Of Jerseys and Journeys

MARK SIEGEL

Yogesh Khanal is not an athlete, but he collects soccer jerseys when he travels. Jerseys are a comfortable and comforting alternative to hospital gowns. On Wednesday, he wore a blue one from Zanzibar; on Friday, it was a golden Colombian with crimson shorts and fuzzy yellow booties. These days, his cherubic face sometimes hides behind a slightly menacing beard. His big brown eyes cycle from moist to playful to placid.

Yogesh refuses telemetry and postpones vital signs. He receives visitors from a hospital bed, his long frame stretched out beneath a dream catcher bejeweled with origami. A stuffed cheetah, penguin, and giraffe stand guard beside him, and his room is crowded with jars of homemade yogurt, vegetarian take out, and multi-hued flowers. Beside the bathroom and a corner window, there is a cot for his mother, covered in plain white sheets.

Late Friday evening, I came to wish Yogesh good-night and found him alone. He tells me about climbing to Everest Base Camp with his father in their native Nepal, each step an effort at 18,000 feet. He once isolated himself from the outside world on the serene beaches of Ghana. His uncle told him once that he’d seen so many places in his young life that there would soon be nowhere left to go. I believe his travels have made him worldly and wise, open to adventure, sensitive, generous, and endlessly caring.

Yogesh worries about his parents and family. He shows a video on his phone from his adorable nieces; they love the little dresses Uncle Yogesh bought for them and hope he feels better soon. We’ve informed his fellowship director that he won’t be coming to San Francisco in July, and he responded with best wishes for his recovery. Yogesh finds it fitting somehow that his illness arose at a transition point, at the end of his chief year.

We discuss his religious tradition, a mixture of Buddhism and Hinduism, his place in the universe, and a sense of peace he feels as he faces the future. We briefly discuss the “what ifs,” and I witness a courage that is new to me, despite many years caring for the sick. He thinks he’ll move to San Jose to live with his brother’s family. Maybe he’ll seek treatment in California; he’ll definitely spend time by the pool. He is a gifted writer and I ask him to write something for me as a keepsake.

Yogesh has loved generously for thirty-one years and oceans of love are coming back to him now like waves to the shore. Affection expresses itself in text messages, videos, visits from friends and classmates, vegetarian banquets, generous donations, Spotify playlists, apartment cleaning, offers of spare bedrooms, and appointments for massage.
therapy. His physicians are superb. The hospital, department, and residency pray for him. We offer comfort and he comforts in return.

I tell Yogesh that I am traveling to Las Vegas on Saturday for the Program Directors’ Meeting with next year’s chiefs and most of residency leadership. I will check in regularly and think about him constantly. I embrace Yogesh, and tell him that I love him.

Outside the door, a crowd of visitors waits to enter. We snap pictures and share hugs before I leave for the night.
Yale-New Haven Hospital is fortunate enough to have an elite team of nurses that roam the wards and, at a moment’s notice, leap into action to deliver critical care. Any time. Any place. The Beeson Beat had a chance to speak with two of these SWAT nurses, Carol Bowen and Kathleen Mottram, to learn more about their awesome job and how we can work with them more effectively. This is an edited transcript from an interview with them:

**Beeson Beat: What is a SWAT nurse? What are the things that you do everyday? We see you often in scary situations but do you guys do other stuff too?**

A SWAT nurse is an experienced ICU nurse who has been in the ICU pool for at least one to two years. We are expected to be comfortable working in every part of the hospital. Each shift, there are two SWAT nurses assigned. For a hospital as large as Yale, our job can become pretty demanding. We work on a page system and respond as needed. We have many jobs, but our priorities are RRTs. We have to be available for all RRTs that are called at any time. Some of our other jobs are helping floors with patient care, being a nursing resource, a mentor, and assisting with difficult IV insertions. We are very experienced with ultrasound-guided IV insertions. Often we have issues where there are limited or no open ICU beds in the hospital. It is our responsibility to bring the ICU to the patient when this happens. As critical care nurses, we can provide intensive care and monitoring until the unit bed becomes available. This prevents delays and improves patient outcomes.

