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1 A 68-year-old man presents to the hospital with a 3-hour history of crushing substernal chest pain. He reports that the symptoms developed suddenly and were accompanied by sweating and nausea. The chest pain has been getting worse, is not exacerbated by deep inspiration, and does not radiate to his jaw or either arm. He endorses rales and tachycardia of breath but denies subjective fevers, chills, headache, cough, abdominal pain, and diarrhea. He has a history of coronary artery disease, hypertension, diabetes, and gastroesophageal reflux disease (GERD). He takes aspirin, lisinopril, metformin, and omeprazole. His family history is significant for hypercholesterolemia in both parents, and his father died of a heart attack at the age of 60. He has a 40 pack-year history of smoking, and denies any alcohol or illicit drug use. On examination, the patient is afebrile with a blood pressure of 150/96 mmHg, heart rate of 89 beats per minute, respiratory rate of 18 breaths per minute, and oxygen saturation of 97% on room air. He appears diaphoretic. There is an S3 on cardiac auscultation, with mildly elevated jugular venous pulsations and bilateral rales on pulmonary examination. His dorsalis pedis and posterior tibial pulses are diminished bilaterally, with mild swelling around his ankles. His initial laboratory values and ECG (Figure 1-1) are shown below.

Figure 1-1