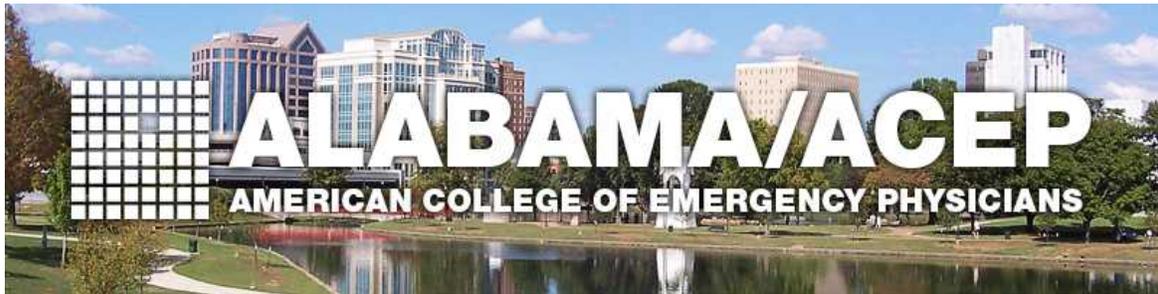


A Newsletter for the Members of the Alabama Chapter

Winter 2018



Sarah Nafziger, MD, FACEP
Alabama Chapter President

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Welcome New Members!

ALACEP President's Message

Sarah Nafziger, MD, FACEP

I just spent the last 15 minutes standing in the hallway of my hospital talking to a cardiologist. For most of us that may seem absurd because, let's face it, who has time to stand around and talk anymore? We are all incredibly busy at work and, as always, patient care comes first. The topic of our conversation, however, was something important that I think is relevant to all of us.

She was telling me how important she believes it is for the ED physicians and the inpatient physician staff to develop a relationship and to interact with one another outside of patient handoff conversations. The logic is that through those professional relationships, we can begin to see the world from each other's perspective and develop a professional respect and trust that will benefit our patients. I wholeheartedly agree and have seen this to be true over and over throughout my career. Our conversation touched on some of those sensitive areas such as avoidable admissions, unresponsive on-call physicians and unprofessional behavior. Those are topics that can be uncomfortable to discuss, but in this setting, I was at ease because I have known this cardiologist for years, and we have developed a strong professional relationship. It was a productive interaction that led to some good ideas that can fix some of the problems that hamper our productivity.

I bring up this topic because I think it's important for us to be reminded that we are part of the medical staff at our hospitals. Whether we work in the academic or community hospital setting, we aren't just some person off the street hired to do a job and go home. We are doctors and that should mean something. If we are to be treated with the respect that we deserve, we have to make sure that we are playing our part, which sometimes means spending some time outside of our shift interacting with our colleagues.

I know the argument. We all chose emergency medicine because we don't want to spend time outside of our shift answering phone calls and doing paperwork and going to meetings. But the reality is, if we are to have a seat at the table and be treated with the respect we crave, we have to participate in some activities outside of clocking in and clocking out for a shift. Integrating ourselves into the medical professional community is vital to making sure that we have those relationships established when we are caring for our patients and time is critical.

Consider taking the time to go to a medical staff meeting, participate in a hospital committee, attend a lecture, or attend an event with your colleagues. Of course, this won't fix all of the

problems we have in the ED, but it's a start. The rewards of mutual professional respect and a collegial relationship are worth the effort!

Big Changes to EMS Protocols Decided

The state EMS meeting was held Dec. 12 in Clanton at the Alabama Power Conference Center. Some major protocol changes were made affecting patient care in the area of pain management and trauma transport.

For improvements in managing pain, and also to address the morphine shortage, ketamine has been added for several indications. It may be used in abdominal pain, fractures, dislocations, chest pain, excited delirium, burns, bites, envenomations, among others. This is also approved for the pediatric population.

Diltiazem, nicardipine and labetalol have been added as well for their indications of dysrhythmia and hypertensive emergencies. It is also interesting that valium has been removed for treatment of seizures.

