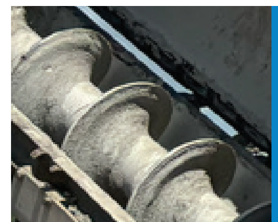
ACEP4U

Group Tasked to Look at Urgent Care Setting

SEE PAGE 6



CASE REPORT

Foot Amputation

SEE PAGE 15

CASE REPORT

The Silent Swell

SEE PAGE 15

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NOVEMBER 2024 Volume 43 Number 11

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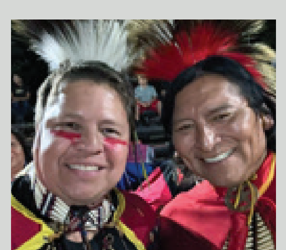

Q&A

A Chat with Native American Emergency Physicians

SEE PAGE 12

AIRWAY MANAGEMENT

Neonatal Resuscitation

SEE PAGE 13

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For more clinical stories and practice trends, plus commentary and opinion pieces, go to:
www.acepnow.com

Rhode Island Member Dr. Tony Cirillo Chosen ACEP President-Elect

Council chooses new leaders, tackles key issues at ACEP24

by NANCY CALAWAY, CAE

L. Anthony Cirillo, MD, FACEP, was chosen as ACEP's new President-Elect by the Council at its meeting in Las Vegas during ACEP24. Dr. Cirillo will serve one year as President-Elect before becoming ACEP President during ACEP25 in Salt Lake City.

Dr. Cirillo is a past Chair of the ACEP Board of Directors. He also served as the Board Liaison to the ACEP Emergency Medicine Practice Committee, as well as the Medical Directors, Cruise Ship Medicine, and Emergency Medicine Practice Management and Health Policy Sections of Membership. Additionally, Dr. Cirillo is

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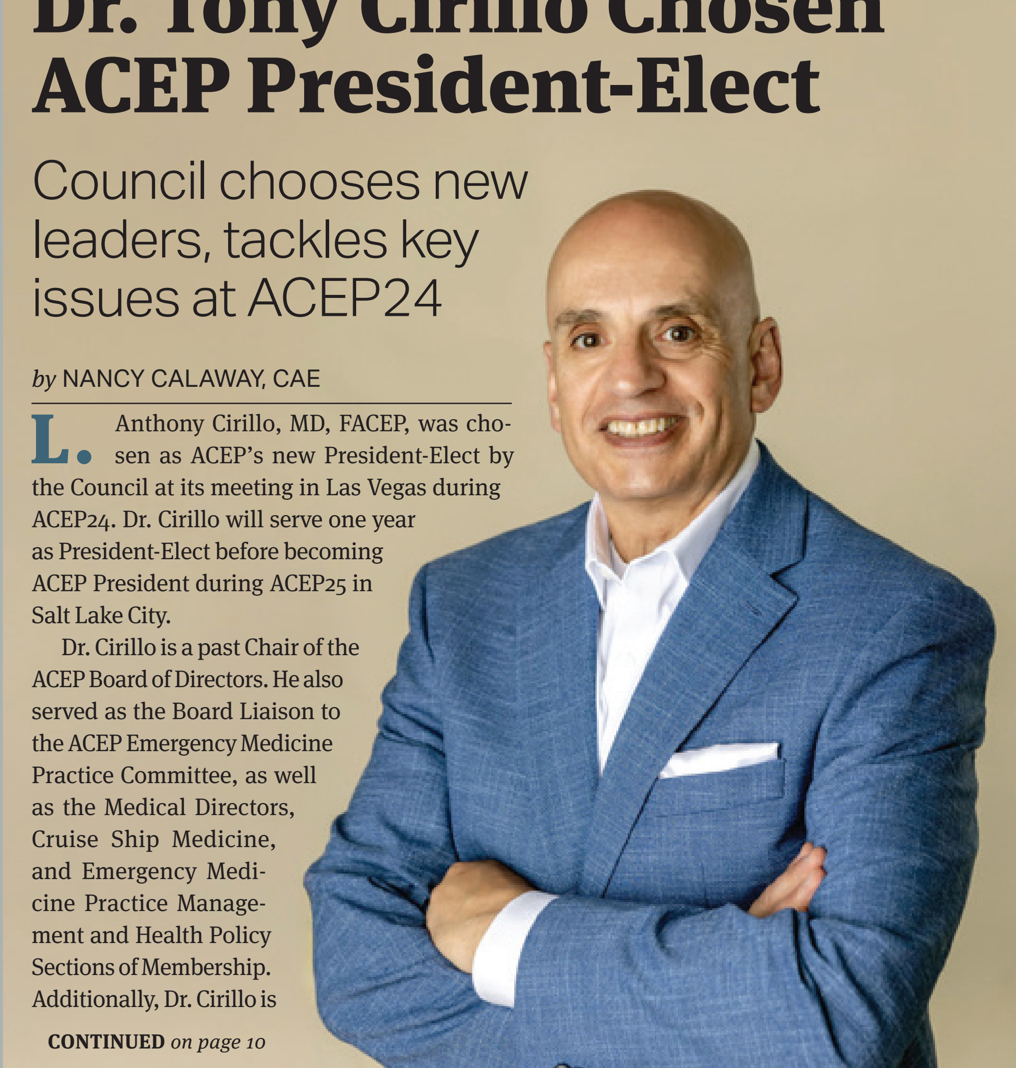
ACEP

AHRQ Summit on Boarding Made Possible by ACEP Advocacy

After years of explaining the toll of boarding on patient care and physician well-being, the message finally has landed on ears that can do something about it.

