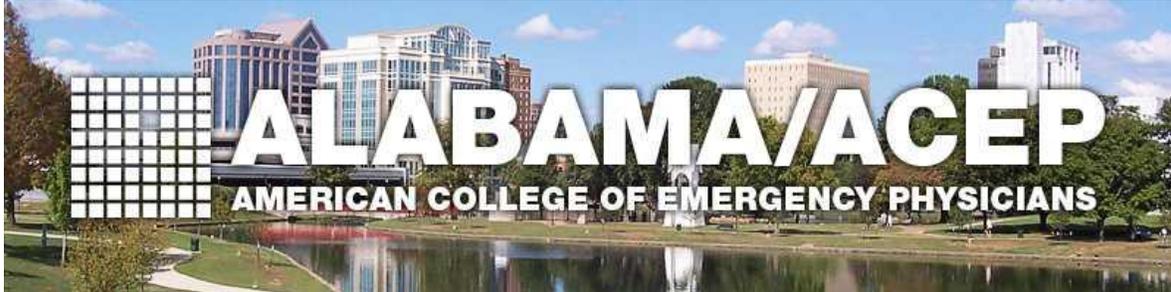


A Newsletter for the Members of the Alabama Chapter

Winter 2019



**Michael Bindon, MD, FACEP**  
**Alabama Chapter President**

[Denise Louthain](#), Executive Director  
877-225-2237 | [Website](#)

## **ALACEP President's letter** **Michael Bindon, MD, FACEP** **President, Alabama Chapter of ACEP**

I hope everyone has returned safely from ACEP's 50th Anniversary Scientific Assembly feeling refreshed and energized. Whether it is a new clinical pearl, a new life hack, or a new networking connection, we always leave these meetings fired up about the great specialty that is Emergency Medicine. Milestones such as 50th anniversaries tend to give rise to reminiscing about where we have been as well as taking stock of where we are, so let's do both.

We all know that Emergency Medicine is a young specialty. ACEP celebrated its 50th anniversary this year after being founded in 1968. Two years later, the first Emergency Medicine residency was begun in 1970 at the University of Cincinnati. One year later in 1971, the first Department of Emergency Medicine was formed at the University of Southern California. Emergency Medicine was not even officially recognized as a specialty by the American Board of Medical Specialties until 1979, less than 40 years

ago.

Though our specialty is young, we have already moved into an era of legitimacy and respect within the house of medicine. On a local scale, Emergency Medicine physicians are increasingly holding leadership roles in their hospitals serving as heads of hospital committees, boards of directors, and chiefs of staff. This trend is occurring on a national scale as well. In 2015, Dr. Steven Stack became the 170th President of the American Medical Association. At that time, he became both the first EM physician to serve as President and also the youngest physician in the history of the AMA to become President.

All of this reminiscing should bring forth some emotions. If you were part of the group of physicians that helped EM to attain its current position, then you should feel great pride in what has been accomplished so far. If you are a younger physician you should feel appreciation and gratitude to the men and women who came before you to lift EM up to where it is today.

On a personal note, I finished residency a little less than 10 years ago so I probably fall into that latter group of physicians. As such, I have an extreme appreciation for those who came before me and the battles they fought. I had the good fortune to join a group of all EM trained and boarded physicians that had been at my hospital for almost three decades. One of my partners was Dr. John McMahon who was actually one of the first two EM trained and boarded physicians in the state of Alabama. Dr. McMahon and the rest of the group I joined had firmly established a track record of providing top-notch patient care and conducting themselves with a high level of professionalism. As a result of the years of work put in by my group before I ever set foot in the hospital, I arrived and was greeted by consultants who were appreciative and collegial, administrators who were supportive and valued my input, and a nursing staff who believed in me and my skill set based on their experience with all of my senior partners. I know this wasn't always the case in Alabama ED's 30 to 40 years ago. I also know that my experience is not unique. If you are an Emergency Physician falling on the younger end of the spectrum, I encourage you to take a moment to thank one of your senior partners for the role they played in advancing EM in our state. If you are an Emergency Physician who helped lay the foundation for EM in this state, let me say thank you for all that you have done and continue to do!