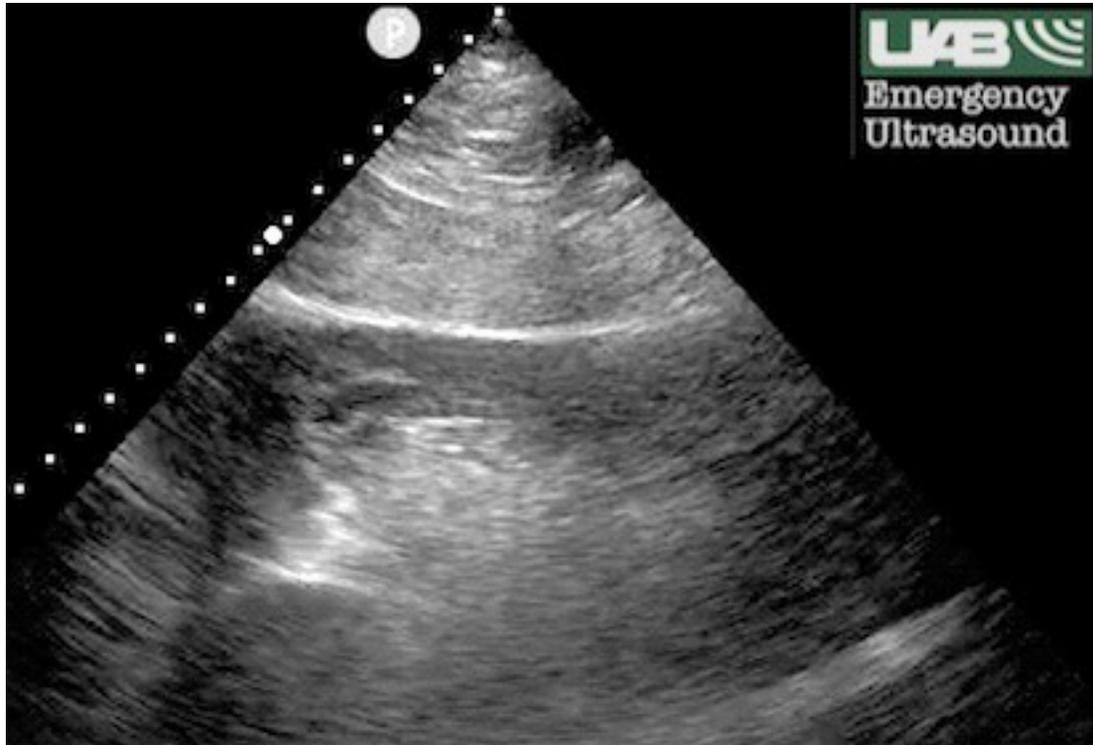
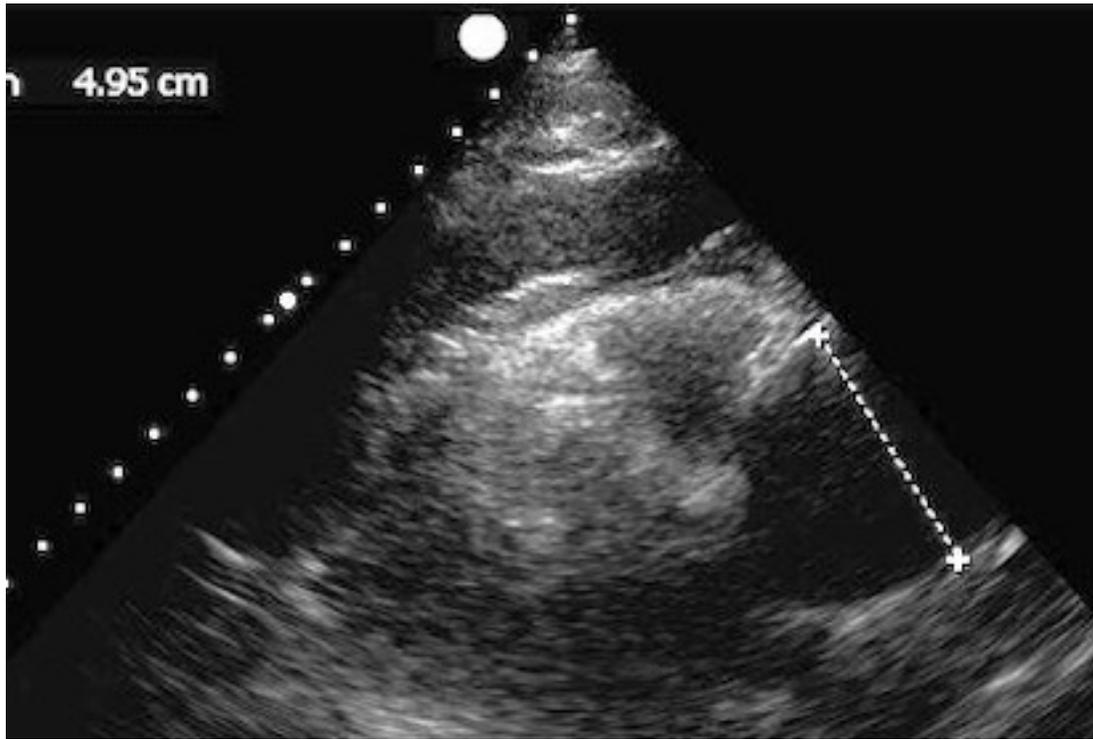
A huge change will be the use of long spinal boards ONLY for acute trauma patients with evidence of paralysis and to assist in transport. If used in the assist of transport, they are to remove the board once the patient is on the stretcher. As a clinician, you have noted that many patients are left on these boards too long, causing increased pain, discomfort and even early decubitus. Many studies have shown this as well. These boards are to be used ONLY for the above indications.

