

Chapter 1 : Dr. Kostas Sideridis - Syosset NY, Gastroenterology

Dr. Kostas Sideridis is one of the best gastroenterologists in Syosset, NY with over 11 areas of expertise, including Gastrointestinal Diseases (GI Diseases), Hepatitis C, and Hemorrhoids. See Dr. Sideridis's patient ratings and reviews, share your experiences, and search for doctors at Vitals.

Medblue book by Dr. The authors have worked to ensure that all information in this book is accurate at the time of publication and consistent with general psychiatric and medical standards, and that information concerning drug dosages, schedules, and routes of administration is accurate at the time of publication and consistent with standards set by the U. Food and Drug Administration and the general medical community. As medical research and practice continue to advance, however, therapeutic standards may change. Moreover, specific situations may require a specific therapeutic response not included in this book. For these reasons and because human and mechanical errors sometimes occur, we recommend that readers follow the advice of physicians directly involved in their care or the care of a member of their family. Books published by American Psychiatric Publishing, Inc. American Psychiatric Publishing, Inc. Includes bibliographical references and index. Clinical medicine—Handbooks, manuals, etc. Mentally ill—Medical care—Handbooks, manuals, etc. We extend our deep appreciation to all our contributors for sharing their knowledge, insight, and discernment. We acknowledge with gratitude and affection Steve Kamholz, Harry Steinberg, and Kumar Alagappan for invaluable help in planning the book and making it an academic priority for the faculties of the Department of Medicine and the Department of Emergency Medicine at Long Island Jewish Medical Center. We thank John Kane, Bruce Levy, Jim Levenson, and Roger Kathol for their guidance in our effort to understand and refine the knowledge objectives of medical training in psychiatry. We are indebted to Elisse Kramer-Ginsberg for statistical consultation during the research phase of this project. Last, but certainly not least, we thank Bernadette Riordan for processing words, calming anxieties, and keeping it all together. What Do We Need to Know? These undesirable outcomes have been explained in terms of systemic obstacles to health care, behavioral aspects of psychiatric disorders, physical consequences of mental illnesses, and side effects of psychotropic drugs Goldman However, psychiatrist-related reasons are clearly just as important and include inadequate history taking and premature diagnostic closure Sternberg , as well as a reluctance to perform physical assessments Krummel and Kathol The requirements for certification in psychiatry in the United States include 4 months of medical training but do not specify knowledge objectives Accreditation Council for Graduate Medical Education The traditional setting for this training has been the medical ward of a teaching hospital, where psychiatry residents work alongside medical residents involved in the care of patients with acute myocardial infarction, congestive heart failure, pneumonia, respiratory failure, septicemia, phlebitis, cirrhosis, and malignancies Thompson and Byyny We lack empirical data that show how this type of knowledge is used in psychiatric settings. What we do know is that life-threatening and terminal diseases are both infrequently encountered by and beyond the scope of care of the professional staff and support services of a self-standing psychiatric hospital. Our discussions with hundreds of psychiatry residents and attending physicians indicated their perception that the traditional training has not prepared them well for the medical problems of psychiatric patients and has not decreased their reliance on medical consultation to address symptoms of acute illnesses, side effects of psychotropic drugs, and manifestations of chronic degenerative disorders. What do psychiatrists need to know about physical illnesses? The patients' men and women' ranged in age from 8 to 98 years. The average length of stay was 32 days. A total of 2, medical consultations and 1, follow-up visits were performed for patients. The highest rate of medical utilization was recorded for patients with dementia 2. Patients with schizophrenia, substance use disorders, and intermittent explosive disorder required an average of 0. The 2, initial consultations were requested to evaluate specific problems. In the symptom category, the most common request was to evaluate patients who had just had a fall 6. Other common reasons for medical evaluation were high blood pressure 6. Abnormalities found through laboratory tests included hyperglycemia 8. The reasons for the majority of medical consultations requested in the psychiatric hospital were a limited group of symptoms, signs, and abnormal

laboratory test results. The three major groups of problems were potential side effects of psychotropic drugs falls, hyperglycemia, hypotension, hyponatremia, nausea, constipation, leukopenia, pain symptoms, and respiratory and urinary tract infections. These findings made possible the elaboration of a realistic, evidence-based curriculum for enhancing the medical knowledge of psychiatrists. The curriculum is presented here as the first evidence-based overview of medicine for psychiatrists in training or practice. Preface xxvii

