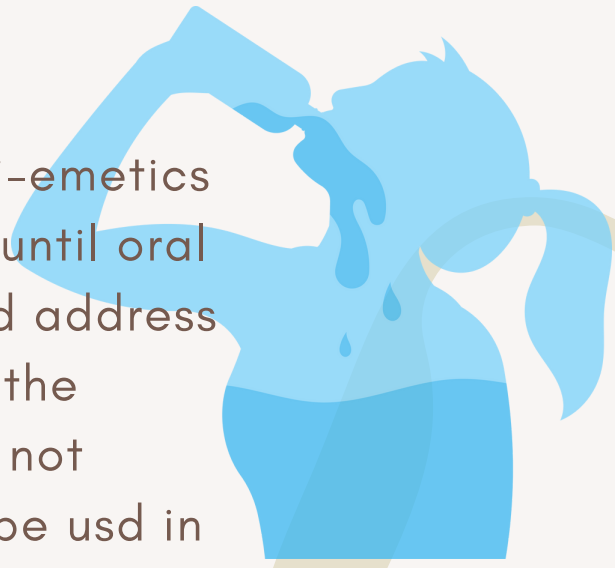
QUESTIONING THINGS

While it's important to characterise the symptoms themselves in assessing for gastroenteritis, the causes should also be considered. Ask about sick contact, recent travel and while we're used to asking about dodgy takeaways, don't forget that ingesting contaminated water e.g. while swimming can be another source of infection.

FLUID STATUS

As always, vitals are key. Beware of borderline tachycardias in athletes and elderly people, as fitter people can have low baselines and those on beta blockers may have a blunted response to insults. Assessing hydration is vital for these patients.

MORE THAN FLAT 7UP



Oral rehydration is the goal. Use anti-emetics and short-term IV fluids if necessary until oral intake is tolerated. Check bloods and address any electrolyte imbalances or AKI. In the absence of red flags, antibiotics are not necessary, but anti-diarrhoeals may be usd in over 12s with ongoing excessive bathroom trips.

STAY SHARP

Look out for red flags. Fever, signs of sepsis, bloody diarrhoea or a history of travel should raise your alarm. Consider other causes if symptoms are prolonged. Bloody or travellers diarrhoea may warrant fluorquinolone use, but if campylobacter is in the picture use azithromycin.

WEIL WE'RE TALKING RED FLAGS...

Weil's disease, AKA leptospirosis, can occur after exposure to farmland or contaminated water (often from poor weather). It can cause jaundice, but more importantly causes organ- and life-threatening damage to kidneys and the liver. Local guidelines should be consulted, but it is commonly treated with doxcycline and is *notifiable*.

Red eyes in Gastroenteritis: think Weil's disease

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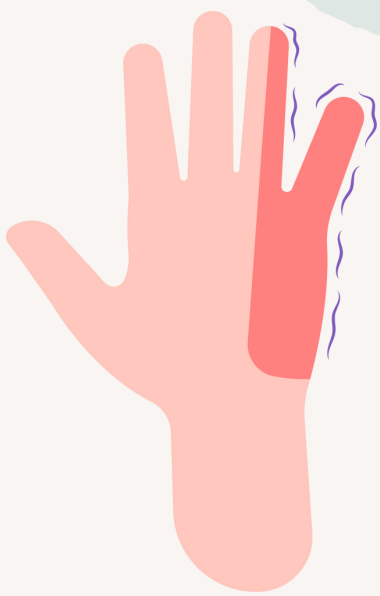
PEARLS

DISTAL ULNAR PALSY (DUP)

CLINICAL SUSPICION



Rule out serious causes of neurological symptoms. Probe the extent of deficit, ask about other symptoms and characterise the progression and impacting factors.

Ask about risk factors like new bikes, ill-fitting bikes and a change in training regime, as well as any injury history.

FEATURES

Sensory changes are confined to ulnar distributions and there may be some motor weakness to look out for too. These symptoms are exacerbated by hyperextension.

MANAGEMENT

Modification is key! Without changes in training intensity and bike optimisation the nerve won't recover and this could lead to muscular atrophy.

Additional options include short term courses of anti-inflammatories or steroids. Decompression is rarely necessary. EMG studies may be useful in prolonged symptoms.

the ABCs of DUP

- **A**dd tape to handlebars
- **B**ike fit
- **C**hange position
- **D**ecrease intensity

RECOVERY

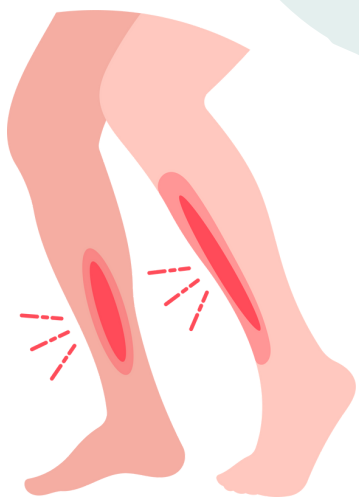
Modifications allow symptoms to resolve, but this may take weeks with motor involvement. For any athletes attending the Emergency Department it's worthwhile considering screening for REDS syndrome to help them back to peak performance.

PEARLS

MEDIAL TIBIAL STRESS SYNDROME (MTSS)

SHIN SPLINTS?

Shin splints, or MTSS, is the precursor to stress fractures commonly seen in long distance runners and the military.



S - posterior medial tibial border
O - gradual
C - ache, sharp to touch
R - none
A - swelling at muscle insertion
T - exertional
E - loading and resistance worsens, pre-activity stretching improves
S - varies

Night pain, swelling

ASSESSMENT

SOCRATES will never do you wrong, but there are some specific things to look out for. Ask about changes in training intensity, impact of other activities on symptoms and any recent injury. MRI is inaccessible so history and exam are vital.

WHO GETS IT?

Risk factors include being a female, having a history of MTSS/having increased BMI and biomechanical factors.

MANAGEMENT

Acutely (2-6 weeks), manage pain with simple analgesia and icing. In the subacute phase, half the distance, and avoid hills and uneven surfaces. Use non-impacting exercise to maintain fitness.

Consider OPD MRI if no improvement/prolonged symptoms. X-ray if concern for bone lesion or recent trauma. Physio can prevent recurrence as can a switch to mid-foot running with orthoses.

WHAT ELSE COULD IT BE?

Sprain
Scarring (previous injury)
Exertional compartment syndrome

Fracture
Tendon rupture
Popliteal artery entrapment
Referred back pain/sciatica