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## Bougie First Intubation

### By Sean Vanlandingham, MD MBA

Working in a rural emergency department with no anesthesia or ENT back-up, I have a particular anxiety about the risk of intubating patients with predicted difficult airways. I am always on the lookout for opportunities to minimize risk in these scenarios.

Lately I have noticed a renewed love affair for the Bougie among EM airway experts. That strange little blue stick is currently en vogue, as many are recommending its use with *every intubation* and not just the difficult ones. This follows a simple logic... If you are not able to adeptly use the bougie on an easy patient, what makes you think it will be helpful to you when you try it on a difficult patient? Becoming proficient at any procedure requires repetition and practice in order to develop dexterity and fine motor skills that will be consistently reliable.

A recent article ([PMID: 29800096](#)) in JAMA tested this theory by comparing first pass success rates for bougie first intubation versus standard attempt with the endotracheal tube + stylet. It was a large prospective study with EM residents at an urban institution. The results were convincing. First pass success for the bougie-first approach versus standard approach for difficult airways was 96% versus 82%, respectively. The study also found no significant difference in the duration of intubation or incidence of hypoxia between the two groups.

That is powerful evidence. With an absolute risk reduction of 14%, bougie-first intubation has a number needed to treat of only 7. In layman's terminology, this means that you are only wasting 7 blue sticks for every one potential airway disaster you avoid.

We use Seldinger technique for nearly every other tube we place in a patient's body. Central lines, arterial lines, pneumocatheters are all advanced over a guidewire to ensure proper positioning. Even the Melker technique for cricothyrotomy has shown that airway success can be improved with use of a guidewire. So, it seems fitting that the next evolution of endotracheal intubation would involve using the bougie as a "guidewire" to improve your chances of proper positioning in the trachea.

As a resident, I remember once being scolded by an attending for over-reliance on the bougie. However, in the rural ER with no back-up, I have adopted the bougie as one of my best friends in the resuscitation bay. In conjunction with standard airway best practices such as proper positioning and adequate preoxygenation, the bougie is an

excellent best practice to ensure you provide the highest quality of emergency care in the communities who need it the most.

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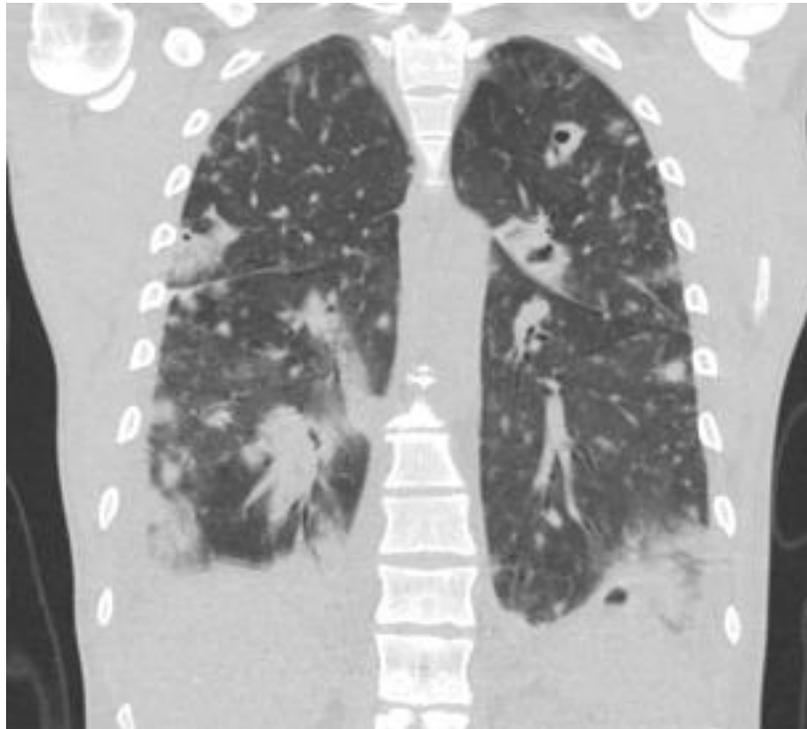
## Ultrasound Case of Interest