There are often several emergencies happening throughout the hospital at the same time, requiring the two SWAT nurses to divide up. Many times we have to triage multiple pages at once, sometimes walking a nurse through a situation over the phone because we are unable to get to their floor right away. Time management is a big key to our job. Keeping a cool head is another. We are first responders to intubation on the floors and emergency codes, such as a code blue, TART or stroke. We transfer all patients that require monitoring to tests and to higher levels of care. If there is a patient fall, we respond to provide a backboard and collar and ensure spinal precautions are used. We walk into a room where we don’t know the patient, their situation, their history, and have to gather as much information as we can to make a rapid decision. The nurses and residents know us and trust us. They depend on us to always know what to do and (laughing) sometimes this can be more pressure than you know.

**BB: What was your path to become a SWAT nurse? How’d you choose to do SWAT?**

We all worked on floors and then ICUs for years before coming to the resource pool and applying to be SWAT. There are about seventeen of us between day and night shifts. We rotate being SWAT, so we do SWAT some shifts and work as ICU nurses other shifts. This is a good thing because it keeps our critical care skills sharp. Many times a nurse will call us about a patient because they are concerned. Even if it is not an RRT we come to evaluate the patient situation. We are not LIPs, but the general floor nurses often look to us as mentors. They find it easier to trust another nurse than the doctor sometimes. We will go over the patient’s plan with them. Because we have the years of critical care experience and knowledge base we can offer suggestions that general floor nurses may not have thought of yet. There are often many new RNs on the floor that are meeting this particular patient experience for the first time. I remember being in their shoes, and how overwhelming it can be. I believe they like the idea that they can call and just run a situation by us. Many times we will tell them they need to contact their physician because the patient is doing worse, but at others we reassure them that they are doing everything right and the patient is stable. This reassurance and the knowledge that these nurses can come to us with anything are the things that bring the most thanks.

Patient advocacy is very important to us. We are familiar with all the hospital policies and what is acceptable for the floors. Sometimes a nurse will call us to the floor because they know their patient is sick, but the doctor is just not listening to them. If we agree that this patient needs certain interventions or needs to be moved to a higher level, we will make the appropriate phone calls and move up the chain of command. We have the knowledge and experience to
advocate for the patient when for whatever reason the primary nurse may feel uncomfortable doing so. Sometimes I joke that I feel like a cop when I go to the floors because I will ask the physician what the plan is and then say “I agree, sounds good.” Like they somehow need my approval to do their job. This can be particularly helpful on nights, when the on-call physician has so many patients that it’s nearly impossible for them to have eyes on everyone. Sometimes the floor nurses have a difficult time communicating to the physician regarding their patient’s condition. There have been times that, after discussing a patient with a doctor, they said, “Oh, I didn’t know that was happening.” Proper communication is key in the hospital and it can be beneficial to combine physician and nursing input.

BB: What are ways that residents can be helpful? What is a common thing that residents do to upset SWAT nurses? What can we do to help advance the care of the patient?

Residents are helpful in many ways. I feel I can speak for every nurse when I say: listen to us. You may have spent a lot more years in school, but we have more experience. We have seen more, we have been in similar situations and we know the potential outcome. Don’t ever discredit a nurse’s opinion. Let us in on your plan. We are not here to bully anyone or tell people what we say goes. We are here for the patient and just want the best possible care. Sometimes a resident’s job can be very stressful, especially with a large patient load. We are here to help you. We are not here to say you can’t do your job. If we say the patient is too much for the floor, that’s probably the case.

What we hate the most as SWAT nurses is when a resident demands an IV, or insists that their patient’s IV takes priority over another patient’s care. There is an IV decision tree policy every resident should have memorized on orientation. At Yale-New Haven there is no such thing as an IV team. We help out, but our priorities are sick patients. We start IVs as a courtesy when we have the time. If a patient is hypotensive we will respond ASAP to establish access, but, if it is not an emergency, we cannot promise that we will be there. There are only two of us for the hospital and if we cannot get there, it’s simply because we are too busy. We don’t do arterial sticks, so if your patient needs STAT labs, it’s better if you get them arterially than waiting for us to show. Many of these patients are beyond possible for peripheral IVs and residents need to acknowledge this. We are not miracle workers; if we say we cannot get it, it is your responsibility to obtain access. So my advice to residents is to learn how to place EJs, TLC, and stick arteries, or find colleagues that do.

