

19th Edition Internal Medicine Core

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 | |
| 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 | |

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: |
|---|---|
| <p>Statin intensity is defined as:</p> <ul style="list-style-type: none"> High-intensity statin therapy (e.g., atorvastatin 40–80 mg daily, rosuvastatin 10–20 mg daily) lowers LDL cholesterol by approximately 50%. | <p>Statin intensity is defined as:</p> <ul style="list-style-type: none"> High-intensity statin therapy (e.g., atorvastatin 40–80 mg daily, rosuvastatin 20–40 mg daily) lowers LDL cholesterol by approximately 50%. |

Endocrinology:**Page 1-25, Adrenal Gland > Mineralocorticoids**

| <i>Text currently reads:</i> | <i>Text should read:</i> |
|---|--|
| 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. |

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

| <i>Text currently reads:</i> | <i>Text should read:</i> |
|--|---|
| 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. Endoscopic banding +/- somatostatin (such as octreotide) or sclerotherapy. | Primary therapy of actively bleeding varices is endoscopic banding +/- somatostatin (such as octreotide) or sclerotherapy. |

General Internal Medicine:**Page 15-36, Preventive Medicine > Screening Tests > Lung Cancer**

| <i>Text currently reads:</i> | <i>Text should read:</i> |
|---|---|
| The USPSTF issued a recommendation in 2013 in favor of annual low-dose CT scan screening (Grade B) of individuals who meet all of the following criteria: <ul style="list-style-type: none"> Adults 55–80 years of age Current smokers or those who have quit within the past 15 years ≥ 30 pack years of smoking history | The USPSTF issued a recommendation in 2021 in favor of annual low-dose CT scan screening (Grade B) of individuals who meet all of the following criteria: <ul style="list-style-type: none"> Adults 50–80 years of age Current smokers or those who have quit within the past 15 years ≥ 20 pack years of smoking history |

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**

| <i>Text currently reads:</i> | <i>Text should read:</i> |
|--|--|
| 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**

| <i>Text currently reads:</i> | <i>Text should read:</i> |
|---|---|
| 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

| <i>Text currently reads:</i> | <i>Text should read:</i> |
|---|---|
| <p>Clues to analyzing possible RTA:</p> <ul style="list-style-type: none"> • 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. | <p>Clues to analyzing possible RTA:</p> <ul style="list-style-type: none"> • 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. |

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

| <i>Text currently reads:</i> | <i>Text should read:</i> |
|--|--|
| 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. |

Neurology:

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

| <i>Text currently reads:</i> | <i>Text should read:</i> |
|---|---|
| 2) Executive function—reasoning. Do they understand appropriate danger? Can they perform their activities of daily living (ADLs), such as grocery shopping? | 2) Executive function—reasoning. Do they understand appropriate danger? Can they perform their instrumental activities of daily living (IADLs), such as grocery shopping? |

Page 12-48, Neuropathies > Polyneuropathies > Other Causes of Axonal Neuropathies

| <i>Text currently reads:</i> | <i>Text should read:</i> |
|---|--|
| <p>Know other somewhat common causes of axonal polyneuropathy, including:</p> <ul style="list-style-type: none"> • Toxins, such as heavy metals (e.g., lead, arsenic) • Chemotherapy drugs (e.g., vincristine) • Isoniazid • B₆ (pyridoxine) overdose from nutritional supplements • Organophosphates • Systemic illnesses (myeloma, amyloidosis, porphyrias, thyroid disease, hepatitis viruses, amyloidosis, and HIV/AIDS) | <p>Know other somewhat common causes of axonal polyneuropathy, including:</p> <ul style="list-style-type: none"> • Toxins, such as heavy metals (e.g., lead, arsenic) • Chemotherapy drugs (e.g., vincristine) • Isoniazid • B₆ (pyridoxine) overdose from nutritional supplements • Organophosphates <p>Systemic illnesses (myeloma, amyloidosis, porphyrias, thyroid disease, hepatitis viruses, amyloidosis, and HIV/AIDS)</p> |

Oncology:

Page 9-21, Lung Cancer > Screening

| <i>Text currently reads:</i> | <i>Text should read:</i> |
|--|--|
| <p>Based on findings of the National Lung Screening Trial, the NCCN, the American College of Chest Physicians, and other professional societies, low-dose CT (LDCT) scanning for lung cancer screening is now recommended in high-risk individuals. The demonstrated benefit of LDCT is a relative reduction in mortality from lung cancer of 20% and a 6.7% reduction in all-cause mortality. The risk reduction is achieved by finding lung cancer at an early stage and surgically resecting it. USPSTF 2020 draft guidelines recommend annual screening with LDCT for patients who are between 55 and 80 years of age, have smoked ≥ 20 pack years, and are either current smokers or have quit within the past 15 years. Additional caveats to those who should be screened include:</p> | <p>Based on findings of the National Lung Screening Trial, the NCCN, the American College of Chest Physicians, and other professional societies, low-dose CT (LDCT) scanning for lung cancer screening is now recommended in high-risk individuals. The demonstrated benefit of LDCT is a relative reduction in mortality from lung cancer of 20% and a 6.7% reduction in all-cause mortality. The risk reduction is achieved by finding lung cancer at an early stage and surgically resecting it. USPSTF 2020 draft guidelines recommend annual screening with LDCT for patients who are between 50 and 80 years of age, have smoked ≥ 20 pack years, and are either current smokers or have quit within the past 15 years. Additional caveats to those who should be screened include:</p> |

Psychiatry:**Page 16-28, Complications of Drug Therapy**

| | |
|---------------------------------|---|
| Heading currently reads: | Heading should read: |
| Complications of Drug Therapy | Complications of Psychotropic Drug Therapy |

Page 16-28, Complications of Drug Therapy

| | |
|---|--|
| Text currently reads: | Text should read: |
| Beware of the possible complications of drug therapy: | Beware of the possible complications of psycho tropic drug therapy: |

Pulmonary Medicine:**Page 6-3, Diagnostic Tests > Pulmonary Function Tests (PFTs)**

| | |
|---|--|
| Text currently reads: | Text should read: |
| Spirometry cannot measure reserve volume. | Spirometry does not measure residual volume. |

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; <i>no content change</i>; Nocardia heading deleted. Nocardia is not a Fungi | Text moved to Bacterial Pneumonia heading; no content change |
| <i>Nocardia asteroides</i> 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. | <i>Nocardia asteroides</i> 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. |