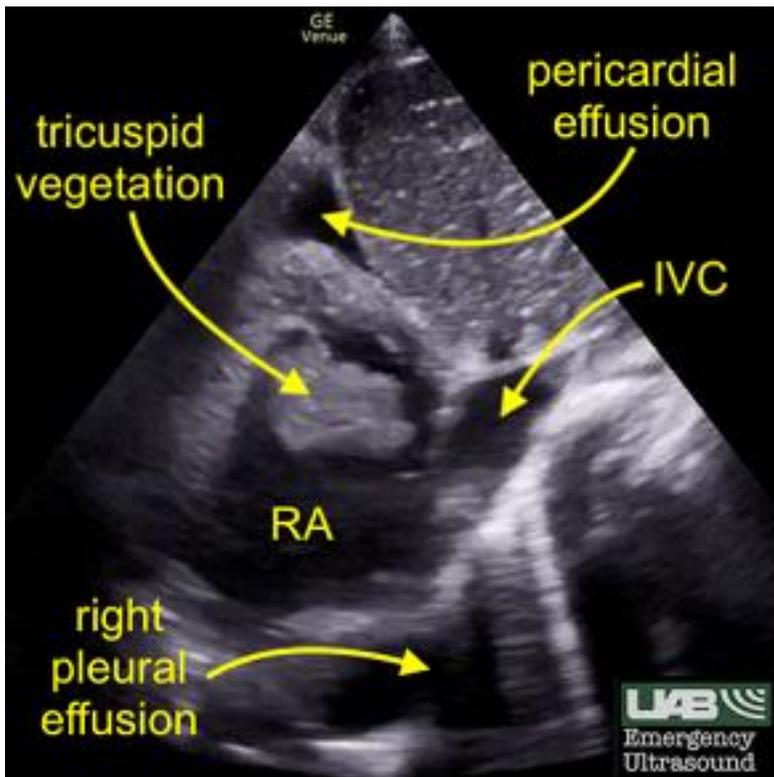
This 28M presented with 2 wks of cough productive of brown sputum, fever, fatigue and dyspnea. He was also sent in by his primary care physician due to leukocytosis and thrombocytopenia. He has also had weight loss and dark pink/maroon spots to his feet and ankles 2 days prior.

In the ED, he was initially afebrile with HR 122, later febrile to 101, RR 21, SpO2 99%, BP 93/53.

Physical exam was also notable for petechial lesions to feet and ankles as well as needle marks to L forearm.

Bedside ultrasound was performed:





Bedside echo was notable for a very large mobile vegetation on the tricuspid valve, a small pericardial effusion and right pleural effusion.

Further diagnostic data showed WBC 17k, platelets 17k, Na 120, Cr 5, LA 2.5. Hep C +, All blood culture bottles (6/6) positive for MSSA. CT Chest without contrast showed evidence of septic emboli.

The patient received V/Z and 30 ml/kg IV NS in the ED and was admitted to the MICU. Subsequent echo noted a tricuspid vegetation measuring >3 cm.

His clinical course was complicated by the need for hemodialysis, thoracentesis for bilateral pleural effusions. The patient is still hospitalized at this time.

Note: the size of the patient's vegetation puts him at increased risk for embolic events and death. In a multicenter prospective study of patients with infective endocarditis, one year mortality was ~20%. For patients with a vegetation size >15 mm, relative risk for death was 1.8, **nearly twice** the risk of patients with smaller vegetations.

Thuny F, Di Salvo G, Belliard O, et al. Risk of embolism and death in infective endocarditis: prognostic value of echocardiography: a prospective multicenter study. *Circulation*. 2005 Jul 5;112(1):69-75.