This book is organized to reflect the realities confronting clinicians who work in self-standing inpatient psychiatric settings. We modified the traditional organ-system approach by grouping some of the topics according to a common feature, such as cardiac arrest, abnormal vital signs, pain, signs of common infections, and respiratory distress. The presentations are structured to discuss essential features in clinical presentation, differential diagnosis, risk stratification, and management in the psychiatric setting. We concentrated our efforts on documenting the way in which psychiatric disorders and their treatment produce pathophysiological changes and change the classic presentation of common and serious conditions. Our work is not intended to replace well-established print and electronic resources of medical knowledge; instead, we have created a new tool for the complex practice of psychiatry in the twenty-first century. Program Requirements for Residency Training in Psychiatry. Accessed May 8, Mortality and medical comorbidity among psychiatric patients: Comorbid medical illness in psychiatric patients. *Curr Psychiatry Rep* 2: What you should know about physical evaluations in psychiatric patients. *Gen Hosp Psychiatry* 9: Physical health monitoring of patients with schizophrenia. *Am J Psychiatry* Testing for physical illness in psychiatric patients. *J Clin Psychiatry* 47 suppl 1: The Education of the General Internist. Clinical Presentation Cardiac arrest encompasses a spectrum of presentations, from the patient who suddenly clutches his or her chest and collapses to the choking patient. Ventricular tachycardia is defined as a rapid heart beat—usually faster than beats per minute—that originates from a ventricular focus. Because the ventricles contract independently of the atria, there is no coordination between atrial emptying and ventricular filling. In ventricular tachycardia, this lack of coordination results in ineffective filling of the left ventricle and, thus, diminished cardiac output. Ventricular tachycardia is usually initiated by a series of premature ventricular contractions and is characterized on an electrocardiogram ECG as a tachycardia with wide QRS complexes. Ventricular tachycardia may be classified as monomorphic a regular rhythm arising from only one focus with indistinguishable QRS complexes or polymorphic an irregular rhythm with QRS complexes of various morphologies. Ventricular tachycardia may be further classified by duration. Nonsustained ventricular tachycardia lasts less than 30 seconds, and sustained ventricular tachycardia has a longer duration. Torsades de pointes is usually caused by drugs, such as Class IA antiarrhythmics and some antipsychotics, or by electrolyte imbalances particularly hypomagnesemia and hypocalcemia that prolong the ECG Q—T interval. Symptoms suggestive of ventricular tachycardia include palpitations, light-headedness, confusion, anxiety, diaphoresis, syncope, shortness of breath, seizures, and chest pain. These symptoms are the result of general hypoperfusion of the heart and brain. If left untreated, ventricular fibrillation quickly leads to cardiac arrest. The condition is characterized by a highly disorganized and irregular pattern of ventricular contraction that results in ineffective pumping of blood to the rest of the body and thereby leads to decreased tissue perfusion and to hypoxia and complete hemodynamic collapse. This arrhythmia is usually encountered in acute myocardial ischemia, and risk factors for its development include history of coronary artery disease, severe congestive heart failure, congenital heart disease, cardiomyopathies, valvular disease, and recent cardiac surgery. Ventricular fibrillation is also found in patients who have been electrocuted or have sustained direct trauma to the heart. Differential Diagnosis The clinician must assume that a patient who is unresponsive, not breathing, and without a palpable pulse is experiencing cardiac arrest. Other conditions that may be considered in this scenario include acute respiratory arrest due to tracheal obstruction, severe hypothermia, status epilepticus, and toxic overdoses particularly of opioids Table 1—1. Risk Stratification Patients at risk for developing sudden cardiac arrest have a history of coronary artery disease, valvular heart disease, myocarditis, cardiomyopathy, recent cardiac surgery, congenital heart disease, end-stage renal Cardiac Arrest 5 TA BL E 1 —2. Open the airway look, listen, and feel ; use jaw thrust, chin lift maneuver. Provide positive pressure ventilations; give two slow breaths; use bag-valve-mask device with tight seal around nose and mouth. Begin

