End-of-Life Care Debated

Emergency physicians should weigh the benefits and harms of life-sustaining medical treatments for patients who are near the end of life, especially if their quality of life is affected by preexisting conditions such as dementia. The issue of providing “medically futile” treatments to patients in emergency departments was the subject of the James D. Mills Jr., Memorial Lecture, “Compassionate Care or Futility Panel: The Dilemma of Futility Treatment in the ED.”

Wednesday’s lecture featured a panel of experts who reviewed the challenges that arise from requests for futile treatment. The panel, led by moderator Dr. Gregory L. Henry, consisted of Dr. Jerome R. Hoffman, Dr. Daniel J. Sullivan, Dr. Arthur R. Dorse, and Dr. Gregory L. Larkin. Emergency physicians should reflect on their role in starting a “cascade of expensive care rolling down the hill,” recommended Dr. Henry, who is an ACEP past president and adjunct clinical professor of emergency medicine at the University of Michigan, Ann Arbor. “Everybody in this room who is practicing must decide, are you just following orders or are you an independently thinking individual,” he challenged attendees. Furthermore, emergency physicians must ask themselves whether they are serving individual patients or whether they have a larger responsibility to society as a whole. “It takes no intelligence or courage to stick in a tube, intubate, start IVs, give pressors, raise blood pressure on a 90-year-old who is demented,” Dr. Henry commented. “It takes some courage to take one step back and say, what’s the point?”

Providing some words of caution from the legal perspective, Dr. Sullivan said, “It takes no intelligence or courage to say, what’s the point?” Because “it takes some courage to take one step back and say, what’s the point?”

Las Vegas Shatters Attendance Record

The attendance at this year’s ACEP Scientific Assembly in Las Vegas was by far the largest ever seen, with more than 4,931 emergency medicine specialists registered for all 4 days, and hundreds more single-day registrants, guests, and exhibitors.

The previous attendance record was set in 2009, when more than 4,600 emergency medicine specialists visited Boston. This is the third consecutive year ACEP has seen record attendance at Scientific Assembly.

ACEP would like to thank everyone who came to Las Vegas to make this the most successful Scientific Assembly ever. See you next year in San Francisco, Oct. 15 to 18, 2011.
Airways come in many shapes and sizes.

Just like GlideScope video laryngoscopes.

GlideScope® video laryngoscopes are designed for the wide variety of airway cases in your facility. From the all-new digital Cobalt AVL to the portable Ranger to the reusable GVL®, GlideScope configurations are available for patients from preterm to morbidly obese.

No matter which one you choose, every GlideScope video laryngoscope is designed to provide a consistently clear, real-time view of the airway and tube placement, enabling swift intubation.

Visit us at ACEP, Booth #2143, Sept. 28-30, Las Vegas, NV.

800.331.2313 | verathon.com
Systematic Approach Helps With Rashes

Even the most seasoned emergency physicians may be stumped by patients presenting with a rash because of the sheer number of possible diagnoses. On Friday at 11 a.m., they’ll get some help from Dr. Heather M. Murphy-Lavoie.

“Rashes are intimidating to most emergency physicians because they simply don’t know enough about them, and sometimes they can represent a life-threatening process,” she said. In “Approach to the Unknown Rash,” she will present a systematic approach to help narrow down the diagnosis to a few important choices.

There are now more than 3,000 recognized dermatologic diagnoses, according to Dr. Murphy-Lavoie, assistant professor of emergency medicine and surgery and assistant director of the emergency medicine medical clerkship at Tulane University, New Orleans. However, depending on their clinical appearance, rashes can be divided into four broad categories: diffuse erythematous, maculopapular, vesiculo-bullous, and petechial/purpuric.

“I will go over an algorithm for each of these four categories, and the participants will have a chance to practice using the algorithms with a wide variety of cases,” she said.

Each algorithm is a decision tree, with the main differential diagnoses shown at the various branch points, along with lists of distinguishing or unique characteristics to further narrow the diagnosis. A careful history is a critical first step to identifying any rash. Dr. Murphy-Lavoie said. The physician should ascertain the patient’s age, duration of the rash, associated symptoms, recent travel, contact with sick individuals, medications (especially new ones), vaccinations, and past medical, menstrual, and sexual history.

Next comes the physical examination, which stresses vital signs, particularly the presence or absence of certain worrisome findings such as hypotension, tachycardia, fever, or mental status change.

Then the rash is thoroughly evaluated, including notation of its distribution, any evidence of neurotic excoriation, and involvement of any extensor or mucosal surfaces, she said. The rash’s appearance often provides vital clues to its etiology. Attributes to note include scale, moistness, color, hyperpigmentation or hypopigmentation, honey crusting, umbilication, blanching, and palpability.

A Wood’s lamp examination may be useful. For example, rashes that appear green under this lamp may harbor the fungus causing tinea capitis, whereas those that appear coral red may suggest the presence of erythema. At this point, physicians can draw on the algorithms to narrow down the possibilities and pinpoint the most likely diagnoses, Dr. Murphy-Lavoie said.

Petechial/purpuric rashes, for example, can run the gamut from clinically unimportant blemishes to critical early signs of life-threatening conditions. The algorithm begins with the presence or absence of fever, since the most serious petechial/purpuric rashes are accompanied by this sign.

“Approach to the Unknown Rash” (FR-287)
Friday, Oct. 1
11 a.m. - 11:50 a.m.

PHOTOS COURTESY DR. HEATHER M. MURPHY-LAVOIE

Example of a bullous rash to the hands.

Example of a vesicular rash to the fingers.

Example of a maculopapular rash to the hand and thigh.

Example of a maculopapular rash to the foot.

How to Read the Subtle Signs of Tachycardias

Patients with a rapid heartbeat may arrive in the emergency department almost daily, but the commodiousness of the presentation doesn’t minimize the importance of prompt, accurate diagnosis. Interpreting the electrocardiogram is critical in the diagnosis and treatment of the patient with tachycardia. On Thursday at 4 p.m., during “Advanced Recognition and Treatment of Tachycardias,” Dr. David F.M. Brown will present an approach to interpreting ECGs in the ED.