Thanks to a steady drumbeat of work from ACEP leaders and advocacy staff in Washington, D.C., the Agency for Healthcare Research and Quality (AHRQ) hosted a "Summit to Address Emergency Department Boarding" in October.

This multi-stakeholder, invitation-only event brought together emergency physicians, emergency nurses, hospital leaders, patients, and others for some tough talk about boarding, a national public health crisis.

A recording of the Summit is available on AHRQ's YouTube channel, and the agency has committed to publishing an actionable report in the coming months.

ACEP proudly uses our wide-ranging influence to work tirelessly with any stakeholder who has a role in crafting solutions to the boarding crisis. We also want to ensure that emergency physicians have a seat

CONTINUED *on page 7*

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Trouble North of the Border

PAGE 9

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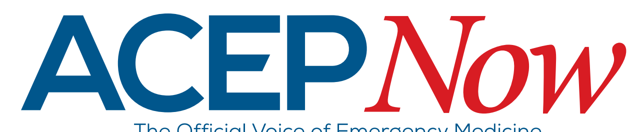

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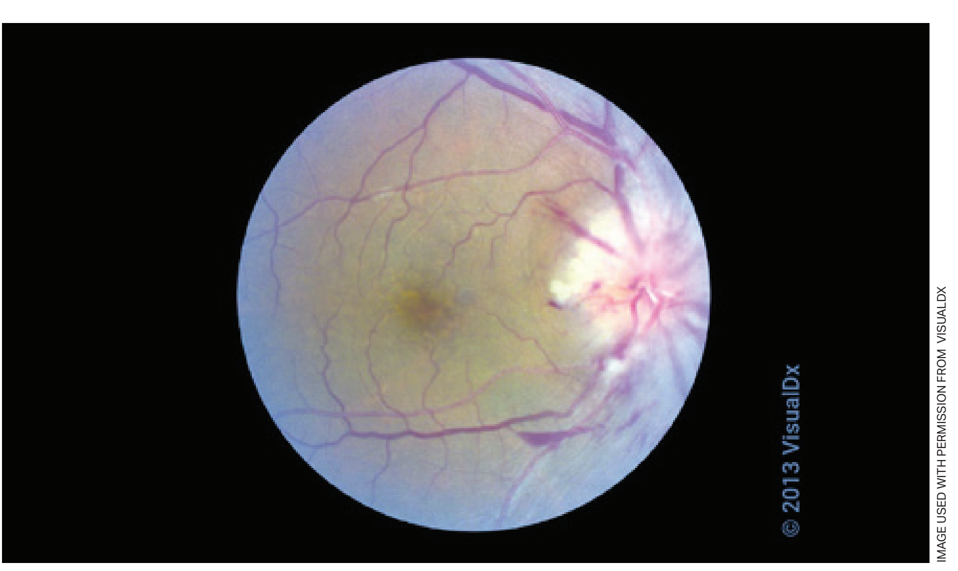

IMAGE USED WITH PERMISSION FROM VISUALDX

A 45-year-old woman presents with eye pain and vision loss. Funduscopic examination is shown.

Question: What is the diagnosis?

a. INH toxicity
b. Lyme disease
c. Methanol poisoning
d. Optic neuritis
e. Papilledema

ANSWER *on page 22*

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Inside
16 | EM CASES
17 | PEARLS FROM THE EM LIT
18 | KIDS KORNER
19 | EQUITY EQUATION
20 | AIRWAY

UPDATES AND ALERTS FROM ACEP

NEWS FROM THE COLLEGE

ACEP, Others Ask Licensure Boards, Hospitals to Support Workers' Mental Health

As part of Suicide Prevention Month in September, ACEP joined Dr. Lorna Breen Heroes Foundation and the ALL IN: Wellbeing First for Healthcare to encourage licensure board and hospitals to take action to prevent suicide in the health care workforce. Notable progress already has been made. The coalition's Wellbeing First Champion Challenge has helped 34 licensure boards and 375 hospitals verify that their licensing or credentialing applications are free from intrusive mental health questions and stigmatizing language.

"This coalition is instrumental in the vital work to preserve and protect health care workers' mental health," said Aisha Terry, MD, MPH, FACEP, Immediate Past President of ACEP. "There are still too many physicians who avoid seeking mental health care out of legitimate fear they could lose their professional license or face career setbacks due to stigma surrounding treatment. Together, we are driving critical changes to reduce barriers to mental health care and will continue to work tirelessly to ensure that those who manage our nation's health care safety net are empowered to seek the mental health care they need and deserve."

Licensure boards, hospitals, health systems, and insurance companies are encouraged to use the coalition's licensing and credentialing toolkits to audit and change (as needed) their applications, forms, and addendums to be free of intrusive mental health questions and stigmatizing language. By then verifying the applications with the coalition, they can join the ranks of Wellbeing First Champions and further safeguard the mental health and wellbeing of health workers nationwide.