BB: Any tips on when to call an RRT? Do you notice if we call too early or too late most of the time?

Tips on calling an RRT? If you are thinking it, call it. Extra help is never a bad idea.
Twenty-Five Years of Yale Primary Care

YIHAN YANG and LISA SANDERS

We’re like a big family. These words often used to describe the Yale Primary Care Residency. This sense of family shared between residents and faculty alike could not have been more palpable than at the YPC reunion.

On October 9th 2015, over three hundred physicians from across the US and beyond returned home to their old stomping grounds in New Haven to celebrate the 25th anniversary of YPC. The weekend festivities began with a cocktail party at the Union League Café. Saturday morning was devoted to talks about the growth of primary care from new leaders and old teachers. Highlights of the morning included talks by two founding faculty: David Podell, a rheumatologist, and Majid Sadigh, an infectious disease specialist, who talked about the cases and experiences that made their years with YPC so memorable. Saturday evening, a formal gala took place at the Omni. Men in tuxedos and women in gowns packed the upstairs ballroom to honor the rich history of the program.

The first quarter century of YPC has seen tremendous growth and evolution of the program. YPC accepted its first class of residents in 1989 under the leadership of Dr. Rosemary Fisher and graduated its first cohort of categorical residents in 1992. Since then, under the guidance of Dr. Stephen Huot, YPC has trained more than five hundred physicians. Over one hundred graduates continue to work in the state of Connecticut, of which seventy percent remain in general Internal Medicine.

Within the last two years, YPC moved to its new home base in the St. Raphael’s Campus of Yale-New Haven Hospital, and welcomed a new program director, Dr. John Moriarty. At the Saturday evening gala, the YPC family voiced a continued dedication to training leaders in Internal Medicine who care for patients, the community, and each other with humanism and joy. To this end, alumni generously contributed to an educational endowment fund that now has grown to over $200,000.

At the heart of YPC’s accomplishments are the incredible bonds forged between residents and faculty alike. Alumni voiced a shared excitement in reuniting with the colleagues and mentors who supported them through the highs and lows of residency training. One alumnus commented, “It was amazing how we shared the same memories, values, and insights, how we could finish one another’s thoughts, and find humor in the same things after being apart for over a decade!” Members of the YPC family have “the pleasure of being part of something bigger than ourselves,” said faculty member Auguste Fortin. “Like pebbles in the water, the ripples have gone out and just think for a moment of all the people… who have been touched, who are better off because of their contact with the Yale Primary Care program.” If the remarkable attendance at the reunion says anything, it says that this ripple makes a deep impression. As one alumnus eloquently stated, the reunion was “a culmination of a quarter century of devotion to our calling and to each other.”
The black and grey dots surrounding the 25th reunion logo represent all the residents who have passed through our program; the red and blue lines are the residents whom those trainees have trained; the surrounding dots are all the patients cared for by those directly and indirectly shaped by the primary care program since the beginning.

Amazing, isn’t it?
Did Your Interview Go Well?

ARMAND RUSSO

Ranking your fellowship choices only to lament that you were not sufficiently graceful during your interviews serves minimal purpose. The decision was likely already made based on your array of verifiable features.

Statistical evidence suggests that an algorithm is much more useful to predict complex outcomes. As your previous successes fit the chosen concept of a good fellow for an institution, the less your interview charm matters. The interviewer should have limited power in opening the door for you.

At least so says Daniel Kahneman, author of the international bestseller “Thinking, Fast and Slow” and winner of the 2002 Nobel Prize in Economics.

A large part of Kahneman’s winning work deals with bias in human judgment. One particular aspect is the halo effect. If you have taken statistics you know that the number of observations you make help your overall statistical accuracy. Eventually your observations will hover around a mean if the variable is evenly distributed. In other words, the observations will “regress towards the mean”. So if your data point falls far from the mean, most likely the next point will be closer to the mean.