“The physician being confronted with an ECG of a patient with an increased heart rate must consider a broad differential diagnosis,” said Dr. Brown, vice chair of emergency medicine at Massachusetts General Hospital and associate professor at Harvard Medical School, both in Boston. He will review how to identify and manage patients with atrial and ventricular tachycardias through an interactive session of clinical cases and ECGs. The session will emphasize accepted management approaches but will address therapeutic controversies. “The goal is to improve physicians’ abilities to recognize tachyarrhythmias, to interpret electrocardiograms of patients with tachyarrhythmias, and then to manage the patients’ clinical presentation in the emergency department,” he said.

“The physician should always ask two questions when interpreting a tachycardic ECG: Is the QRS complex narrow or wide? And, is the rhythm irregular or regular?” he said. “If you answer those two questions, you then narrow the differential diagnosis down to a manageable list of possibilities, and it becomes easier to correctly interpret the ECG.”

The session will aim to help participants identify narrow- and wide-complex, regular and irregular tachycardias; differentiate supraventricular tachycardias on a 12-lead ECG; distinguish wide-complex supraventricular tachycardias from ventricular tachycardias; and understand the link between preexcitation syndromes and tachyarrhythmias. Dr. Brown will present a logical approach to tachycardia diagnosis and treatment based on anatomy and pathology, and will discuss reentrant supraventricular tachycardias, wide-complex tachycardias, and tachycardias associated with bypass tracts, otherwise known as preexcitation syndromes.

“One controversy Dr. Brown will explore involves stable wide-complex tachycardias. “For example, in the patient with suspected stable ventricular tachycardia, are medications effective or should the clinician move promptly to sedation and synchronized cardioversion?”

Advanced Recognition and Treatment of Tachycardias” (TR-237)
Thursday, Sept. 30
4 p.m. - 4:50 p.m.
Orthopedic Exams Can Be Fast and Thorough

A n orthopedic exam need not be laborious and time-consuming to ferret out the nature and extent of an orthopedic injury, according to Dr. Daniel C. Garza.

In a Master Clinician Series session, “The Rapid High-Yield Ortho Exam in the ED,” to be presented Friday at 10 a.m., he will describe how to perform this efficient yet thorough exam—which can provide a wealth of information on a given bone or joint in as few as 2 minutes—and share some clinical pearls for managing the patient with an orthopedic injury.

“Orthopedic injuries are commonly encountered in the emergency department, and therefore, a sound orthopedic exam is an important part of our practice,” commented Dr. Garza, who is an assistant professor in the departments of orthopedic surgery and surgery at Stanford (Calif.) University and medical director for the San Francisco 49ers football team.

“The goal of the course is not only to teach good technique, but also to explain the reason why a particular exam should be performed. This means understanding the biomechanics of the original injury as well as understanding the biomechanics behind the particular provocative exam,” he explained. “This will help our attendees to perform an orthopedic examination that is efficient, yet thorough.”

Dr. Garza assumes that most emergency physicians attending this session will already have experience with treating orthopedic injuries in their practice, he said. Hence, he plans to review exams that were learned during medical training and to highlight some tips and tricks for injuries that participants may not have previously encountered.

In the latter category, Dr. Garza will discuss the optimal approach to patients with an acute injury (enabling the physician to still get a thorough exam when pain, swelling, and/or deformity is present); approaches to unique populations such as pediatric, elderly, or obese patients; and exam techniques not commonly taught in emergency medicine curricula.

“Case examples will be used to illustrate clinical pearls that attendees may use in their everyday practice,” he said. And participants can expect to see plenty of images and video of actual pathologies from his own clinical experiences.

“The session is structured to provide a framework from which each attendee can build upon, depending on their particular expertise and interests,” added Dr. Garza.

The talk will also address the finer points of properly documenting clinical findings. “Emergency physicians should develop a system for documenting any orthopedic injury that will cover all of the important elements from the standpoint of patient care, medical-legal considerations, and effective communication with the consultant,” he explained.

Rounding out the session, Dr. Garza will share some pearls for communicating with orthopedic surgeons. In this part of the talk, attendees will learn how to understand “ortho-speak” and how to describe any injury in 20 seconds or less. They will also have a chance to familiarize themselves with the myriad acronyms used in the specialty.

“Developing good exam skills as well as an understanding of orthopedic terminology and points of emphasis will help attendees better communicate with orthopedic consultants,” he commented.

“As we all know, effective communication with consultants can play a large role in quality of patient care.”

Medically Futile Care at Life’s End

van, president of the Sullivan Group, Risk Management Consulting, and assistant professor of the department of emergency medicine at Cook County Rush Medical College in Chicago, encouraged emergency physicians to understand the relevant laws regarding medically futile care.

In particular, conflict often arises in the situation of a positive right to care, where “somebody says do everything, and you know with every fiber of your being it’s the wrong thing to do.” In such cases, “you are at risk—the courts haven’t gotten behind you, the legislature hasn’t gotten behind you.”

Before physicians will be able to be comfortable withholding or withdrawing care in such situations, certain events must occur, according to Dr. Sullivan.

“We need a social mandate—we need society to move on this issue. We need clear-cut legislation, and that legislation probably has to be federal,” he said. Finally, “we need immunity—civil, criminal, disciplinary.”

Attitudes toward end-of-life care and medical futility differ across cultures, said Dr. Hoffman, a professor of emergency medicine at the LA County-USC School of Medicine in Los Angeles. For example, views regarding allocation of resources and individual versus societal rights and responsibilities vary widely.

“We have to have the discussion as a society, how much does the individual have the right to the rest of us how to use our shared resources,” he said. Also, “do we as individuals have the right to demand unlimited resources from our society?”