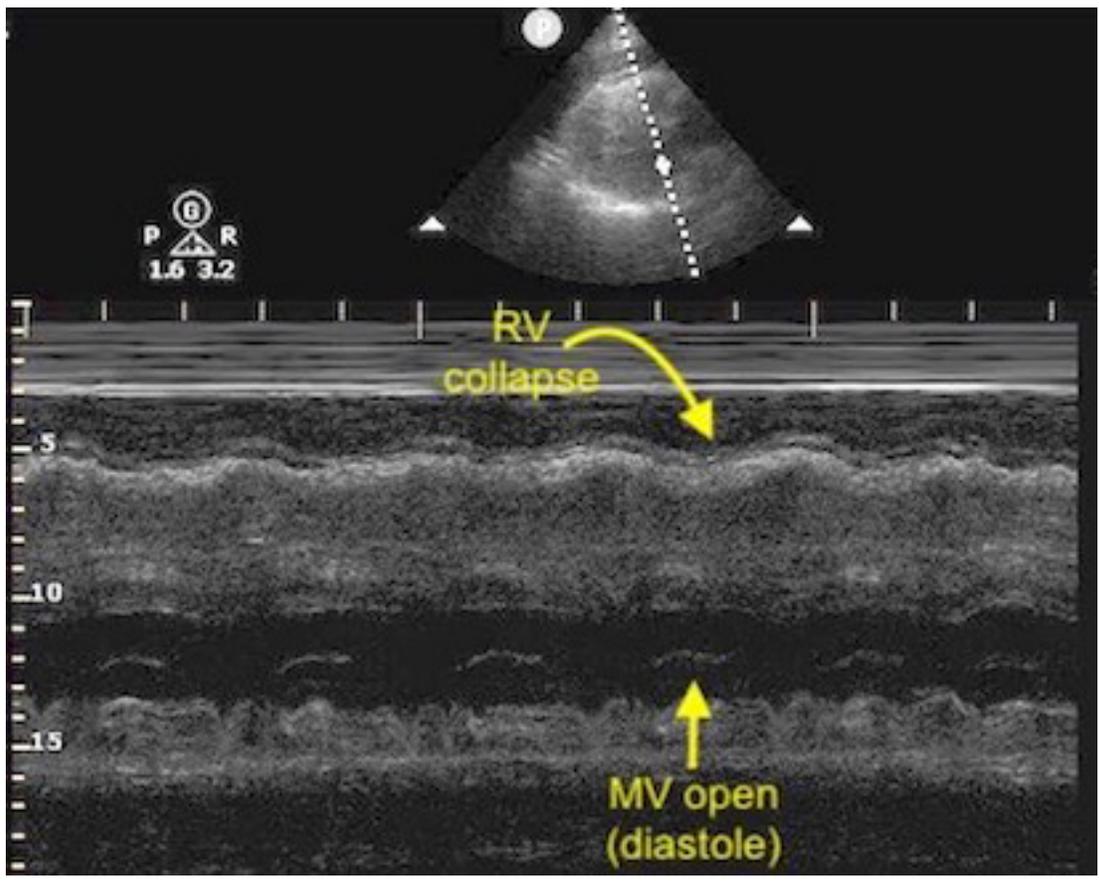
These have yet to be officially approved by the State Committee of Public Health, but look for them coming this spring. The next meeting is March 6 in Tuscaloosa. Thanks to Dr. John McMahon, Board of Directors member, who is our liaison to this committee, and keeps us updated on all changes.