Copywrite permission has been obtained from the UAB Department of Emergency Medicine Division of Ultrasound, Dr. David C. Pigott MD Co-Director of UAB EM Emergency Ultrasound

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## Editorial

### **The Case of my Career: The Case of the Surprise Ending** **Linda B Thompson, MD, FACEP, FAAEM**

It was May of my internship (1989) when JD, an otherwise healthy 33-year old man, came to the ED with nausea, vomiting and diarrhea. It was a very busy day in the ED and it was felt that this patient had a simple gastroenteritis. He was placed in a room and IV fluids were started. Because the only room available was one of the more equipped rooms, he was automatically placed on a cardiac monitor. This move would save his life. A short time later, the monitor alarm went off and he was found to be in Torsade de

pointes. A code ensued and after defibrillation, he went back into a normal sinus rhythm. He was subsequently admitted to the cardiology service. At this point, it was felt that the gastrointestinal illness must have led to electrolyte abnormalities resulting in the abnormal cardiac rhythm. This would seem like a run-of-the-mill case.

However, it turned out to be more complex.

After 2 weeks, I was assigned to the cardiology service and JD became my patient. Within the previous 2 weeks, he had been in and out of the CCU because he would go into Torsade while in a floor bed and have to be transferred back to the CCU. The GI service had been consulted and felt the patient may have Celiac Disease and was being evaluated for this. Two additional issues developed; he developed aplastic anemia and was developing a profound generalized weakness. The significance of the weakness was not initially grasped and felt to be due to the IV Magnesium that was being used to treat the recurrent Torsade. The Hematology service had evaluated the patient and done a bone marrow biopsy. The results of the biopsy returned the first day of my cardiology rotation. The results demonstrated Myelodysplastic Disorder. The Hematology service recommended several tests to run in order to discern the etiology of this disorder. Their note was signed and then as a P.S., they stated, "Oh by the way, send a heavy metal screen."

A heavy metal screen involved obtaining a 24-hour urine sample and then processing time. As we were undertaking the hematology work up recommendations, the profound weakness became equivalent to quadraparesis. It was felt that this might be due to the IV Magnesium, so the Magnesium drip was stopped and a temporary pacer was placed.

The evening before JD was scheduled to have a permanent pacemaker placed, his heavy metal screen returned positive for arsenic. Not only was the screen positive for arsenic, but the levels were higher than any recorded in a living human being.

This find changed the course of treatment and involved a FBI investigation. The treatment involved being given BAL injections. He did not require the pacemaker.

Actually, the BAL injections lead to resolution of the recurrent Torsade and the bone marrow recuperated. He did, however, remain a quadriplegic.

HERE IS THE SURPRISE ENDING---WAIT FOR IT—

As JD was receiving the scheduled BAL injections, the FBI took hair samples (pubic hair given that arsenic is in ambient air) and was able to determine that JD was receiving the

arsenic while in the hospital. With this result, a sitter was placed with JD. His family could only be in the room with the sitter present. The family could not feed him, bring him food or be alone with him. His family included a wife, 2 children under 5 years of age, and a mother—who by the way-- was heir to JD's life insurance policy. His Torsade resolved. His Bone Marrow recovered. He remained a quadriplegic. Within a few weeks, he was transferred to an acute inpatient rehabilitation unit. One day while on this unit, the wife arrived. She asked the sitter to leave the room because she needed to have sex with her husband. The sitter would not leave, but did offer to “turn her back” to give them some privacy. At this point, the wife took a baby food jar from her purse. In the jar was a creamy substance that the wife had made from Fire Ant poison. She proceeded to take this cream, (a sensual cream as I have come to refer to it) and smear it on her breasts. She then mounted JD, and he proceeded to lick this cream off her breasts. The FBI was waiting in the corridor and was able to “catch her in the act.” She was arrested and is currently in prison. JD remains a quadriplegic –at least since I last checked on him.

#### EPILOG:

When JD's wife went before the judge, she told him that she did not want to kill JD. She was concerned that JD would be upset over the amount of money she had spent over the proceeding Christmas holiday, so she used the arsenic just to make him a little sick so he would not be able to get involved with paying bills and balancing their checkbook. She apparently started her poisoning in January by sprinkling the Fire Ant poison on his tomato sandwiches for work. Somehow, it progressed to a sensual cream.