The coalition agreed that, like everyone, health workers deserve the right to pursue mental health care without fear of losing their job. However, overly invasive mental health questions in licensing and credentialing applications prevent health workers from seeking support and increases the risk of suicide. Such questioning tends to be broad or stigmatizing, such as asking about past mental health care and treatment, which has no bearing on a health worker's ability to provide care and violates the Americans with Disabilities Act.

The Wellbeing First Champions for Licensing reports that:

- Twenty-nine state medical boards have been recognized as Wellbeing First Champions, representing a 16 percent increase from last year, with Oregon, South Carolina, Tennessee, and Virginia now recognized.
- For the first time, a state dental board (Texas) and four state nursing boards (Mississippi, Missouri, Nebraska, and Oklahoma) are recognized as Wellbeing First Champions.
- Additionally, in collaboration with the National Association of Boards of Pharmacy, state pharmacy boards are actively auditing and verifying their applications to be recognized in the coming year.

The Wellbeing First Champions for Credentialing reports that:

- 375 hospitals across the country have been recognized as Wellbeing First Champions, representing a 400 percent increase from last year (75 hospitals).
- Jackson and Coker Locums Tenens and Envision Healthcare also verified their internal applications and forms.
- For the first time, an insurance company (PacificSource Health Plans) is recognized as a Wellbeing First Champion.

ACEP Tells Congress It Must Fix Flawed Medicare Payment System

Medicare cuts are looming unless Congress acts. That's why ACEP and more than 100 organizations are urging Congress to provide clinicians with the financial stability needed to ensure access to high-quality care.

"Step one is ensuring that Medicare payments to clinicians in 2025 and beyond are adjusted each year with an inflationary update," the group wrote in a letter to the four highest-ranking members of the Senate and House of Representatives. "Congress must act before the end of 2024 to provide clinicians with the financial stability needed to ensure beneficiaries continue to have access to high-quality care.

The Medicare Physician Fee Schedule is the only payment system within Medicare that lacks an inflationary update. Bipartisan legislation would add a permanent inflationary update, and two additional bills have been introduced to change budget neutrality requirements. The letter points out that "clinicians continue to face ongoing financial challenges operating their practices since the

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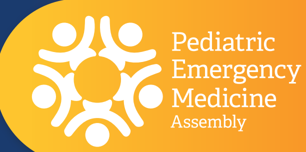
ACEP Anytime

CME FROM ACEP'S BIGGEST EVENTS



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Submit Your Abstract

Showcase your work at the premier Emergency Medicine research venue.

Abstracts Due February 28, 2025

The American College of Emergency Physicians' 2025 Research Forum is dedicated to the presentation of original research related to emergency medicine by investigators in clinical basic science.

ABSTRACT REVIEW PROCESS

Abstracts will be peer-reviewed in a blinded manner. Review criteria focus on the validity, reliability, generalization, and novelty of the findings, and the projected magnitude of impact on the quintuple aim. Notification letters will be emailed late June 2025.

ACCEPTED ABSTRACTS

The top abstracts will be presented during daily plenary sessions; others will be presented during themed oral and poster sessions.

AWARDS

Best Overall Abstract and Early Career Investigator Awards will be selected among the top scoring abstracts by the ACEP Research Committee. Selected medical student and resident presentations will be judged during a dedicated session by members of the ACEP Research Committee, with award selection based on presentation quality, research methodology, and potential clinical impact.

1. Best Overall Abstract Award
2. Best Early Career Abstract Award
3. Best Resident Abstract Award
4. Best Medial Student Abstract Award

ABSTRACT SUBMISSION REQUIREMENTS

Abstracts must meet the following submission criteria:

1. Abstracts should represent original research that has not been published in peer-reviewed form. Case reports or subject reviews are not accepted.
2. Abstract submission instructions are available on ACEP's website.
3. Abstracts must be submitted by 11:59 PM CT on February 28, 2025.
4. Abstracts must adhere to the Annals of Emergency Medicine format with following subheadings: study objectives, methods, results, and conclusion.
5. Abstracts are limited to 3000 characters not including spaces. Accepted abstracts will be published as received; no copy editing will be performed.
6. A small table or figure will be accepted. Figures must be black and white with at least 300 dpi.
7. Authors should not be identified via the title or body of the abstract.

Learn more at: acep.org/rf or call 800-798-1822 ext. 6 or 972-550-0911
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RESIDENCY SPOTLIGHT

INTEGRIS SW EM RESIDENCY

Instagram: @integris_em_res
Location: Oklahoma City, Okla.
Year founded: 2000
Number of residents: 30
Program length: 4 years

INTEGRIS RESIDENCY

The monthly journal club meeting.

What does your program offer that residents can't get anywhere else?

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What are some fun activities residents like to partake in or recently participated in?

We have multiple wellness events yearly and an emphasis on general resident wellness. We have resident retreats. Several of the residents compete in beach volleyball. Many play golf together. Multiple residents hunt and do different outdoor activities together. We had a recent journal club at Main Event, as well as different nice steak houses. An upcoming Friendsgiving journal club will be hosted at an attending's house.

How should potential applicants learn more about your program?

Complete the form online at Emergency Medicine Residency | INTEGRIS Health (integrisok.com) or contact our Residency Supervisor at Rachel.vasquez@integrishealth.org.