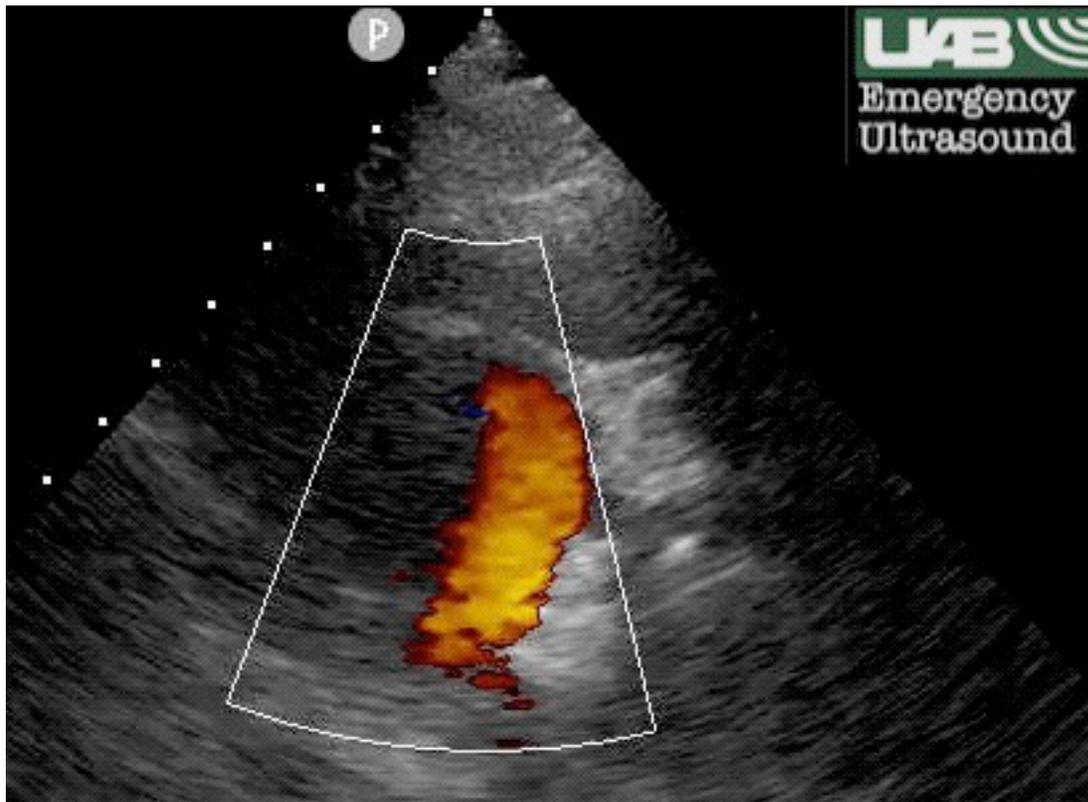
Ultrasound Use in Early Diagnosis of Aortic Dissection
David Pigott, MD, RDMS, FACEP
Co-Director, Emergency Ultrasound, UAB

Within the last two weeks, we've had two cases of type A aortic dissection, both of which were seen and diagnosed on rapid bedside ultrasound. One patient presented in extremis and CV surgery was called in from home based on the bedside ultrasound. The CV surgery attending was ready and waiting in the OR by the time the CT angiogram was completed, expediting surgical repair in an unstable patient with hemopericardium and tamponade (as seen in the images below).









Another patient was diagnosed with a subacute Type A aortic dissection but the clinical picture was complicated by the patient's peripheral neurologic symptoms as well. The bedside ultrasound, however, demonstrated a very well-defined intimal flap within the aortic arch and extending well below the diaphragm. The images in these cases highlight the importance of identifying two important findings in patients with suspected proximal aortic dissection. The presence (or absence) of hemopericardium and/or tamponade, and the presence of a dilated aortic root (>4 cm).

Additionally, both patients underwent suprasternal ultrasound of the aortic arch where an aortic dissection flap was clearly visible in both cases. One patient also had a moderate to large hemopericardium with evidence of pericardial tamponade. Note the presence of RV diastolic collapse on both the subxiphoid and parasternal long axis (LAX) views. M-mode was used in the LAX view to identify diastole (i.e., when mitral valve is open). The RV free wall is seen collapsing inward (toward the septum) during diastole, confirming the diagnosis of tamponade.

Ultrasound of the suprasternal notch is typically performed using the phased array (cardiac) probe, with the probe marker oriented toward the patient's right. The aortic arch will then be visible in a coronal view with the branches seen in the upper part of the screen.