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## Welcome New Members

Joseph Barber  
Roger Boyington, DO  
Rachel Elizabeth Brown  
Racheal Lynn Davidson  
Gustavo Samuel Garcia  
Carlos Garcia Galindo  
Leah Olson Grcevich  
Amir Khiabani  
Ellen Pappas  
Raul Humberto Rodriguez

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## NEWS FROM ACEP



### Bedside Tools

ACEP has a number of web-based tools for you to use at the bedside. From sepsis, to acute pain to agitation in the elderly – we’ve got you covered!

- [ADEPT](#) - Confusion and Agitation in the Elderly ED Patient
- [ICAR2E](#) - A tool for managing suicidal patients in the ED
- [DART](#) - A tool to guide the early recognition and treatment of sepsis and septic shock
- [MAP](#) - Managing Acute Pain in the ED
- [BEAM](#) - Bariatric Examination, Assessment, and Management in the Emergency Department. For the patient with potential complications after bariatric surgery

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### Unscheduled Procedural Sedation: A Multidisciplinary Consensus Practice Guideline

The new ACEP policy statement, *Unscheduled Procedural Sedation: A Multidisciplinary Consensus Practice Guideline*, was approved by the Board in September 2018 and has been endorsed by several other organizations. [Read the final version of the policy here.](#)

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### Social Media Policy

Make sure you're protecting yourself. ACEP has a new social media policy to help keep you and your patients safe. [Read the policy here.](#)

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## New Policy Statements, PREP and Information Paper

During their January 2019 meeting, the ACEP Board of Directors approved the following new or revised policy statements/PREP/information paper:

### New Policy Statements:

[Autonomous Self-Driving Vehicles](#)

[Reporting of Vaccine Related Adverse Events](#)

### Revised Policy Statements:

[Advertising and Publicity of Emergency Medical Care](#)

[Economic Credentialing](#)

[Emergency Physician Stewardship of Finite Resources](#)

[Medical Services Coding](#)

[Patient Information Systems](#)

[Providing Telephone Advice from the ED](#)

### Revised Policy Resource and Education Paper (PREP)

[Military Emergency Medical Services](#)

### New Information Paper:

[Suicide Contagion in Adolescents: The Role of the Emergency Department](#)

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## Articles of Interest in *Annals of Emergency Medicine* - Winter 2019

Sam Shahid, MBBS, MPH

Practice Management Manager, ACEP

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.

Shih HM, Chen YC, Chen CY, Huang FW, Chang SS, Yu SH, Wu SY, Chen WK. **Derivation and Validation of SWAP Score for Very Early Prediction of Neurological Outcome in Patients with Out-of-Hospital Cardiac Arrest.**

The aim of this study was to establish a simple and useful assessment tool for rapidly estimating the prognosis of patients with out-of-hospital cardiac arrest (OHCA) after their arrival at an emergency department (ED). A total of 852 patients admitted from January 1, 2015 to June 30, 2017 were prospectively registered and enrolled into the derivation cohort. Multivariate logistic regression on this cohort identified four independent factors associated with unfavorable outcomes: initial nonshockable rhythm, no witness of collapse, age >60 years, and pH  $\leq$ 7.00. The shockable rhythm–witness–age–pH (SWAP) score was developed and one point was assigned to each predictor. For a SWAP score of 4, the specificity was 97.14% for unfavorable outcomes in the derivation cohort. The study concluded that the SWAP score is a simple and useful predictive model that may provide information for the very early estimation of prognosis for patients with OHCA.

Chinn E, Friedman BW, Naeem F, Irizarry E, Afrifa F, Zias E, Jones MP, Pearlman S, Chertoff A, Wollowitz A, Gallagher EJ. **Randomized Trial of Intravenous Lidocaine versus Hydromorphone for Acute Abdominal Pain in the Emergency Department.**

This randomized, double blind clinical trial compared the efficacy and safety of intravenous lidocaine to that of hydromorphone for the treatment of acute abdominal pain in two emergency department (ED) in the Bronx, NY. Adults weighing 60-120 kg were randomized to receive 120 mg of IV lidocaine or 1 mg of IV hydromorphone. 30 minutes after administration of the first dose of study drug, participants were asked if they needed a second dose of the investigational medication to which they were randomized. The primary outcome was improvement in 0-10 pain scores between baseline and 90 minutes. Out of the 154 patients enrolled, 77 received lidocaine and 77 received hydromorphone and by 90 minutes, patients randomized to lidocaine improved by a mean of 3.8 points on the 0-10 scale, while those randomized to hydromorphone improved by a mean of 5.0 points. The study concluded that IV hydromorphone was superior to IV lidocaine, both for general abdominal pain and a subset with nephrolithiasis.