“In Europe, they call this having choices—we are going to choose among different therapies, we are going to choose the one that makes sense because it’s rational, gives us a bang for our buck, and we continue it. In America, we don’t call it choices; we call it rationing.”

In particular, conflict often arises in the situation of a positive right to care, where “somebody says do everything, and you know with every fiber of your being it’s the wrong thing to do.” In such cases, “you are at risk—the courts haven’t gotten behind you, the legislature hasn’t gotten behind you.”

Before physicians will be able to be comfortable withholding or withdrawing care in such situations, certain events must occur, according to Dr. Sullivan.

“We need a social mandate—we need society to move on this issue. We need clear-cut legislation, and that legislation probably has to be federal,” he said. Finally, “we need immunity—civil, criminal, disciplinary.”

Attitudes toward end-of-life care and medical futility differ across cultures, said Dr. Hoffman, a professor of emergency medicine at the LA County-USC School of Medicine in Los Angeles. For example, views regarding allocation of resources and individual versus societal rights and responsibilities vary widely.

“We have to have the discussion as a society, how much does the individual have the right to the rest of us how to use our shared resources,” he said. Also, “do we as individuals have the right to demand unlimited resources from our society?”

“In Europe, they call this having choices—we are going to choose among different therapies, we are going to choose the one that makes sense because it’s rational, gives us a bang for our buck, and we continue it. In America, we don’t call it choices; we call it rationing.”

Dr. Larkin cautioned that new legislative mandates could have dire consequences for the specialty.

“We will be, as emergency physicians, part of these shared accountability schemes, where repeat visits will not be paid for and these resources will be restricted,” he noted. “I guess if we don’t continue to try to be stewards of our resources, we are going to be closing more and more emergency departments.”

The Best People Work at the Best Places

EMA has been honored by NJBIZ as one of the best places to work. A leader in Emergency Medicine since 1977, EMA delivers an unrivaled compensation package with the best ownership track anywhere. We offer fair, early, and equal partnership for all our physicians, resulting in one of the best physician tenure records in the industry. Your potential for professional growth is limitless.

Join the amazing team of physicians at EMA and take your career to incredible heights.

Please visit EMA in Booth #825

The Sign of Excellence in Emergency Medicine®

Emergency Medical Associates

877.893.4865 Fax 888.487.4982 jobseemamd.com • WWW.EMA-ED.com
Rorrie Lecture: Health Care Reform Brings Challenges and Opportunities

It's been several months since President Obama signed the Patient Protection and Affordable Care Act into law, and many emergency physicians are still wondering how they will fit into this new vision for health care delivery.

During the Colin C. Rorrie Jr. Lecture on Thursday, Dr. Brent Asplin will explain why health care reform was able to pass, what challenges lie ahead, and what it means for emergency medicine.

According to Dr. Asplin, chair of the department of emergency medicine at the Mayo Clinic in Rochester, Minn., the key to understanding health care reform lies in cost and value. “The overarching theme of all of this is that health care costs are growing at an unsustainable rate.”

Since emergency physicians understand both of those concepts, they are well positioned to thrive under health care reform. But that’s not to say there won’t be challenges, starting with the influx of new patients expected in emergency departments around the country.

Previous attempts to enact comprehensive health care reform failed because lawmakers could not agree on whether cost-cutting should come before coverage expansions. While that remains a sticking point on both sides of the debate, it was overcome by the crushing costs facing both the Medicare program and middle-class families, he said. For example, several estimates show that without changes in the health care system, by 2016, an average health insurance policy will consume more than 35% of a family’s income, more than even for middle-class families. Now that the law has passed, many observers are wondering if it will live up to promises to reduce health care costs. Dr. Asplin said much will depend on how the law is embraced by physicians. And emergency physicians will have a big role to play. “We’re right in the middle of this no matter what, so our perspective is really critically important.”

For example, the new requirement for hospitals to curb readmission rates changes the expectations for emergency physicians. And the creation of Accountable Care Organizations and bundled payments will force physicians working inside and outside the hospital to work together, which means emergency physicians will likely need to change how they interact with primary care physicians.

While the challenges are obvious, there are also opportunities, Dr. Asplin said. If emergency physicians are successful in reducing readmissions to the hospital and curbing unnecessary visits to the emergency department, they could negotiate to bring some of those systemwide savings back to emergency medicine. These negotiations will not be easy, he said, but health care systems will soon discover how important emergency physicians are for the success of these initiatives.

Health care reform also provides new opportunities for emergency physicians to get engaged on system design, and will allow the specialty to demonstrate its value to the hospital and to the system as a whole. “Emergency physicians are systems experts,” Dr. Asplin said. “We’re able to get things done when other people in the system are either unwilling or unable to do it.”

Enjoy comprehensive ED revenue management solutions that combine robust technologies with outstanding business services. From advanced reporting to onsite physician documentation education, EPBS-Intermedix has the proven processes and flexible solutions to meet your practice’s demands.

Find out what EPBS-Intermedix can do for you today.

Visit Booth #1643 for your chance to win a free Apple iPad!
Tailor Vasopressor Therapy to Individual Patients

When vasopressors are used to treat patients in hypotensive shock, individualizing this therapy is paramount, according to Dr. Peter M. DeBlieux.

In a session to be held on Friday at 8 a.m., “Vasopressor Use in the Emergency Department,” he will discuss state-of-the-art use of this important class of agents, illustrating with real-world cases some key concepts regarding the timing of therapy, the optimal drug(s) to use, and the appropriate dosages.

Hypotension in the emergency department is directly correlated with increased mortality, and even brief bouts appear to worsen clinical outcomes, according to Dr. DeBlieux, director of emergency medicine services at the Medical Center of Louisiana at New Orleans; clinical professor and director of resident and faculty development for emergency medicine at Louisiana State University Health Sciences Center; and clinical professor of surgery at Tulane University, also in New Orleans.

