19th Edition Internal Medicine Core

Endocrinology:

Page 1-25, Adrenal Gland > Mineralocorticoids

Text currently reads:	*Text should read:*
Aldosterone is discussed extensively in the Nephrology section. It increases Na^+ resorption and, hence, K^+ and H^+ excretion in the distal tubules, causing hypokalemia and a **metabolic acidosis**. Increased Na^+ resorption means increased water retention and the tendency for hypertension. The release of aldosterone is mainly controlled by both the renin-angiotensin system and the K^+ level, but ACTH does have some effect.	Aldosterone is discussed extensively in the Nephrology section. It increases Na^+ resorption and, hence, K^+ and H^+ excretion in the distal tubules, causing hypokalemia and a **metabolic alkalosis**. Increased Na^+ resorption means increased water retention and the tendency for hypertension. The release of aldosterone is mainly controlled by both the renin-angiotensin system and the K^+ level, but ACTH does have some effect.

Infectious Disease:

Page 4-49, Bacteria > *Rickettsia*

heading pathway changed to:

Page 4-49, Bacteria > Gram-Negative Bacteria > *Rickettsia*

Page 4-49, Bacteria > *Rickettsia* > Q Fever

heading name and pathway changed to:

Page 4-49, Bacteria > Gram-Negative Bacteria > *Coxiella burnetii*

Page 4-85, Antiviral Agents

Text currently reads:	*Text should read:*
Foscarnet is used in patients with **ganciclovir**-resistant herpes infection or as an alternative to ganciclovir for CMV.	Foscarnet is used in patients with **acyclovir**-resistant herpes infection or as an alternative to ganciclovir for CMV.

Nephrology:

Page 7-1, Renal Tests > Urinalysis (U/A) > Reagent Strip Testing

Text currently reads:	*Text should read:*
U/A is useful in patients with urinary symptoms such as dysuria, urinary frequency, and urinary urgency. U/A, in combination with urine culture, can quickly diagnose UTI. See more in the **Geriatric Medicine** section.	U/A is useful in patients with urinary symptoms such as dysuria, urinary frequency, and urinary urgency. U/A, in combination with urine culture, can quickly diagnose UTI. See more in the **Infectious Disease** section.

Page 7-46, Acid-Base Disorders > RTAs > Review of RTAs

Text currently reads:	*Text should read:*
Clues to analyzing possible RTA: • All types of RTA cause a NAGMA. • Positive UAG is seen primarily in those with impaired distal acidification: distal (Type 2) and Type 4 RTA. • **Proximal (Type 1)** RTA can cause hypercalciuria +/− nephrocalcinosis or stones; always elevated urine pH; and hypokalemia. • **Distal (Type 2)** is characterized by HCO_3^- wasting. Especially consider MM and Fanconi syndrome. With Fanconi syndrome, the patient can present with metabolic acidosis, hypoglycemia, hypophosphatemia, hypokalemia, and hyperchloremia. • Type 4 is caused by aldosterone deficiency or resistance and is marked by mild acidosis and hyperkalemia. Consider causes of hyporeninemic hypoaldosteronism (chronic obstructive uropathy, diabetic nephropathy, and NSAIDs).	Clues to analyzing possible RTA: • All types of RTA cause a NAGMA. • Positive UAG is seen primarily in those with impaired distal acidification: distal (Type 2) and Type 4 RTA. • **Distal (Type 1)** RTA can cause hypercalciuria +/− nephrocalcinosis or stones; always elevated urine pH; and hypokalemia. • **Proximal (Type 2)** is characterized by HCO_3^- wasting. Especially consider MM and Fanconi syndrome. With Fanconi syndrome, the patient can present with metabolic acidosis, hypoglycemia, hypophosphatemia, hypokalemia, and hyperchloremia. • Type 4 is caused by aldosterone deficiency or resistance and is marked by mild acidosis and hyperkalemia. Consider causes of hyporeninemic hypoaldosteronism (chronic obstructive uropathy, diabetic nephropathy, and NSAIDs).

Page 7-55, Potassium Disorders > Hypokalemia > Causes of Hypokalemia

Text currently reads:	*Text should read:*
To determine the cause of hypokalemia, first look to the history and physical exam to see if there are obvious causes (e.g., vomiting, diarrhea, diuretic use). Usually the cause is obvious, but if it is not, assess urinary K^+ excretion to determine if there is renal K+ wasting (Figure 7-19 on page 7-56). This can be done with a 24-hour urine K^+ measurement or a spot urine potassium:creatinine (K:Cr) ratio. If urinary K^+ excretion is low (< 20 mEq/day or spot urine K:Cr ratio **< 1 mEq/g**), the kidney is responding appropriately: Look again for GI sources of K^+ loss (e.g., surreptitious vomiting, laxative use) or a reason for transcellular shifts (e.g., hypokalemic periodic paralysis). If urinary K^+ is high (> 20 mEq/day or spot urine K:Cr ratio **> 1 mEq/g**), this indicates renal K^+ wasting. In this case, the acid-base status and the BP can guide you to the correct diagnosis. See Figure 7-19 on page 7-56.	To determine the cause of hypokalemia, first look to the history and physical exam to see if there are obvious causes (e.g., vomiting, diarrhea, diuretic use). Usually the cause is obvious, but if it is not, assess urinary K^+ excretion to determine if there is renal K+ wasting (Figure 7-19 on page 7-56). This can be done with a 24-hour urine K^+ measurement or a spot urine potassium:creatinine (K:Cr) ratio. If urinary K^+ excretion is low (< 20 mEq/day or spot urine K:Cr ratio **< 13 mEq/g**), the kidney is responding appropriately: Look again for GI sources of K^+ loss (e.g., surreptitious vomiting, laxative use) or a reason for transcellular shifts (e.g., hypokalemic periodic paralysis). If urinary K^+ is high (> 20 mEq/day or spot urine K:Cr ratio **> 13 mEq/g**), this indicates renal K^+ wasting. In this case, the acid-base status and the BP can guide you to the correct diagnosis. See Figure 7-19 on page 7-56.