Ballard DW, Kuppermann N, Vinson DR, Tham E, Hoffman JM, Swietlik M, Davies SJD, Alessandrini EA, Tzimenatos L, Bajaj L, Mark DG, Offerman SR, Uli K, Chettipally UK, Paterno MD, Schaeffer MH, Richards R, Casper TC, Goldberg HS, Grundmeier RW and Dayan PS, for the Pediatric Emergency Care Applied Research Network (PECARN), Clinical Research on Emergency Services and Treatment (CREST) Network, and Partners HealthCare. **Implementation of a Clinical Decision Support System for**

### **Children with Minor Blunt Head Trauma at Non-negligible Risk for Traumatic Brain Injuries.**

This study utilized a secondary analysis of a non-randomized clinical trial with concurrent controls conducted at 5 pediatric and 8 general EDs between 11/2011 and 6/2014, enrolling patients <18 years-old with minor blunt head trauma. After a baseline period, intervention sites received electronic clinical decision support (CDS) providing patient-level cITBI risk estimates and management recommendations. The following primary outcomes in patients with 1 intermediate PECARN risk factor were compared pre- and post-CDS: (1) ED computed tomography (CT) proportion adjusting for age, time trend, and site and (2) prevalence of cITBI. The results showed that providing specific risks of cITBI via electronic CDS was associated with a modest and safe decrease in ED CT use in children at non-negligible risk of cITBI. [Full text available here.](#)

Akhlaghi N, Payandemehr P, Yaseri M, Akhlaghi AA Abdolrazaghnejad

### **A. Premedication with Midazolam or Haloperidol to Prevent Recovery Agitation in Adults Undergoing Procedural Sedation with Ketamine: A Randomized Double-Blind Clinical Trial**

This study evaluated the effect of midazolam and haloperidol premedication for reducing ketamine-induced recovery agitation in adult patients undergoing procedural sedation. They randomized emergency department patients older than 18 years who needed procedural sedation to receive one of the following three interventions in double-blind fashion 5 minutes prior to receiving ketamine 1 mg/kg IV: distilled water IV, midazolam 0.05 mg/kg IV, or haloperidol 5 mg IV. The main study outcomes were recovery agitation as assessed by the maximum observed Pittsburgh Agitation Scale (PAS), and by the Richmond Agitation-Sedation Scale (RASS) at 5, 15, and 30 minutes after ketamine administration. For the 185 patients undergoing adult procedural sedation, premedication with either midazolam 0.05 mg/kg or haloperidol 5 mg IV was shown to significantly reduce ketamine-induced recovery agitation while simultaneously delaying recovery. [Full text available here.](#)

Remick K, Gausche-Hill M, Joseph MM, Brown K, Snow SK, Wright JL, AAP Committee on Pediatric Emergency Medicine and Section on Surgery, ACEP Pediatric Emergency Medicine Committee, ENA Pediatric Committee. **Pediatric Readiness in the Emergency Department**

The American Academy of Pediatrics (AAP), the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) published updated joint guidelines, "Pediatric Readiness in the Emergency Department," that recommend ways health care providers can make sure every injured or critically ill child receives the best care possible. The joint policy statement, published in the November 2018,

represents a revision of the 2009 policy statement and highlights recent advances in pediatric emergency care that may be incorporated into all emergency departments that care for children. The statement emphasizes the importance of evidence-based guidelines and includes additional recommendations for quality improvement plans focusing on children and disaster preparedness. [Link to \*Annals\* publication.](#)

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## See Your Impact

You serve your community. ACEP is honored to serve you. Since 1968, ACEP has united and amplified the collective voice of emergency physicians across the world. We know you face challenges, and it's our mission to protect your interests and make it easier for you to provide the highest quality care for your patients. As an ACEP member, you are a direct contributor to important initiatives that propel the profession forward. Our [2018 Annual Report](#) illustrates how your support makes an incredible impact on emergency medicine.