“Emergency medicine physicians are faced with patients in shock states on a daily basis. We are tasked with identifying the etiology and then treating the patients appropriately to improve outcomes,” he commented. To this end, the session “will offer the best evidence for managing vasopressor therapy in cardiogenic, septic, spinal, hemorrhagic, and anaphylactic shock states,” he said. “Understanding vasopressor agents that offer the best clinical evidence for improved outcomes is essential information for emergency medicine providers.”

When it comes to the timing of initiation of vasopressor therapy, patients’ intravascular volume status (or so-called tank) is key, Dr. DeBlieux said. Assessing this status is an essential first step.

It is now standard practice to administer crystalloid intravenous fluid for initial volume resuscitation before starting vasopressors and to give repeated boluses of normal saline while checking patients’ vital signs and pulmonary findings.

“Utilizing bedside ultrasound in shock states to simultaneously assess global cardiac function and volume status by documenting inferior vena caval inspiratory diameter changes has grown in popularity,” he noted. “This complements the practice habit of measuring central venous pressures.”

Additional means of assessing volume status include respiratory variation of arterial wave forms in mechanically ventilated patients and the presence of blood pressure response to passive leg raising.

Currently available vasopressors include the sympathomimetic agents—dopamine, dobutamine, epinephrine, norepinephrine, and phenylephrine—which exert their end-organ effects by stimulating adrenergic receptors, as well as amrinone and glucagon, which do so by other mechanisms.

These agents have differing profiles with respect to whether and how much they stimulate the various types of adrenergic receptors, Dr. DeBlieux said. Therefore, they have different net cardiovascular effects that must be taken into consideration. The clinical scenario often dictates the choice of vasopressor(s) as well, he noted. For example, a patient in shock caused by an overdose of tricyclic antidepressants is usually given dobutamine with or without norepinephrine, whereas a patient in shock caused by anaphylaxis is typically given epinephrine.

The key take-home message for emergency physicians when using vasopressors is to “treat each patient as an individual and avoid dogmatism, a ‘fixed recipe’ approach,” Dr. DeBlieux said.

In addition, because initial therapy may not be sufficient in some cases, patients should be evaluated for the need for ongoing treatment.

“We use the minimum dose of vasopressor required to meet a defined goal or end point.” And finally, “utilize ultrasound early and often to assess cardiac function and to assist in determining intravascular volume status.”
Patients with headache present diagnostic challenges in the emergency department. Is their condition a benign primary headache or a secondary headache being caused by a serious or life-threatening condition?

One way to differentiate is with the S-N-O-O-P mnemonic, Dr. Andrew Chang will explain in his presentation “Stop the Pounding: Update on Headache Assessment and Treatment” on Friday at 12 p.m. The mnemonic includes the following steps: assess Systemic signs and symptoms (fever, night sweats, myalgias, and weight loss), look for Neurologic signs and symptoms (behavior changes, diplopia, pulsatile tinnitus), determine type of Onset (sudden or thunderclap headache) and age of patient at Onset (after age 50, primary headaches become rare), and ask about any Pattern change (is the headache significantly different from any experienced in the past?).

Dr. Chang will describe some potentially life-threatening headache presentations in the ED, including subarachnoid hemorrhage (SAH), cerebral venous sinus thrombosis, and carotid dissection. He will also discuss the “thunderclap” headache. Do not just ask patients if their headache was “sudden,” because that could mean different things to different patients. Instead, ask, “How quickly did your pain go from 0 to 10?” advised Dr. Chang, associate professor at Albert Einstein College of Medicine and an attending physician in the department of emergency medicine at Montefiore Medical Center in the Bronx, N.Y.

In addition to SAH, the differential diagnosis for thunderclap headache includes carotid dissection, cavernous venous sinus thrombosis, pituitary apoplexy, ischemic stroke, spontaneous intracranial hypotension, third ventricular colloid cyst, and reversible cerebral vasoconstriction syndrome, Dr. Chang said.

Sentinel hemorrhage is an important warning sign that also presents as a thunderclap headache. This precedes SAH anywhere from hours to weeks. Non-traumatic aneurysmal SAH occurs in approximately 30,000 people each year, and mortality is high (40%), with up to 30% experiencing substantial neurologic deficit.

Abrupt onset, maximal pain at onset or soon thereafter with vomiting, blurred vision, and/or neck pain are classic symptoms of SAH. However, emergency physicians miss the diagnosis in about 5%-15% of cases, mainly because of failure to appreciate the spectrum of disease and the limitations of the CT scan, as well as failure to perform and correctly interpret the lumbar puncture.

About half of patients present with mild symptoms. The headache can resolve or improve with or without treatment. A normal neurologic examination does not rule out SAH.

The CT scan should be performed first, though its sensitivity is dependent on timing and drops significantly with each passing day. Sensitivity is also dependent on the generation of the CT scanner used. If the CT findings are negative in a patient with suspected SAH, a lumbar puncture should be performed, he said; however, an estimated 25%-50% of emergency physicians will not do a lumbar puncture in these patients.

If the lumbar puncture is negative (zero red cells in tube 4 or no xanthochromia), the patient can be safely discharged from the ED, with outpatient follow-up recommended, according to the 2008 ACEP Clinical Policy on Acute Headache. One caveat is to consider the other conditions mentioned earlier, especially if the headache has a thunderclap onset.

Dr. Chang will also provide tips for the diagnosis and treatment of migraine (the most common primary headache disorder).

■ SNOOP to Find Cause of Dangerous Headaches

ANDREW CHANG, M.D.

Image shows classic star-shaped pattern due to aneurysmal SAH.

COURTESY DR. ANDREW CHANG

“Stop the Pounding: Update on Headache Assessment and Treatment” (FR-304)

Friday, Oct. 1, 12 p.m. – 12:50 p.m.
Fast ENT Diagnosis Is Critical

Rapidly progressive nasopharyngeal infections, tracheostomy malfunctions, and nasopharyngeal hemorrhage are among the ear, nose, and throat conditions that Dr. Teresa S. Wu will discuss on Thursday, at 10 a.m. in her session entitled “Nightmare ENT Emergencies.”