NEWS

CONTINUED FROM PAGE 3

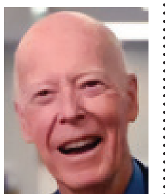
Medicare payment system has failed to keep pace with inflation. In 2025, the proposed 2.8 percent payment reduction will coincide with an expected 3.6 percent increase in medical practice cost inflation, as measured by the Medicare Economic Index. When adjusted for inflation, Medicare physician payments have decreased by 29 percent from 2001 to 2024. This is clearly not sustainable."

Please voice your support for stabilizing Medicare physician payment by visiting the ACEP Advocacy Action Center.

Remembering Dr. Stewart

Longtime ACEP member and emergency medicine pioneer Ronald Stewart passed away on October 21 after a prolonged illness. He was 82.

A 1986 winner of the prestigious James D. Mills Award for his outstanding contributions to the specialty, Dr. Stewart was widely known for his pioneering role as one of the first physician medical directors in EMS. His expertise and passion for pre-hospital care were highlighted in popular culture when he served as a medical consultant for the iconic TV show *Emergency!* The character Dr. Bracken, who worked alongside Johnny and Roy, was inspired by his work. This public recognition not only brought EMS into the spotlight but also highlighted the critical role physicians like Dr. Stewart played in shaping the future of emergency care.



Known for a lifetime of leadership in the ED, Dr. Stewart became Medical Director for the Pittsburgh EMS system, where his vision and dedication revolutionized emergency care. His influence further grew as he developed the Emergency Medicine Residency Program at the University of Pittsburgh, which would go on to train countless emergency physicians. After his time in Pittsburgh, Dr. Stewart returned to his native Nova Scotia, where his contributions continued to advance emergency medicine. As the Minister of Health for the province, he developed a comprehensive EMS system, which included groundbreaking efforts in community paramedicine.

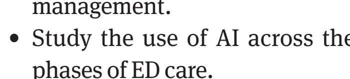
His contributions were so significant that Canada honored him with its highest civilian award, the Order of Canada Companion. His work in Nova Scotia continues to serve as a model for EMS systems. A memoir about his life, "Treat Them Where They Lie," was recently released by Nimbus Publishing Limited. Co-author Jim Meek and Dr. Stewart tell of his role in the development of modern emergency medicine.

ACEP Task Force to Look at AI

Your opinions are needed by ACEP's AI Task Force in a quick survey related to artificial intelligence in the emergency department.

The survey will help the Task Force in its objectives to:

- Explore the current landscape of AI utilization in emergency medicine.
- Determine who would benefit from AI and strategies to avoid bias.
- Propose best practices for preparing emergency physicians and their teams using AI.
- Understand the stakes of AI in emergency medicine for privacy, HIPAA compliance, and risk management.
- Study the use of AI across the phases of ED care.
- Determine best practices for responding to AI and system failures.
- Organize knowledge gained from objectives into an electronic toolkit.



BREAK ROOM

The Private Equity Wave in Health Care (September 2024)

On behalf of TeamHealth's 14,000 physicians and advanced practice clinicians who deliver exceptional care to every patient we treat, I would like to further crystalize the on-the-record comments I made before your article published on September 10 about the impact of private equity on emergency medicine.

Top among TeamHealth's values is the advancement of clinical care and uncompromised patient safety. It's why, in our more than 40-year history, we have *never* had a strategy to balance bill patients, and we *never* will. Our patient-first strategy was core to TeamHealth before the federal *No Surprises Act*. It's also why we continue to fight so ardently against insurers: to protect every patient from surprise medical bills and ensure fair reimbursement for emergency medicine clinicians.

I appeal to you and the entire American College of Emergency Physicians. The collective power of 42,000 emergency medicine physicians is immense and cannot be ignored in insurers' corporate boardrooms or the halls of Congress. We can use our voices to increase Medicare and Medicaid reimbursement, stop corporate insurers from cutting our contracts to pad their profits, and guarantee that every patient receives exceptional care in any emergency room nationwide.

Let us come together on issues that impact all practices, large and small and irrespective of ownership or affiliation, by uniting against abusive practices that will destroy emergency medicine.

We must create opportunities to thrive in an ecosystem that allows us to recruit the best and brightest to the specialty and do the best for our patients.

—Jody Crane, MD, MBA, TeamHealth Chief Medical Officer

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"Excellent. Glad I attended."

"Well worth my time and money. Very clinically relevant material."

"I have been to MANY of your courses and this was excellent as usual."

"Excellent. I really like the new format. 5 stars."

"Easily one of the highest value courses for me."

"A new experience in delivering CME which I found refreshing and engaging."

"Really like the new fomat."

"Loved the new format! Not only more interesting but more rapid fire and helped to sort out the best studies from the chaff."

"Excellent format, schedule, and material. Don't change a thing."

"Great course. Distilled so much information down to accessible amounts that can help in real practice."

"Extremely useful and well-designed course."

"Exactly what I wanted, needed, and have come to expect."

"Have been attending this course for 30 years. I really like the format change. Excellent CME opportunity."

"I totally enjoyed it. It was informative yet a relaxed atmosphere to learn in!"

"This was an impressive course. The faculty were excellent."

"Great! I am never bored. Very fast paced but exactly what we need as ER providers."

"My fourth course. Easily one of the highest value (for me) on offer."

"Fantastic - the new format was much better."

"10 out of 10."