Cardiology:
Page 13-11, Procedures and Labs > Pulmonary Artery Catheterization (PAC)

Table currently reads:

Table 13-3: Pulmonary Artery Catheterization Scenarios					
Condition	**RA Press (mmHg)**	**Pulmonary Artery Press (mmHg)**	**PCWP (mmHg)**	**BP (mmHg)**	**Comments**
Normal	< 8	**(13–28)/(3–13)**	4–12	110/70	
Tamponade or constrictive pericarditis	18	32/18	19	70/50	Diastolic pressure equal in all 4 chambers!
RV failure due to RV infarct	15	21/11	10	70/50	RV unable to fill the L heart: high RA pressure and low PCWP and CO
Biventricular failure	18	30/20	20	70/50	Low CO in setting of high RA and PCWP; cardiogenic shock is common!
Mitral stenosis	18	90/32	30	110/70	
Pulmonary HTN	18	90/32	10	110/70	

Table should read:

Table 13-3: Pulmonary Artery Catheterization Scenarios					
Condition	**RA Press (mmHg)**	**Pulmonary Artery Press (mmHg)**	**PCWP (mmHg)**	**BP (mmHg)**	**Comments**
Normal	< 8	**(15–25)/(8–15)**	4–12	110/70	
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Mitral stenosis	18	90/32	30	110/70	
Pulmonary HTN	18	90/32	10	110/70	

Page 13-38, Coronary Artery Disease (CAD) > Treatment of Hyperlipidemia > 2018 ACC / AHA Guidelines on Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Disease (ASCVD) Risk in Adults

Text currently reads:	*Text should read:*
Statin intensity is defined as: • High-intensity statin therapy (e.g., atorvastatin 40–80 mg daily, rosuvastatin **10–20 mg** daily) lowers LDL cholesterol by approximately 50%.	Statin intensity is defined as: • High-intensity statin therapy (e.g., atorvastatin 40–80 mg daily, rosuvastatin **20–40 mg** daily) lowers LDL cholesterol by approximately 50%.

Gastroenterology:
Page 14-62, Liver > Cirrhosis > Complications of Cirrhosis > Esophageal / Gastroesophageal Variceal Hemorrhage > Active Bleeds

Text currently reads:	*Text should read:*
Primary therapy of actively bleeding varices is **HBV is the only hepatitis virus composed of DNA. The incubation period is 1–6 months. It is transmitted by contaminated blood products and infected body fluids.** ndoscopic banding +/− somatostatin (such as octreotide) or sclerotherapy.	Primary therapy of actively bleeding varices is endoscopic banding +/− somatostatin (such as octreotide) or sclerotherapy.

Neurology:
Page 12-10, Dementia > Workup > Diagnosis of Dementia

Text currently reads:	*Text should read:*
2. Executive function—reasoning. Do they understand appropriate danger? Can they perform their activities of daily living (ADLs), such as grocergy shopping.	2. Executive function—reasoning. Do they understand appropriate danger? Can they perform their **instrumental** activities of daily living (IADLs), such as grocergy shopping.

Pulmonary Medicine:
Page 6-75, Immunosuppressed Patients > Lung Pathogens in the Immunosuppressed > Fungi > Nocardia
content moved to
Page 6-73, Immunosuppressed Patients > Lung Pathogens in the Immunosuppressed > Bacterial Pneumonia

*Text currently Nocardia heading; **no content change**; Nocardia heading deleted. Nocardia is not a Fungi*	*Text moved to Bacterial Pneumonia heading; no content change*
Nocardia asteroides lung infections are usually seen in T-cell deficient patients (not those with humoral deficiency) and in patients with pulmonary alveolar proteinosis. The pulmonary lesions may cavitate. Brain abscesses and subcutaneous dissemination can occur. This is treated with sulfonamides.	*Nocardia asteroides* lung infections are usually seen in T-cell deficient patients (not those with humoral deficiency) and in patients with pulmonary alveolar proteinosis. The pulmonary lesions may cavitate. Brain abscesses and subcutaneous dissemination can occur. This is treated with sulfonamides.

Women's and Men's Health:
Page 11-18, Office Gynecology > Polycystic Ovary Syndrome (PCOS) > Pathophysiology

Text currently reads:	*Text should read:*
In summary, in PCOS, estrogen, androgen, and FSH levels are increased, whereas LH is decreased.	In summary, in PCOS, estrogen, androgen, and **LH** levels are increased, whereas **FSH** is decreased.