The need for rapid diagnosis and immediate lifesaving procedures to address these and other airway-compromising ENT emergencies can throw the emergency department into a tailspin, according to Dr. Wu, clinical associate professor of emergency medicine at the University of Arizona, Phoenix. She will discuss the common, subtle, and key clinical findings associated with these conditions and offer tips and tricks for expediting diagnoses and avoiding pitfalls.

“Clinical practice and research has shown that saving these patients requires three critical steps,” Dr. Wu said. “The clinician must first be able to recognize the ENT emergency that is presenting. Then, the practitioner must be able to pull the trigger to initiate aggressive and often invasive treatment. And finally, these situations often call for clinicians to be inventive and creative with the resources available to them in these life-threatening situations.”

For example, tracheostomy patients frequently present to the ED with complaints such as displaced tube, hypoxia, respiratory distress, mucous plugs, increased secretions, or bleeding. Clinicians must be prepared to manage life-threatening complications immediately.

Dr. Wu will use case presentations to illustrate how readily available resources can be used to aid in diagnosis and early detection and how basic equipment can be used to secure a rapidly decompensating airway. She will also discuss the use of medical imaging studies such as bedside ultrasound.

**“Nightmare ENT Emergencies”**

Thursday, Sept. 30, 3 p.m. - 3:50 p.m.

Tips Offered for Better Care

New uses of readily available tools and materials—such as angiocatheters, tourniquets, and over-the-counter antacids—can improve the quality of patient care and help emergency physicians manage many of their daily challenges.

During “Tricks of the Trade” on Friday at 9 a.m., Dr. Rachel L. Chin will offer hints and tips in the context of case-based scenarios. One example is the case of a 23-year-old man with a peritonsillar abscess presenting to the ED with a sore throat, right-sided peritonsillar swelling, and uvular deviation. To optimize the view of the peritonsillar space for needle aspiration of the abscess, “use a laryngoscope with a Macintosh (curved) blade,” recommended Dr. Chin, professor of clinical emergency medicine at the University of California, San Francisco. “This obstructs the view less than a tongue blade plus penlight and provides focused lighting.” For the aspiration itself, “use a spinal needle with the sheath trimmed such that 1.5 cm of the needle is exposed, reducing the risk of a too-deep puncture,” she said.

In the case of a 2-year-old homeless man presenting with a humeral abscess and severe foot odor resulting from accumulated perspiration and bacteria in his socks, encasing the patient’s feet in “antacid boots”—surgical boots filled with 30-40 mL of over-the-counter antacid—will neutralize the foot odor within 3-2 minutes, Dr. Chin said. To minimize the purulent smell from the abscess drainage, “suction the pus directly into a closed container,” she said.

Dr. Chin will also describe other tips, incorporating material from Dr. Michele Lin, associate professor of emergency medicine at UCSF and former ACEP News’ “Tricks of the Trade” columnist.

**“Tricks of the Trade”**

FR-276

Friday, Oct. 1, 9 a.m. - 9:50 a.m.

Procedural Sedation in Children Requires Finesse

Administering sedation to a frightened child with a broken bone, laceration, or more severe injury can be a daunting task.

Dr. Amy Baxter will discuss the best way to sedate a frightened child during Thursday’s “Advanced Pediatric Procedural Sedation Management” session starting at 10 a.m.

“Procedural sedation is not general anesthesia. To understand safety with sedation, practitioners need to know how and when to reduce pain,” said Dr. Baxter, director of emergency research for Pediatric Emergency Medicine Associates and clinical associate professor at the Medical College of Georgia in Augusta.

“Many physicians tend to look at procedural sedation as if consciousness were all or nothing, and don’t understand why they still need to worry about pain control for the intervention,” she added. “Procedural sedation in the ED requires more finesse, balancing recovery time and procedural success. New data supports the notion that sedation is safer with good analgesia.”

In this session she will discuss in detail the risks and benefits of available agents for procedural sedation of children, and explain how best to match sedation regimens with specific procedures and how to incorporate appropriate sedation strategies for children in the ED as well as nonpharmacologic approaches.

“More widespread use of deep sedatives has led to an explosion of the literature and the concurrent development of the field of procedural sedation,” she said. Dr. Baxter will review the growing literature addressing the use of propofol with other medications to optimize sedation in the ED. Most new studies focus on propofol plus ketamine in a one-to-one mix. “The side effects of ketamine and propofol balance each other nicely, so that makes this combination a logical choice for polypharmacy,” she said. “The metabolism and pharmacokinetics of the two are different enough that current research is being conducted into using them separately—for example, using ketamine as an induction agent with propofol.” She will also discuss smaller studies of propofol plus fentanyl or remifentanil.

Dr. Baxter will discuss examples of procedural sedation. “We hereas we might want propofol and fentanyl for a lumbar puncture, ketamine with or without other adjuncts may be more appropriate for abscess drainage. A painless laceration may need sedation to achieve stillness but doesn’t need pain control when appropriate topical medications are used.”

In children, Dr. Baxter approaches procedural sedation as a continuum. “Not every child requires sedation for an MRI, but some children require sedation for an IV start.” She will also discuss newer sedatives such as desmopressin.

**“Advanced Pediatric Procedural Sedation Management”**

TH-190

Thursday, Sept. 30, 10 a.m. - 10:50 a.m.