In other words, a person who did really well in a race, is more likely to do less well in the next heat, and the person who did the least well is likely to do better than his previous worst. That doesn’t mean that the runner who now does worse isn’t a good runner, it is just regression to the mean.

The halo effect is just such a bias that rejects the notion of regression to the mean. It takes one episode of great success and uses that to determine the entire character content of the person. It also makes someone’s actual skill difficult to determine. Kahneman worked for the Israeli Military in 1955 and he was tasked to develop an interviewing scheme for army officers that did away with “an impression” by the interviewer and replaced it with six concrete questions about teamwork, national pride, and so on. The candidate could answer matter-of-factly and the interviewer could document the answer on a scale of one to six. This was shown to be 40% better at predicting the success of a recruit during officer training than the previous method of intuition.

The idea was simple and elicited controversy from the interviewers because they reckoned they were being reduced to machines. The rationale for using an algorithm for intuition is that the algorithm performs better for detecting small differences. Most of us don’t have halos, so differences between us are harder to parse objectively. Intuition is too biased to discern these clearly.

An interview should never dictate the way you view yourself.
The Chronicles of the Word Cancer

ANTONIOS CHAROKOPOS

Over the latter half of the past century, the use of the word cancer in our daily lexicon seemed to amplify in conjunction with our increasing exposure to radiation and synthetic chemicals. Advances in medical diagnostics led to earlier detection of various cancers, which has renewed and focused attention on a perceived cancer epidemic. But cancer is hardly a novel disease entity.

In 400 BC Hippocrates first used the Greek word for crab, karkinos, to describe his malignant tumor findings. Our modern word cancer is derived from the Latin word for crab. So Hippocrates endowed us with the term, but left us no explanation. Why did he choose it?

In the centuries to follow, other physicians have speculated as to why Hippocrates chose the crab to symbolize the ailment of cancer. In the second century a prominent Greek physician, Galen of Pergamon, rationalized that the connection was a literal visual association. "As a crab is furnished with claws on both sides of its body, so, in this disease, the veins which extend from the tumour represent with it a figure much like that of a crab."

Several hundred years later the Greek physician Paul of Aegina expanded upon Galen of Pergamon’s earlier hypothesis, by noting a similarity of instinctual actions. He speculated: “The veins are distended, and spread around like the feet of the animal called crab, whence the disease has derived its appellation. However, some say that it is so called because it adheres with such obstinacy to the part it seizes that, like the crab, it cannot be separated from it without great difficulty.”

The 19th century parasitologist Dr. Louis Westenra Sambon added another layer of complexity to the symbolic creature of Hippocrates, likening the parasitic habitation of a crab to that of a tumor in its host: “According to Sambon it would be surprising if the ancient Greeks, who consumed crabs largely as a luxurious article of food...had failed to notice that strange, large, fleshy, tumour-like parasite so frequently seen hanging from the underside of the crab’s abdomen.” This parasite is frequently identified as the barnacle Sacculina carcini (Figure 2). Just as a small parasite clings to the crab for sustenance, so too do the malignant cells increase vascularization to parasitically draw in greater nutrients and oxygen.

Whether because of its crab-like vascular appearance, or its crab-like sticky adherence, or its crab-like parasitic resemblance, the term cancer has stayed in our vocabulary for good. May the efforts of researchers and clinicians exhibit similar crab-like persistence in helping us combat cancer and its devastating consequences.

References:
3. Image #1: http://peabody.yale.edu/teachers/strength-numbers
4. Image #2: https://commons.wikimedia.org/wiki/File:FMIB_46491
Art historian Tamar Garb may have put it best: “If Van Gogh is the quintessential mad genius, Modigliani is the quintessential tubercular alcoholic.”

Amedeo Clemente Modigliani (July 12, 1884 – January 24, 1920) was indeed a lush and a playboy, but he had it somewhat rough from the start. He was born in the Tuscan city of Livorno, Italy right after his relatively affluent Jewish family had lost all of their fortune. His arrival literally saved them from eviction (a law at that time prevented creditors from seizing the bed of a mother with a newborn child). Then, at the not-yet-ripe age of eleven years, he contracted tuberculosis and suffered from several bouts of pleurisy.