THE YEAR IN REVIEW

Emergency Medicine & Acute Care

2025 COURSE

Wm. Kenneth Milne, MD

Roya Caloia, DO, MPH

7 Top-Rated Locations

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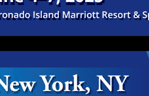
March 10–14, 2025
Wailea Beach Resort - Marriott, Maui

New Orleans, LA
April 30–May 3, 2025
New Orleans Marriott
NOLA JAZZ FEST

Hilton Head, SC
April 30–May 3, 2025
Hilton Beachfront Resort & Spa Hilton Head Island



San Diego, CA
June 4–7, 2025
Coronado Island Marriott Resort & Spa

New York, NY
June 18–21, 2025
New York Marriott Marquis

Key West, FL
December 1–5, 2025
Casa Marina Key West, Curio Collection by Hilton

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The emphasis – clinical studies published exclusively in 2024, carefully selected for their potential to impact your practice. These studies will be presented simultaneously by a pair of enthusiastic faculty.

Evidence-Based Content

This is not merely a review course, rather it is an in-depth exploration of the foremost studies published in 2024. Additionally, it features a series of concise traditional presentations and faculty panels – all designed to impact your practice.

Tag-Team Faculty Format

Two physician faculty will jointly present and critique the studies, adding their perspectives based on prior research and clinical experience. Our faculty are knowledgeable, well-versed in the medical literature, and enthusiastic about engaging with participants.

No PowerPoint Slides

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"I have been a supporter of these courses since the 1990s. That speaks for itself!"

"Awesome. Format of the literature review is a great way to challenge "the way we've always done it."

"I love that there were no slides."

"I always leave feeling that my time was well spent."

"It was fast moving which kept your interest."

"Clinically relatable and timely. Would come back again."

"Nice to have research dissected for me."

"Absolutely loved it."

"It was different from what I've experienced before but in a way was better than just sitting through PowerPoints."

"Fantastic - I would do it again."

"I liked the rapid-fire, highlights style that the course utilized."

"Excellent (once again)."

"I've been attending CME conferences for the past 36 years and this course is in my top 5."

"Excellent new format. Really current and useful. I think the standardization of presentation format really helps convey the info effectively."

"I love the new format!"

"The best course I've attended in years. The enthusiasm of the instructors was evident."

"I overall loved the new format of the course with multiple presenters taking turns presenting the topics."

"Best one yet. Like the new format. Will come again."

"Great. It was my first course done in this format without slides and focusing on studies. I liked it and learned a lot."

"I love the format, especially the quick end summary of each article at the end of each session."

"I have never attended this course before, and can say I will HIGHLY recommend this to colleagues."

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ACEP TASKS EP GROUP TO LOOK AT URGENT CARE SETTINGS

by DARRIN SCHEID, CAE

You can't pretend urgent care centers aren't here, and you can't help but notice when a board-certified emergency physician colleague goes to work for one.

What should ACEP do about it?

The first step to answering that is a mission of ACEP's newest fact-finding group, the Urgent Care Task Force, which met for the first time on Sept. 30 during ACEP24 in Las Vegas.

Created by Immediate Past President Aisha T. Terry, MD, MPH, FACEP, co-chaired by Ohio emergency physician and ACEP Past President (2008–09) Nicholas Jouriles, MD, FACEP, and California emergency physician and urgent care physician Joe Toscano, MD, and supported by current ACEP President Alison J. Haddock, MD, FACEP, the Urgent Care Task Force is a proactive step toward identifying where ACEP and emergency physicians fit in the urgent care center practice setting and how engagement might benefit members—both in and out of these facilities.

The creation of the Task Force comes at a time when urgent care centers continue to establish themselves as a growing part of the health care system.

Some say they bridge a gap between primary care physicians and emergency departments (EDs). Others say they provide substandard patient care, particularly if they lack board-certified emergency physicians as part of the staffing model.

"One of the key objectives is to figure out what is the landscape today and how it might change," said Dr. Terry, who stopped by the first Task Force meeting to provide direction. "Physicians are taking a greater role in urgent care centers, so we need to think about the skill set necessary to do that well and how it differs from our skill set that we currently have. What new skills might we need to ensure that we're prepared to do it? And I don't think we can have this conversation without some recognition of the role of nurse practitioners and physician assistants in that space, as well."

The urgent care industry has seen exponential growth in recent years.

According to the College of Urgent Care Medicine, the United States is home to approximately 14,000 urgent care centers and 27,000 practicing clinicians. The association was established in 2004 and now serves as the leading organization for the industry, representing more than 3,500 member centers and providers. This industry, though still in its relative infancy compared to EDs, has become an alternative for patients seeking immediate care for non–life-threatening conditions.

One ACEP Task Force member compared the current urgent care landscape to EDs when they were first incorporated into hospitals, setting the stage for the creation of ACEP 56 years ago.

The Task Force meeting at ACEP24 brought together 15 emergency physicians, including some who participated remotely.

The focus was to define the objectives, explore the differences between urgent care and other health care models, and establish a roadmap for the Task Force's work. A significant part of their discussion was to investigate how ACEP could provide resources for emergency physicians transitioning to urgent care settings, as well as develop an understanding of how urgent care centers are regulated and managed.

The Task Force's objectives range from analyzing the current landscape of urgent care to the creation of an Urgent Care Section of Membership for those who practice in this setting or might move in that direction. One of the key objectives is to distinguish urgent care from similar models, like freestanding EDs. Task Force members agreed that this distinction is crucial, as the two models operate differently and cater to distinct patient needs. Urgent care centers focus on providing immediate but non-emergency care, while freestanding EDs are designed to offer the full range of emergency services, albeit outside of a traditional hospital setting.