**THE SOLUTION IS IN THE PROCESS: How to Improve ED Flow, Minimize Risk and Maximize Reimbursement With and Without the Help of Technology**

Miami Hilton Downtown, Miami, FL

isEDIS Symposium

November 12-15, 2010

**Why attend the EDIS Symposium?**

If you have questions about implementing your Emergency Department Information System, we have someone with the answers:

- New topics: this year’s course focuses on being able to evaluate the processes at your own institution and consider new approaches to those challenges
- High-tech lectures with solutions that may or may not include a full EDIS: what other (less expensive) options are out there for you?
- Cutting-edge seminars
- Information targeted specifically for each member of the multidisciplinary team — Nurses, Physicians, and IT Specialists
And baseball games. Walks in the park and ballet recitals. We're Emergency Medicine Physicians and we're champions for life. If you're dedicated to delivering the best in emergency medicine, and living life to its fullest, consider a career with EMP. We're a democratic group that’s owned and operated by emergency physicians that understand life is precious—and so is living it. Visit emp.com to discover how you can create your own schedule your entire first year.

EMP
Emergency Medicine Physicians

Opportunities in over 60 locations across the USA including: AZ, CA, CT, HI, IL, NV, NY, NC, OH, OK, PA and WV.

We scream for ice cream.
Calming Agitated Patients

A n agitated, violent patient comes into your ED. He or she is upset and yelling. You won’t respond to repeated requests to relax, and refuses to be examined. Suddenly, the patient pushes away one of the nurses, knocking the nurse to the ground.

Now what? In his presentation called “Combative, Convulsing, and Crazy: Care of the Altered and Agitated Patient,” to be given Thursday at 1:30 p.m., Dr. William Mallon will discuss how to deal with these patients.

“A lot of times you desensitize someone: manage their pain, calm them down. That will work. But some patients either are so altered that you can’t have a conversation, or [they are] violent. The danger they present is not only to themselves, but [also] to others in the department,” not to mention other patients in the waiting room and on the floor, said Dr. Mallon, an associate professor of clinical emergency medicine at the University of Southern California, Los Angeles.

The only way to get control is physical restraint, followed “almost always” by immediate pharmacologic restraint. In the past, Dr. Mallon said, droperidol was his drug of choice in the ED. But a 2001 black box warning means that droperidol is no longer part of many hospital formularies. “We still use Haldol, we use benzo- zodiazepines, and there are a variety of new drugs out there,” he said, adding that “the newer agents don’t really appear to be that much safer.” And many drugs being used for agitated emergency patients “haven’t really been in the environment that we work in,” he said.

“We don’t see psychiatric agitation per se” for which these agents are approved. “We see acute, undiffer- entiated agitation, and a lot of these patients have acute medical problems,” like toxicologic imbalances due to drug use or overdose; head trauma, or brain bleeds.

Plus, many of these agents may not be appropriate for the most common cause of violence and agi- tation in the ED—alcohol. “Managing sedative hypnotic-in- duced agitation with another seda- tive hypnotic is not a good idea. They’ll stop breathing, and you’ll wind up with aspiration pneumonia,” said Dr. Mallon, who is also di- rector of the division of international emer- gency medicine at Los Angeles County + USC Medical Center. In these cases, haloperidol or droperidol are better options.

*Combative, Convulsing, and Crazy: Care of the Altered and Agitated Patient* (TH-213)
Thursday, Sept. 30, 1:30 p.m. - 2:20 p.m.

Complex Wounds Call for Advanced Closure Skills

E mergency physicians see countless lacerations each year, and are called upon to manage both simple and complicated wounds. On Thursday at 12:30 p.m., they can learn about evidence- based medicine and the latest techniques and suture materials used for managing complicated wounds in “Advanced Wound Closure Techniques,” to be presented by Dr. E. Parker Hays Jr.

“The best wound care is always a mix of science and artistry. Mastering both will re- sult in better, safer, and optimal laceration management,” said Dr. Hays, an associate professor in the department of emergency medicine at the University of North Carolina, Chapel Hill.

Dr. Hays will review the cur- rent literature on wound man- agement, describe advanced wound suturing and alternative closure—including basic plastic surgery techniques and site-spe- cific considerations—and provide pearls for closing complicated and challenging wounds. The case-based for- mat will include dis- cussion of scores of photographs of clo- sure techniques.

“Every practitioner learned to close a simple wound,” said Dr. Hays, also of Carolinas Medical Center in Charlotte, N.C. “The course aims to help them close them more expertly, using evidence-based concepts and in- novative techniques, as well as manage more complicated wounds on specific and special- ized areas of the body.”

“Advanced Wound Closure Techniques” (TH-200)
Thursday, Sept. 30, 12:30 - 1:20 p.m.
Thank You to Our EMRA Underwriters

The leadership and members of the Emergency Medicine Residents’ Association extend sincere appreciation to our gracious supporters who have helped to underwrite the costs of the EMRA Events at ACEP’s Scientific Assembly. We could not accomplish all that we do without your generous support.

SIGNATURE LEVEL
Emergency Medical Associates (EMA)
Florida Emergency Physicians (FEP)
Hospital Physician Partners (HPP)
Staff Care
Shayne Ruffing, The Benefit Planning Group
SAM HSA

PLATINUM LEVEL
American College of Emergency Physicians (ACEP)
Emergency Physicians Medical Group (EPMG)
EMCareerCentral.org powered by Physicians (ACEP)

GOLD LEVEL
Emergency Consultants, Inc. (ECI)
Emergency Medicine Patient

Medtronic introduces two clinical trials in your area.
Physicians interested in referring a patient to either of the trials, please contact the principal investigator in your area listed below.

RESCUE Trial
Evaluation of Endovascular Repair Using the Valiant Thoracic Stent Graft with the Captivia Delivery System in Blunt Thoracic Aortic Injuries

PARENT ELIGIBILITY: Subject with a blunt thoracic aortic injury, who is at least 18 years old, and meets the study’s anatomical criteria.