He moved to Paris to pursue art and hobnob with the Moulin Rouge crowd. He remained poor for his entire life but used his scant funds to court women and maintain an elegant wardrobe. In fact, contemporary artist Pablo Picasso, three years his senior, admired him more for his appearance than his art. He once painted over a Modigliani work he had acquired (he said he needed the canvas).

But painting was not Modigliani’s initial focus; his true passion was for sculpture. Similar to Picasso, he drew inspiration from African mask art. His sculptures are marked by the exaggerated lines and elongated faces that later became the defining features of his paintings. At the time, Modigliani felt that contemporary sculptors such as Auguste Rodin had developed an overreliance on clay. Modigliani chose to sculpt directly from stone. However, inhalation of dust worsened his pulmonary condition and eventually forced him to turn to painting as his main medium.

Although he achieved recognition only toward the very end of his short life, Modigliani is now world-famous for his captivating portraits, most of them of women, all of them marked by graceful elegance, sexual tension, and melancholia. Their sensual intensity—in addition to their nudity—had at times a scandalizing effect; a postcard of one of his reclining nudes was deemed “unfit” for the Unites States Postal Service in the 1950’s.

He was a man of quick temper, short-lived love affairs, and major bohemian panache. He died, still impoverished, at thirty-five from tubercular meningitis. The following evening, his twenty-one-year-old lover Jeanne Hébuterne jumped out of a fifth-story window to her death. She was eight months pregnant with their second child. Recently, an anonymous bidder acquired the portrait of Jeanne Hébuterne, finished by Modigliani just a couple months before his death, at Sotheby’s for $31.3 million.

Modigliani’s tumultuous lifestyle has been romanticized in numerous books, plays, movies, and Internal Medicine residency newsletters. French novelist Michel Georges-Michel made him the tragic hero of the melodrama Les Montparnoses, which is modeled on the opera La Bohème. Additionally, Andy Garcia starred in the movie Modigliani, which received a historically low approval rating of 4% on the website Rotten Tomatoes.

The stigma that came with tuberculosis and poverty had a major impact on Modigliani’s life. He kept his disease a lifelong secret and cultivated his reputation as a hopeless drunk and drug user, which was certainly more in vogue than tuberculosis at the time. One might speculate that his self-
Artists and Their Maladies: Amedeo Modigliani  \textit{(continued)}... 

destructive indulgences and ravenous search for beauty and pleasure were driven by an intuitive urgency to live his limited life to the fullest.

References:
“Modigliani: Misunderstood” By Doug Stewart Smithsonian Magazine

Arts Night Recap

KARL LANGBERG

On a chilly night in January, many of us gathered in The Anylan Center to enjoy food, drink and the artistic talents of our residency colleagues. The evening began with a wonderful reception planned by Nancy DiLella. Guests enjoyed a bountiful feast while perusing paintings, drawings, sculpture, and textiles by artists Samuel Clarke, Suzie Luft, Anne Mainardi, Jordan Sack, Elana Shpall, and Barbara Wanciak.

The show followed the reception and was hosted by the lovely Anne Mainardi in a ravishing emerald green dress and yours truly, Karl Langberg. The opening act was a magnificent performance of the First Movement of Oboe Quartet in F major by W. A. Mozart by members of the Yale Symphony Orchestra: Justine Cohen on the oboe, Jack Qian on the violin, Ben Cherry on the viola, and Fritz Stabenau on the cello. Barbara Wanciak then shared the personal journey behind two of her beautiful paintings. Jana Zielonka and Yungah Lee performed two magical piano and flute duets, by Faure-Pavane and Paul Reade. George Goshua shared a moving piece of narrative non-fiction that he wrote in medical school. Jana took the stage once again to perform an exciting piece, from her days tickling the ivories (professionally!) on Broadway, the overture of the musical “The Fantasticks” by Schmidt and Jones. The effervescent Elana Shpall led the audience in a round of the Monster Game, a delightful art game in which pairs of unsuspecting artists draw two-part monsters together. I wrote a poem for the show embracing the opportunity to care for patients in the hospital that come to the Medical Service despite their chief concern being a problem typically treated by another specialty. Finally the show ended with a spirited and exciting dance by the Yale Internal Medicine Bhangra team consisting of Krishna Upadhyaya, Kartik Sehgal, Marina Mutter, Alison Thompson, Jenna Kim and Bryan Brown. The performances were interspersed with witty banter from the show’s hosts.