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# embrs

## Emergency Medicine Basic Research Skills

### Are you interested in increasing and improving research in emergency medicine?

[Emergency Medicine Basic Research Skills \(EMBRs\)](#) is a 9-day, 2-session program where participants learn how to identify clinical research opportunities and become familiar with clinical research and outcomes. Participants are also eligible to receive an EMF/EMBRs grant based on their research grant application. This course targets: Junior faculty with limited research experience; Physicians in academic and community centers who are interested in research basics; Physicians who have as part of their duties involvement in research, including mentoring young researchers; Fellows in non-research fellowships.

[Click here to learn more](#) and to put your name on the interest list. The next course will take place Dec. 2-7th, 2019 (session 1) and April 14-16, 2020 (session 2).

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### MOC Made Easy

The [New ACEP MOC Center](#) is the "easy button" for MOC! It's a One-Stop-Shop to keep it all together and on track for all things MOC. See what you have to do to stay certified AND what resources ACEP has to help you do it.

ABEM has made (at least) three big changes in the way they present MOC information to diplomates – 1) they launched a new website, 2) they changed the names and order of the MOC components, and 3) they changed the language they use to describe them (no more "Part" anything). ABEM also announced an alternative to the ConCert Exam, which they'll pilot in 2020 and launch in 2021.

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**NEWS FROM THE  
AMERICAN BOARD OF  
EMERGENCY MEDICINE  
FEBRUARY 2019**



**American Board of  
Emergency Medicine**

## **Letter Available to Request Becoming ED Designated Trainer for Lab Procedures**

ABEM can provide a letter of support to ABEM-certified physicians to request that their hospital laboratory director apply for a waiver for ED point-of-care (POC) testing. If the waiver is granted, a designated trainer, who may be an emergency physician, can provide annual competency testing to other ED personnel for POC testing procedures, such as hemocult or urine pregnancy testing, etc. Waivers to allow POC testing by ED personnel help reduce the burden that emergency physicians face by having to undergo annual training by a laboratory representative as well as expedite patient throughput.

The letter and additional information about the waiver are available from physicians' Personal Page on the ABEM portal. To download the letter:

- Sign in to the [ABEM portal](#)
- On the left navigation, click "Print Verification of ABEM Status"
- Under letter type, click "POCT"
- Click "Continue to Next Step"

The letter is available to physicians participating in the ABEM MOC Program.

This is the most recent letter resulting from the continuing efforts of the Coalition to Oppose Medical Merit Badges (COMMB) and is signed by each representative of the Coalition. The rationale for the letter is that physicians participating in MOC have the knowledge, skills, and abilities to provide such training. Also available is a general letter stating that ABEM certification supersedes the need to complete "merit badge" requirements. That letter explains that ABEM's MOC Program is a rigorous form of continuous professional development that contains content critical to the practice of Emergency Medicine, including procedural sedation, cardiovascular care, airway management, trauma care, stroke management, and pediatric acute care.

Certification, therefore, supersedes the need for certifications sometimes required for medical staff privileges or disease-specific care center designations.

## ConCert Fast Facts

- The ConCert Exam is available twice per year—in the spring and the fall
- You can register and take the ConCert Exam during any examination administration in the last five years of your certification
- You do not have to complete all other MOC requirements to register early for the ConCert Exam
- Completing your MOC requirements early does **NOT** reset your certification expiration date (it will be good for the entire ten-year period)
- If you complete your requirements early, your new certificate will be sent toward the end of the final year of your current certification
- 60 *AMA PRA Category 1™ Credits* are available at no charge for passing the ConCert Exam and completing all other MOC requirements (go to [www.abem.org](http://www.abem.org), and click on “Stay Certified,” and “CME Credit Available for ABEM Activities” for more information)

If you have any questions about the ConCert Exam or other MOC requirements, please contact ABEM at 517.332.4800, ext. 383, or [moc@abem.org](mailto:moc@abem.org).

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