RESCUE Trial Principal Investigators:

- Dr. Chad Hughes, Duke University Medical Center, Durham, NC 27710
- Dr. Matthew R. Price, EmCare, Inc., Florida 32610
- Dr. Robert Allen, Memorial Hermann Health System, Houston, TX 77030
- Dr. Philip Chossegros, University of Pennsylvania Health System, Philadelphia, PA 19104
- Dr. Mark Cunningham, University of Arizona Health Sciences, Tucson, AZ 85724
- Dr. Ali Azizzadeh, Stanford Health Care, Los Angeles, CA 90036
- Dr. Joshua Rovin, Michigan State University, East Lansing, MI 48824
- Dr. Clifford Bruley, Scott & White Memorial Hospital, Temple, TX 76508
- Dr. John Kieffer, University of Nevada, Las Vegas, NV 89146

Medtronic Dissection Trial
Evaluation of the Clinical Performance of the Valiant Thoracic Stent Graft with the Captivia Delivery System for the treatment of acute, complicated Type B aortic dissections

PARENT ELIGIBILITY: Subject diagnosed with an acute, complicated Type B aortic dissection with evidence of a dual dissection flaps or rupture, who is at least 18 years old, and meets the study’s anatomical criteria.

Medtronic Dissection Trial Principal Investigators:

- Dr. Scott Severson, University of Vermont Health Network, Burlington, VT 05405
- Dr. Robert White, Heartland UCLA Medical Center, Torrance, CA 90503
- Dr. William Emery, Northwestern Memorial Hospital, Chicago, IL 60611
- Dr. Philip Hens, University of North Carolina, Chapel Hill, NC 27514
- Dr. Ali Azizzadeh, Stanford Health Care, Los Angeles, CA 90036
- Dr. Joshua Rovin, University of Michigan Medical Center, Ann Arbor, MI 48109
- Dr. Chad Hughes, University of California, Irvine, CA 92617
- Dr. Ali Azizzadeh, Stanford Health Care, Los Angeles, CA 90036
- Dr. Joshua Rovin, University of Michigan Medical Center, Ann Arbor, MI 48109
- Dr. Ali Azizzadeh, Stanford Health Care, Los Angeles, CA 90036
- Dr. Joshua Rovin, University of Michigan Medical Center, Ann Arbor, MI 48109

*CAUTION: INVESTIGATIONAL DEVICE. LIMITED BY FEDERAL (OR UNITED STATES) LAW TO INVESTIGATIONAL USE.

For further information please contact:
Medtronic Vascular, 3576 Unocal Place, Santa Rosa, CA 95403, USA
(707) 591-2343

© 2010 Medtronic, Inc. All rights reserved.
UC201100187 EN 8/10
You and your EM colleagues are invited to attend…

A Year 2010 Milestone CME Dinner Summit in Emergency Medicine


Focus on Toll-Like Receptors, the Inflammatory Cascade, and Targeted Clinical Interventions with Antibiotics and Emerging Therapies

Save the Time and Date:
Wednesday Evening, September 29, 2010
Time: 6:00 PM — 9:15 PM
REGISTER NOW: www.CMEreg.com/ACEP

Save the Time and Date:
Wednesday Evening, September 29, 2010
Time: 6:00 PM — 9:15 PM
REGISTER NOW: www.CMEreg.com/ACEP

Don’t Miss Your Last Chance To Visit the Exhibit Hall

Thursday is the last day to visit the Exhibit Hall. If you haven’t yet stopped by, you’ll want to take a few moments to browse among the more than 300 commercial and public service exhibits. Other worthwhile attractions include the ACEP Bookstore, the Wellness Booth, and the Art Gallery sponsored by ACEP’s Medical Humanities section. Many exhibits feature hands-on product demonstrations as well as opportunities for one-on-one consultation with technical and marketing personnel. The Exhibit Hall is open today from 9:30 a.m. to 3:30 p.m.

Skills Labs Offer Hands-On Training

One of Scientific Assembly’s popular features is its interactive skills labs. Every year the skills labs courses are among the first to fill when registration opens. This year, labs included airway imaging, slit lamps skills, trauma ultrasound, and more. Labs are usually limited in size for hands-on, practical training from a faculty member.
San Francisco to Host 2011 Scientific Assembly

It’s not too soon to start planning for next year, when Scientific Assembly moves to San Francisco (Oct. 15-18). The city’s numerous restaurants and unique night spots provide the perfect complement to what promises to be another successful ACEP annual meeting.

If you call ahead now, you might be able to get a dinner reservation at Gary Danko’s, named the city’s most popular restaurant by Zagat for 7 years running. Or check out Bix, a “civilized speakeasy” that mixes great food and sizzling jazz. Try some four-star classic French food at Fleur de Lis, prepared by Chef Hubert Keller, who’s been called the "rebel with a Cuisinart." Or you can dine at Alice Waters’ revolutionary restaurant, Chez Panisse, the Berkeley spot where the “eat local” movement had its tasty beginnings.

As you reconvene with your colleagues, stroll through Chinatown and try an autumnal “moon cake,” a pastry that symbolizes a gathering of friends. Don’t miss the 210-foot wonder, Coit Tower, one of San Francisco’s most spectacular views and a great spot from which to see the city at night. You can look out over the whole city and hear the mournful fog horn from Alcatraz. Be sure to listen for the parrots of Telegraph Hill, the feral flock that has populated the trees near the tower for years.

Try to squeeze in an Alcatraz Night Tour, a unique program limited to just a few hundred visitors each night. You’ll hear compelling stories about the island’s history and you’ll find special programs and activities not offered during the day. Don’t forget to bring a sweater to pull on in the chilly evening air.

For first-class theater, head to SHN, the Broadway of the West, where you can catch most of the New York’s hottest tickets. Or check out the comedy clubs in North Beach—there are more than a dozen that feature side-splitting nationally known comedians.

Plan a trip by day or night to the California Academy of Sciences in Golden Gate Park, the only spot on the planet with an aquarium, a planetarium, a natural history museum, and a four-story rain forest all under one roof. Or head to the Exploratorium, the museum of science, art and human perception, where the After Dark series—exclusively for adults—mixes cocktails, conversation, and playful, innovative science and art. Each evening showcases a different topic, from music to sex to electricity, and includes a cash bar and hundreds of hands-on exhibits.