All and all it was a fantastic night that would not have been possible without the help of Nancy Dilella’s amazing planning skills and the support and encouragement of Dr. Siegel. Arts night is a great Beeson Medical Service tradition that should continue to bring joy and unity to the residency community for years to come.
Choosing Poorly

MERILYN VARGHESE and KARL LANGBERG

The Choosing Wisely Campaign is an initiative by the ABIM to spark conversations among providers and patients to help promote tests and treatments that are supported by evidence, not duplicative of other tests or treatments, free from harm and truly necessary.

Here at the Beeson Beat we want to help share these lists through our game: Choosing Poorly. We have included one fake recommendation and two real recommendations. This issue we will use the list from the HIV Medicine Association.

1. Do not order lymphocyte panels when ordering CD4 counts.
2. CD4 counts should be ordered routinely with viral load testing.
3. Avoid quarterly testing of viral load in patients who have viral load suppression.

Go to page 15 for the answer, and choosingwisely.org to see all the recommendations.

Image Challenge: A Case of Abdominal Distention

JOSHUA BILSBORROW

This patient presented with nausea, vomiting, constipation, and worsening abdominal distention from his extended care facility. Recent medical history was notable for multiple episodes of Clostridium difficile colitis. Admission labs were significant for a creatinine of 2.6 (from a baseline of 1.1). Abdominal plain radiograph demonstrated the following. What is the diagnosis?
**Answer:** Acute Colonic Pseudo-obstruction (Ogilvie Syndrome)

**Acute Colonic Pseudo-obstruction (Ogilvie Syndrome)** features the acute dilation of the colon plus/minus small bowel in the absence of a mechanical obstruction. The condition is more common in patients ≥60 years of age and in men. Hospitalization and/or institutionalization status, recent surgery, metabolic abnormalities (hypokalemia, hypocalcemia, hypomagnesemia), and medications inhibiting intestinal peristalsis are also thought to be important contributing factors. The specific mechanisms leading to acute megacolon are not clearly understood, though its namesake Dr. William Heneage Ogilvie (1887–1971) postulated that dysregulation of the autonomic nervous system was involved.

Initial diagnostic imaging is often with plain abdominal radiographs due to cost and time considerations. However, abdominal and pelvic CT imaging is important to exclude a mechanical cause for the obstruction, which should prompt consideration of surgical management. Patients with cecal diameter ≥12 cm and who fail conservative management for 24 to 48 hours should undergo decompression. Intravenous neostigmine, an anticholinesterase inhibitor, is the first line pharmacological therapy. In patients who fail to improve with neostigmine (or who have contraindications to its use), colonoscopic decompression, percutaneous decompression, or surgical bypass should be considered due to the increased risk of bowel perforation.

This patient was an 83 year-old man with a past medical history significant for multiple *Clostridium difficile* infections, which was thought to potentially be a contributing factor for his recurrent admissions with pseudo-obstruction. His presentation was notable for signs and symptoms consistent with bowel obstruction, along with labs indicating a concurrent acute kidney injury. Abdominal radiographs and CT abdomen/pelvis both demonstrated diffuse colonic dilation without mechanical obstruction. Renal ultrasound further established the presence of bilateral hydronephrosis, due to post-renal obstruction of the ureters by the massively distended bowel loops. Attempts at pharmacological treatment on the medical floor with neostigmine were unsuccessful. Due to worsening hypotension and rising serum lactate, he was briefly transferred to the MICU and required vasopressor support. Given his lack of sustained response with previous colonoscopic decompressions, the general surgery team evaluated him for and subsequently performed a palliative diverting loop cecostomy. His condition then stabilized and he eventually returned to his long-term care facility.