The College of Urgent Care Medicine reports more than 205 million patient visits in 2022 compared to 131 million in EDs, according to CDC statistics. The workforce in urgent care, according to the association, is primarily made up of health care professionals trained in family medicine at 45 percent. Thirty-five percent are trained in emergency medicine, eight percent in pediatrics, and three percent in internal medicine.

"We know that traditional brick-and-mortar practice and ED emergency medicine alone will likely not suffice long term," said Dr. Terry. "It's time to get the building blocks of knowledge that we need to understand this space, and then, more specifically, understand how to ideally insert ourselves into that space in a meaningful way."

The Task Force identified several challenges that need to be addressed. One key issue is the lack of standardized regulations across the urgent care industry. Unlike hospitals and EDs, which are heavily regulated, urgent care centers operate under a patchwork of state-level regulations, making it difficult to ensure consistent quality of care. Another challenge is the relationship between urgent care centers and hospitals. In some cases, hospitals may see urgent care centers as competitors, which can lead to tension and potentially hinder collaboration.

Meeting attendees also highlighted the role of private equity in urgent care operations. While private equity investments have contributed to growth of the industry, there are concerns about how this business model might affect patient care. They agreed that any urgent care initiative undertaken by ACEP must prioritize patient safety and quality of care over financial considerations.

Key action items of the Task Force include organizing a list of objectives, assigning volunteers to work on specific areas, and developing a survey to gauge ACEP member interest and participation in urgent care medicine. The Task Force will also engage with the Urgent Care Association of America (UCA) to ensure that all relevant stakeholders are involved in the process.

The Task Force's goal is to finalize its report by ACEP25 in Salt Lake City in early September.

Urgent Care Task Force Objectives

- Determine the current landscape of urgent care centers, including quantity, locations, volumes, and capabilities, as well as associated physician and non-physician provision of care.
- Make the distinction between urgent care centers, retail clinics, minute clinics, and freestanding EDs.
- Assess the current prevalence of clinical partnerships between emergency medicine and urgent care centers. Make recommendations on a future role in this space, particularly related to collaboration.
- Explore credentialing opportunities for physicians practicing in urgent care centers, including possible ABEM subspecialization, focus practice designation, or board certification.
- Describe the business and financial models of urgent care reimbursement, including the process for when a patient is transferred between an ED and an urgent care center.
- Determine what additional skills might equip and prepare emergency physicians to practice urgent care medicine that are not currently taught in emergency medicine residency.
- Identify resources currently needed by emergency physicians who primarily work in urgent care centers.
- Make recommendations for how to enhance the body of scholarly work related to urgent care practice, and how ACEP might be instrumental in such efforts.
- Generate a list of quality metrics for urgent care centers.