A feasibility study of suprasternal ultrasound of the aortic arch was recently published here:

Kinnaman KA, Kimberly HH, Pivetta E, Platz E, Chudgar A, Adduci A, Stone MB, Rempell JS. Evaluation of the Aortic Arch from the Suprasternal Notch View Using Focused Cardiac Ultrasound. *J Emerg Med.* 2016 Apr;50(4):643-50.e1.

This group also posted an [excellent video review](#) of the technique.

Both patients underwent CTA Chest/Abd/Pelvis in the ED and subsequent aortic arch repair.

Alabama ACEP Website gets an Upgrade

Thanks to national ACEP, our state chapter website is looking fresh and new. Check it out at <http://www.alacep.org/>. Also, don't forget to follow us on Twitter at [@alabamaacep](#)! We will be posting information regarding our upcoming conference in the summer.

Save the Date for Destin this Summer

Start asking off and switching shifts for the SEC/Big12 Conference in Destin this summer, June 4-7! Since ACEP is celebrating 50 years in 2018, the theme will be "Emergency Medicine, Then and Now." As always this is a highly sought after conference, and fun for the whole family. Go to lectures in the morning, and hang out on the beach in the afternoon with your family! More information coming soon! For now, stay in the loop by checking out the [new website](#) and following us on [Twitter](#) and [Facebook](#)!

Upcoming Board Meeting

The next Board of Directors Meeting will be held **March 1, at 9:30 am**, at the Medical Association of the State of Alabama building, 19 S. Jackson St., Montgomery, AL. All members are welcome!



ACEP's Viral Video Campaign to Expose Anthem Policy

ACEP recently launched a video campaign to expose Anthem Blue Cross Blue Shield for denying coverage to emergency patients, based on an undisclosed list of diagnoses, for conditions the insurance giant considers non-urgent. For a copy of the full press release, please contact [Michael Baldyga](#), ACEP Senior Public Relations Manager. This policy is active in six states - Georgia, Indiana, Kentucky, Missouri, New Hampshire and Ohio - but more Anthem states will follow, and more health insurance companies, if this effort isn't stopped. Anthem's policy is unlawful, because it violates the prudent layperson standard that is in federal law and 47 state laws.

Special thanks to ACEP video cast members Dr. Jay Kaplan, Dr. Alison Haddock, Dr. Ryan Stanton and Dr. Supid Bose - and ACEP staffers Mike Baldyga, Elaine Salter, Darrin Scheid and Rekia Speight!

Help us make [the video](#) go viral and top last year's that generated nearly 300,000 views on YouTube and Facebook! Please post it to Facebook pages, e-mail it to colleagues and Tweet about it using [#FairCoverage](#) and [#StopAnthemBCBS](#).



Help Us Celebrate ACEP's 50th Anniversary

You can help us ensure we have the most diverse, and most complete, historical collection of everything!

Follow us on [Twitter](#) and [Facebook](#) to see our weekly Tues/Thurs 50th Anniversary posts
Talking 50th Anniversary on social media? Use [#EMeverymoment](#)

Show your EM pride with ACEP's [new "Anyone. Anything. Anytime." Facebook profile frame](#)

Visit our 50th Anniversary site [here](#) for year-round updates

Got something cool to share about the college's history, or your own with EM? [Click here!](#)

Upcoming CEDR Webinar

In depth review of the steps and process involved using CEDR for Group or Individual 2018 MIPS Reporting. Topics for this webinar will include selection of reportable measures, Advancing Care Information data entry, and Improvement Activity reporting through CEDR.

Register for the [Reporting MIPS through CEDR](#) webinar to be held on **March 13, 2018** at **1:00 PM CDT**. After registering, you will receive a confirmation email containing information about joining the webinar.

ULTRASOUND TRACKER



New ACEP Tool Helps you Keep Track of Ultrasound Scans

Emergency physicians regularly apply for hospital credentials to perform emergency procedures including emergency ultrasound. Theoretically, ultrasound training, credentialing and billing should be no different than other emergency procedures where training occurs in residency and an attestation letter from the residency is sufficient for local credentialing. When such training occurs outside of residency, "proctored pathways" often serve to assure competency. There is still a lack of understanding and awareness in the general medical community that emergency physicians routinely train in and perform point-of-care ultrasound.