Other renowned sites include the storied Haight-Ashbury district; Golden Gate Park’s thousand acres of gardens, lakes, and Japanese Tea Garden; the quaint cable car museum; the Embarcadero; and Fisherman’s Wharf.

Add ACEP’s Scientific Assembly 2011 to your calendar today!
In an effort to encourage the free exchange of emergency department process improvement projects among ACEP members, the ACEP Practice Management Committee has established a forum where this exchange can take place.

Stop by the ACEP Resource Center in the Exhibit Hall Thursday to try it out, or visit it online at www.acep.org/membersurvey.aspx?formid=45474.

Emergency department leaders throughout the U.S. have tried multiple procedures to improve the function of our EDs, said Dr. James Halfpenny, a member of ACEP’s Practice Management Committee. These efforts have included the implementation of fast tracks, physician triage, the management of hallway patients and waiting room patients, ambulance diversions, caring for boarded patients in the ED, improvement in door-to-doctor times, maintenance of excellent patient satisfaction scores during times of ED crowding, and attempts to improve the movement of patients to the inpatient units.

Many improvements are reported in journals, but many more never make it to publication, and those with negative results are almost never reported in peer-reviewed journals, Dr. Halfpenny said. Through the ACEP Web site forum, members can share the results of their process improvement projects, disclose roadblocks, and reveal processes that led to improvement and sustainability. The forum will establish an area in which to tap into the vast quantity of data on clinical operations that ACEP members can provide. With the knowledge and experience obtained from this site, members’ future improvement projects will likely be more successful. In addition to data from their process initiatives, ACEP members will be asked to provide information about their institution (including ED size, average in-hospital census, and availability of specialists), their project, the rationale for a specific intervention, and replicable details including an implementation plan, evaluation methods, results, and insights. Members may submit this information anonymously or provide contact information to share their solutions to crowding. Case studies will be available exclusively to ACEP members.
EMF Events Fund Research

For the 14th year, the ACEP Council exceeded its goal of donations for the Emergency Medicine Foundation and gave $128,602. The Tennessee Chapter was the first chapter to give at 100% participation from its members. EMF thanks the ACEP Council for their generosity.

Dr. J. Bruce Moskow (left), Dr. Brooks F. Bock, and Dr. Patrick Crocker joined several conference attendees Tuesday evening at the EMF party.

EMF has funded innovative clinical and laboratory research for more than 35 years and leads the way in emergency medicine education and research. To date, EMF has funded nearly $30 million in grants for these purposes.

Donations can be made to EMF at the ACEP Resource Center in the Exhibit Hall. Or, if you would like to take home a personalized Las Vegas souvenir, visit the Picis photo booth (Booth 1143 in the Exhibit Hall) and $10 will be donated to EMF for every picture taken. Members of EMF’s Wiegenstein Legacy Society who have included EMF in their estate plans were honored on Sunday night. Current members are:

• Nancy J. Auer, M.D., FACEP
• Pamela P. Bensen, M.D., FACEP
• Andrew J. Bern, M.D., FACEP
• Michael D. Bishop, M.D., FACEP
• Brooks F. Bock, M.D., FACEP
• Kirk W. Brown, M.D.
• Kathleen Cowling, D.O., FACEP
• Gregory L. Henry, M.D., FACEP
• Alexander T. Limkakeng, M.D., FACEP
• George W. Molzen, M.D., FACEP
• John B. Moskow, M.D., FACEP
• Edward A. Panacek, M.D., FACEP
• Leonard M. Riggs, Jr., M.D., FACEP
• John J. Rogers, M.D., FACEP
• Alexander M. Rosenau, D.O., FACEP
• John A. Russ, M.D., FACEP
• David C. Seaberg, M.D., FACEP
• Sandra M. Schneider, M.D., FACEP
• Richard L. Stennes, M.D., FACEP
• Thomas J. Sugerman, M.D., FACEP
• Robert E. Suter, D.O., FACEP
• Marvin A. Wayne, M.D., FACEP
• David E. Wilcox, M.D., FACEP
• Robert M. Williams, M.D., FACEP

Opening Party a Winner

Las Vegas’ glitz and glamour was in full swing Tuesday night during the Scientific Assembly Opening Party. The celebration included live music, great food, and a few sightings of Vegas legends mingling in the crowd.

ACEP Educational Meetings:
Building a Solid Foundation for Quality Emergency Care

Emergency Department Directors Academy
Dallas, TX
Phase I: November 15-19, 2010 and February 21-25, 2011
Phase II: May 2-6, 2011
Phase III: November 16-20, 2010

Reimbursement & Coding
Las Vegas, NV / February 16-20, 2011

Advanced Pediatric Emergency Medicine Assembly
San Diego, CA / April 11-13, 2011

Leadership & Advocacy Conference
Washington, DC / May 22-25, 2011

Scientific Assembly
San Francisco, CA / October 15-18, 2011

Check out www.acep.org/meetings for updates on dates and locations.
“TeamHealth has the feel of a local group with the resources of a national platform. Even as a young physician, I am given opportunities to pursue my interest in advocacy for emergency medicine, while still having time to enjoy my family.”

TeamHealth congratulates its 2010 Medical Directors of the Year!

Every year TeamHealth honors an emergency department medical director from each of its service regions. Selected from more than 300 medical directors and associate medical directors nationwide, these individuals exemplify exceptional leadership at every level. Congratulations to our 2010 honorees!

TeamHealth provides its medical directors with extensive support to help them excel in their leadership roles, including:

- Leadership education and development academy
- Web-based medical director tool kit
- Medical director listserv for sharing best practices
- Regional medical director meetings

Visit us at Booth #1333 for your chance to WIN AN iPAD!