chest compressions for 1 minute ratio of two ventilations for every 15 compressions ; continue CPR until defibrillator becomes available. If no electrical activity is detected, search for and treat underlying causes. Others at risk include patients who abuse drugs particularly cocaine and anyone currently taking antiarrhythmic medication. The chain of survival has four links: Early CPR begins with proper positioning of the patient and the rescuer. If the patient is not positioned on a hard surface, every attempt should be made to gently move the patient onto his or her back with a firm support such as a backboard. If there is any question of cervical spine injury, the goal is to maintain the head, neck, and trunk in line without applying any traction while moving the patient. After the patient is properly positioned, the primary survey, including evaluation of the ABCDs airway, breathing, circulation, defibrillation , is conducted. This movement lifts the tongue off the airway and allows air to pass unobstructed Allied Mobile Health Training The mandible is then lifted forward to relieve any obstruction Cummins All three steps should be done simultaneously Allied Mobile Health Training If no respirations are detected or if they are agonal and sporadic, the rescuer should provide positive pressure ventilations to the patient either by using a bag-valve-mask device or by pinching the nose and delivering two slow, full breaths over a period of 2 seconds each. The adequacy of ventilations can be gauged by the symmetric rise and fall of the chest cavity. Cardiac Arrest 7 Circulation Once two breaths have been successfully delivered to the patient, the rescuer should perform a pulse check. In adults, the pulse check is done by placing two fingers over the carotid artery roughly two fingerbreadths below the angle of the mandible and adjacent to the trachea. The pulse check should last at least 5â€”10 seconds. If no pulse is detected, 15 chest compressions should be delivered immediately to the patient. In children, after delivery of two rescue breaths, the healthcare provider checks for the following: The heel of the other hand is then placed next to the two fingers, and the other hand clasps the heel over the lower half of the sternum. Keeping elbows locked straight and using the hips as a fulcrum, the rescuer should compress roughly 1. CPR is then continued with the ratio of two ventilations for every 15 chest compressions, until a defibrillator is available at the scene. Defibrillation If the patient shows signs of impaired tissue perfusion, such as chest pain, shortness of breath, low or absent blood pressure, or altered level of consciousness, it is imperative that the patient undergo synchronized cardioversion with at least J of electrical energy. The defibrillator must be switched to the synchronization mode to avoid delivering the shock during the ventricular repolarization phase. Electrical defibrillation is the definitive treatment for ventricular fibrillation and pulseless ventricular tachycardia.

Chapter 2 : Dr. Kostas Sideridis, Gastroenterology - Syosset , NY | Sharecare

Dr. Kostas Sideridis, DO is a gastroenterology specialist in Syosset, NY. He graduated from New York College Of Osteopathic Medicine (Nycom) and specializes in gastroenterology.

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Dr. Kostas Sideridis is a gastroenterologist in Syosset, New York and is affiliated with multiple hospitals in the area, including Long Island Jewish Medical Center and North Shore University.

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Dr. Kostas Sideridis MD is a male gastroenterologist in Syosset, NY with over 19 years of experience. Dr. Sideridis is affiliated with Long Island Medical PC in Syosset, as well as North Shore University Hospital in Manhasset.

Chapter 5 : Dr. Ronald Greenberg, Gastroenterology - New Hyde Park , NY | Sharecare

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Dr. Kostas Sideridis, DO of Syosset, NY patient reviews, appointments, phone number and quality report. Compare Dr. Sideridis to other nearby Gastroenterologists in New York.

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Kostas Sideridis, gastroenterologist in Syosset, NY. Home Dr. Sideridis saw more constipation patients than 85% of similar doctors in the NYC area in

Chapter 8 : - NLM Catalog Result

Dr. Kostas Sideridis is a Gastroenterology Specialist in Syosset, New York. He graduated with honors from New York College Of Osteo Medicine Of New York Institute Of Technology in

Chapter 9 : Dr. Kostas Sideridis DO Reviews | Syosset, NY | theinnatdunvilla.com

Overview. Dr. Kostas Sideridis, MD,DO, is a Gastroenterology specialist in Syosset, New York. He attended and graduated from New York College Of Osteo Medicine Of New York Institute Of Technology in , having over 19 years of diverse experience, especially in Gastroenterology.