The [ACEP Emergency Ultrasound Tracker](#) was created to assist members in achieving official recognition of ultrasound skills. This tool allows you to easily keep track of ultrasound scans you have performed over the course of your career in emergency medicine. It also allows you to upload relevant documents that attest to your training. After inputting and self-attesting to your ultrasound information you may download a letter of recognition from ACEP so long as you have attested to meeting the recommendations for emergency ultrasound training put forth in the [ACEP Ultrasound Guidelines \(PDF\)](#). We hope you find this tracker tool helpful and useful in your practice.

New ACEP Award

Community Emergency Medicine Excellence Award

We are pleased to announce that the ACEP Board of Directors approved a new award to recognize individuals who have made a significant contribution in advancing emergency care and/or health care within the community in which they practice. While the College currently has a number of awards to recognize excellence in emergency medicine this award is focused on the emergency physician who has made a significant contribution to the practice of emergency medicine in their community. Examples of significant contributions to the specialty and community may include, but are not limited to, community outreach, public health initiatives, or exemplary bedside clinical care.

Nominees must be an ACEP member for a minimum of five years and not received a national ACEP award previously. **Entries are due no later than May 14, 2018.**

The nomination form and additional information can be found [here](#).

Articles of Interest in *Annals of Emergency Medicine*

Sandy Schneider, MD, FACEP

ACEP Associate Executive Director, Practice, Policy and Academic Affairs

ACEP would like to provide you with very brief synopses of the latest articles in [Annals of Emergency Medicine](#). Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population.

Babi FE, Oakley E, Dalziel SR, et al.

Accuracy of Physician Practice Compared to Three Head Injury Decision Rules in Children: A Prospective Cohort Study.

This study looks at the application of common decision rule regarding head injury in children and compare this to clinical judgement of experienced physicians. The authors did a prospective observational study of children presenting with mild closed head injuries (GCS 13-15). They found their group of clinicians were very accurate at identifying children who had a clinically important traumatic brain injury (sensitivity 98.8%, specificity of 92.4%). This was better than the decision rules also applied to these children which included PECARN, CATCH and CHALICE.

April MD, Oliver JJ, Davis WT, et al.

Aromatherapy versus Oral Ondansetron for Antiemetic Therapy Among Adult Emergency Department Patients: A Randomized Controlled Trial.

Inhaled isopropyl alcohol as an aroma therapy has been described as effective in treating post-operative nausea. In this study, the authors compared inhaled isopropyl alcohol to placebo, alone or with oral ondansetron. They found that the aromatherapy with or without ondansetron had greater nausea relief than placebo or ondansetron alone. They recommend a trial of aromatherapy for patients with nausea who do not require immediate IV treatment.

e Silva LOJ, Scherber K, Cabrera d, et al.

Safety and Efficacy of Intravenous Lidocaine for Pain Management in the Emergency Department: A Systematic Review.

This is a systematic review of the literature on IV lidocaine for pain. There were only 6 randomized control trials of lidocaine for renal colic. The results were variable. Lidocaine did not appear to be effective for migraine headache but there were only 2 studies of this. The authors concluded that we do not have enough data at this time to definitively comment on the use of lidocaine for pain in the ED.

White DAE, Giordano TP, Pasalar S, et al.

Acute HIV Discovered During Routine HIV Screening with HIV Antigen/Antibody Combination Tests in 9 U.S. Emergency Departments

This study looked at HIV screening programs in 9 EDs located in 6 different cities over a 3 year period. There were 214,524 patients screened of which 839 (0.4%) were newly diagnosed. Of the newly diagnosed 14.5% were acute HIV (detectable virus but negative antibody) and 85.5% were established HIV (positive antibody test). This study reminds us that many patients with acute HIV will have a negative screening test that relies strictly on antibody. Many of these patients present with flu like illness as their initial presentation.

Axeem S. Seabury SA, Menchine M, et al.

Emergency Department Contribution to the Prescription Opioid Epidemic.

There has been much discussion of the opioid epidemic in both the professional and lay press. Emergency physicians tend to write a lot of prescriptions but for very small amounts. This study examined prescriptions for opioids from 1996-2012. During this period opioid prescription rates rose in private office settings and declined in the ED. For patients receiving high numbers of opioids, only 2.4% received opioids from the ED.

Welcome New Members

Jarred Anderson

Carlos Cambo Cortes

Jonathan Taylor Grammer

Jordan Lawson

Langston Lee, MD

Cody Lewis

Holman Li

Laura Martin

Nicholas R Quigley

Dylan C Salvador

Benjamin L Stalnaker, MD

Matt Talbott

Rosanne M Zandvliet

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