This abdominal plain radiograph shows multiple dilated bowel loops with preserved haustral markings. Conversely, abdominal films in patients with toxic megacolon demonstrate dilated intestinal loops with either the loss of haustral markings or obscuration by “thumb printing,” a marker of bowel wall edema. Stool can be visualized within several bowel loops. There is also a pigtail catheter present to the left of the vertebral column; nephrostomy tube drainage had been used to relieve this patient’s hydronephrosis on the right side prior to this image being captured.

**Further Reading:**

Chief Concern: Flavorful Pho & Spice

KRISHNA UPADHYAYA

**Subjective:** Our patient is a 4 month old newborn Vietnamese and Thai restaurant named Pho & Spice. Tucked away on Orange Street at the former location of Bentara, Pho & Spice is quickly filling the large shoes left behind by the once popular Malaysian restaurant. Its signature dish is pho, a Vietnamese noodle soup filled with vegetables and herbs, served with or without meat. Recently opened this past winter, Pho & Spice is already warming the hearts of frozen New Haven residents with piping hot pho and flavorful spices.

**Objective:** On physical exam, the exterior is made up of an off-putting, pasty, tan colored façade with large glass windows, reminiscent of a cheap hotel. The inside however is chic and modern, with wooden tables dotted with a sriracha and soy sauce bottle. Disappointingly, the interior lacks many Vietnamese or Thai decorations, which can give ethnic restaurants a unique identity adding to an immersive cultural experience.

Having forged a tongue of steel from a lifetime of spicy Indian food, I bravely ordered the spicy canh chua pho. While waiting for my entree, just ogling the dishes waiters were bringing to other tables made me develop moist mucus membranes. The canh chua was a medley of chicken, pineapple, basil and other vegetables floating around like buoys in a spicy tamarind broth. The array of aromas was astounding. The pungent steam from the sizzling soup was interrupted by the zesty smell of fresh cut lemon wedges. A side plate of bean sprouts, giving off a contrasting earthy scent, placed in the soup to soften and cook right in front of your eyes. The vegetables and chicken were perfectly cooked and melted in my mouth, while the little pineapple bites added a surprising dash of sweetness. The dish wasn’t too spicy for me, but I could see one poor soul nearby who, after soaking his pho in sriracha, was chugging enough water to be confused for someone with primary polydipsia. I also ordered a Chicken Banh Mi sandwich, which is a French baguette filled with Vietnamese spices and vegetables. The sandwich was the perfect contrast to the liquid-heavy pho as it nicely balanced the texture of the meal. I left feeling so full and satisfied I thought I may need a “pho-ley” placed for my impending prolonged post-meal immobility.

**Assessment/Plan:** Food: A, Appearance/Atmosphere: B-, Service: B. In summary, I give Pho & Spice a solid B. The food is truly outstanding and comes in large, eye-widening portions. Additionally, if your wallet is strapped tight because you just registered for Step 3, the prices are surprisingly affordable. I definitely recommend giving this place a try, especially on a cold, frozen night during the New Haven winter.
Intern Spotlight

EMILY PINTO TAYLOR

Chika Okoli
Primary Care PGY-1
Hometown: Buffalo, New York (This New Haven snow? No problem!)
Undergrad: Samford University
Med School: Morehouse School of Medicine
3 Interesting Facts:
1. I am a royal! Well, my family is from Nigeria and my great grandfather on my mother’s side was the king of his town, making my grandmother a princess! My mother spent much of her childhood and adolescence growing up in his fully staffed palace, and I had the privilege of visiting there multiple times during my childhood on family trips to Nigeria. Pretty cool :)  
2. I was a competitive gymnast for 7 years and got to level 10, which is the level before Elite [Olympic training level]. And...I can still do a pretty mean back flip! [Amongst other tricks :) ]
3. I was an extra in the 2011 film Teen Spirit starring Cassie Scerbo (Make it or Break it), Lindsay Shaw (Pretty Little Liars), and Chris Zylka (The Amazing Spider-Man). It was completely unintentional! I tagged along with my older sister, who is an actress, to an audition and the casting director thought I would be good for the movie! Fun times :)