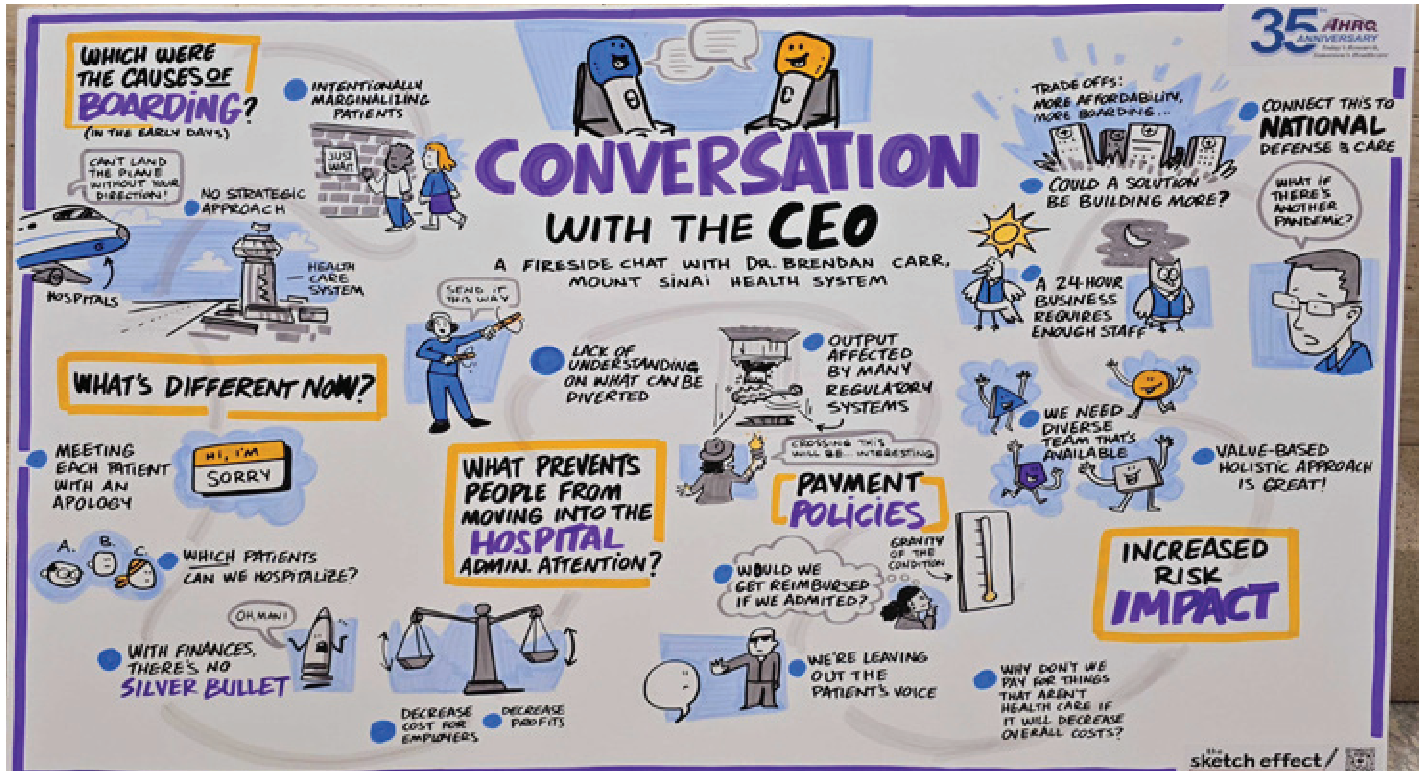
Urgent Care Task Force Survey

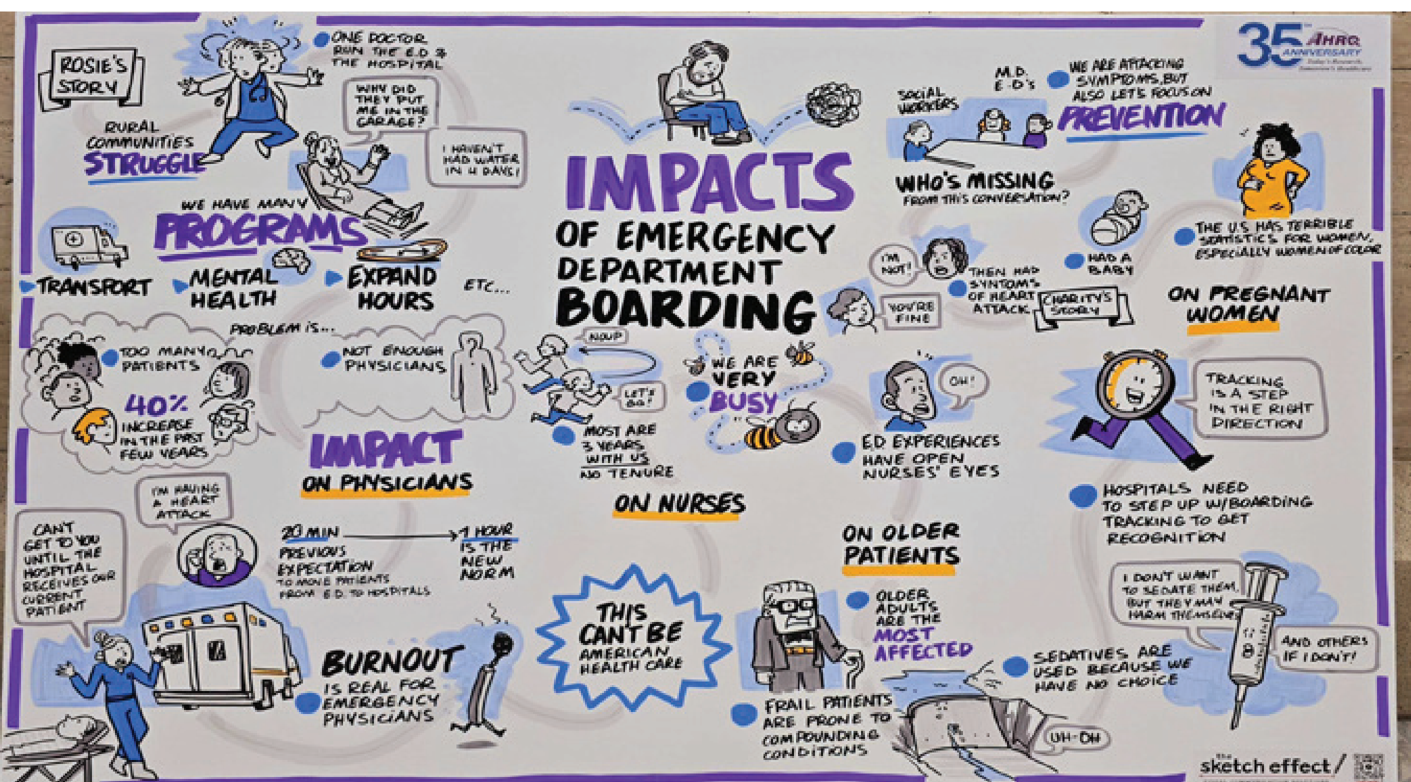
Should ACEP Develop an Urgent Care Section?