Zeynep Kubilay
Trad – PGY1
Hometown: Istanbul, Turkey
Undergrad/ Med School: Yeditepe University
3 Interesting Facts:
1. I had been working in the infection control department at the WHO before starting internship, mainly developing guidelines for surgical site infection prevention, hand hygiene and the Ebola outbreak.
2. I was a doctor working at a Turkish TV show called Crazy Ladies - A Survivor equivalent for women over 60. We traveled to Bali, India and South Africa while the ladies enjoyed bungee jumping, parasailing and all kinds of fun activities.
3. One of my dreams is to finish yoga teacher training and develop that as a side career.

Jennifer Urban
Prelim Derm – PGY-1
Hometown: Southbury, CT
Undergrad: University of Connecticut
Med School: Stony Brook University
3 Interesting Facts:
1. I have been figure skating since the age of 7. I competed in both synchronized and freestyle skating events growing up. I skated in college as part of the UConn figure skating club and I continue to skate now for fun.
2. I have two Havanese dogs at home, Abby and Bella, that love going on long walks and taking naps on the couch.
3. I am a huge Celine Dion fan and had the amazing opportunity to see her perform in her Las Vegas show at Caesars Palace before starting residency.
Records

Extreme values witnessed by our residents and attendings, in patients who have since benefited from our dedicated care.

* New Records

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<th>HIGHEST</th>
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<td>A1c</td>
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<td>Temperature 106.2F—Jenna May Kim</td>
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<td>Troponin 228—Ali Romegialli and Mary Grace Baker</td>
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<td>Bili, total 44.21—George Goshua*</td>
<td>WBC count 239,000—Steph McCarty</td>
</tr>
<tr>
<td>Bili, direct 31.33—George Goshua*</td>
<td></td>
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<tr>
<td>BNP &gt; 70,000—George Goshua</td>
<td></td>
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<tr>
<td>BP 234/106—Jenna May Kim</td>
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<tr>
<td>Calcium 16.6—Andrew Marple</td>
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<tr>
<td>CRP 373</td>
<td></td>
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<tr>
<td>Discharges/day 12—Nikki Bournival &amp; Josh Feuerstein</td>
<td></td>
</tr>
<tr>
<td>Glucose 1710—Amish Desai</td>
<td></td>
</tr>
<tr>
<td>HCV Viral Load &gt; 100,000,000 (log &gt; 8.00)—Albert Do</td>
<td></td>
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<tr>
<td>INR &gt;29.99—Elana Shpall</td>
<td></td>
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<tr>
<td>Insulin Dose 225 units NPH BID—Adam Phillips</td>
<td></td>
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<tr>
<td>Lactic Acid 26—Steph McCarty</td>
<td></td>
</tr>
<tr>
<td>pCO2 188—Sam Clarke*</td>
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</tbody>
</table>

Lowest

<table>
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<tr>
<th>LOWEST</th>
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<tbody>
<tr>
<td>BUN 1—Krishna Sury</td>
</tr>
<tr>
<td>Ferritin 3—Jacqueline Sherbuk</td>
</tr>
<tr>
<td>Hemoglobin 2.2—Aaron Soufer &amp; Elana Shpall</td>
</tr>
<tr>
<td>Platelet Count &lt;1,000—Beth Heuzey</td>
</tr>
<tr>
<td>Prealbumin 3.5—Adam Phillips</td>
</tr>
<tr>
<td>Potassium 1.6—Marina Mutter</td>
</tr>
</tbody>
</table>

Choosing Poorly (continued)...

ANSWER

The fake is #2. CD4 counts are not recommended with every viral load test. Viral loads indicate a patient’s response to treatment. If a patient has stable viral suppression, CD4 count testing should be monitored as follows. Two years after starting treatment, obtain CD4 counts every 3-6 months. After 2 years, if the viral load is undetectable, measure yearly if between 300 and 500. If above 500 consistently, monitoring is optional.

Link: http://www.choosingwisely.org/societies/hiv-medicine-association/
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