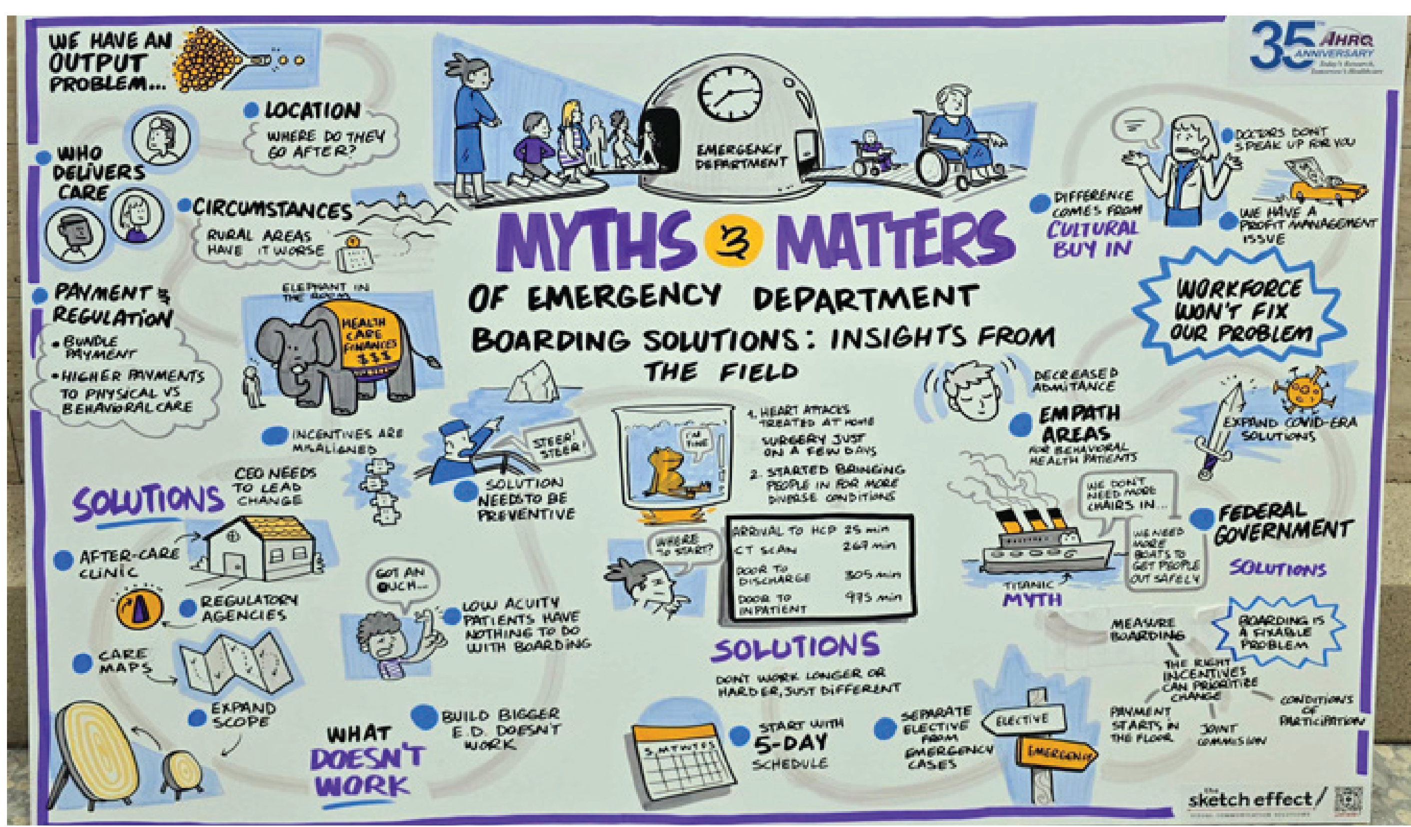
What's the main outcome you would like to see from the Urgent Care Task Force? +

MR. SCHEID is ACEP's Communications Director.

BOARDING SUMMIT | CONTINUED FROM PAGE 1







ACEP

An illustrator at the AHRQ Boarding Summit captured the conversation visually.

at the table for discussions that impact your patients and your practice.

ACEP members were well represented at the October Summit in Washington, D.C., both on the stage and in the audience. Featured speakers included:

- **Brendan Carr, MD, MA, MS, FACEP,** chief executive officer, professor and Kenneth L. Davis, MD, distinguished chair, Mount Sinai Health System, and 2024 winner of ACEP's Colin C. Rorrie, Jr., PhD Award for Excellence in Health Policy
- **Ula Hwang, MD, MPH, FACEP,** professor of emergency medicine and population health, medical director of geriatric emergency medicine, New York University Grossman School of Medicine, past member of the ACEP Geriatric Emergency Department Accreditation (GEDA) Board of Directors
- **Gabe Kelen, MD, FRCP(C), FACEP,** Chair of ACEP's Board of Directors, professor and chair, Department of Emergency Medicine, Johns Hopkins University
- **Brandon Morshedi, MD, DPT, NREMT-P, FAEMS, FACEP,** emergency medicine and EMS physician, University of Arkansas for Medical Sciences; Global Medical Response
- **Jesse M. Pines, MD, MBA, MSCE, FACEP,** chief innovation officer at US Acute Care Solutions and 2023 winner of ACEP's Colin C. Rorrie, Jr., PhD Award for Excellence in Health Policy
- **Peter Viccellio, MD, FACEP,** professor and vice chairman, Department of Emergency Medicine, associate chief medical officer, Stony Brook University Renaissance School of Medicine, ACEP Councillor

They all underscored the same message: Boarding is a public health crisis, and the best way to address the root causes is through a system-wide, collaborative effort.

Many of the physician speakers confronted misconceptions about the causes of boarding during the Summit and clarified that boarding does not occur because of non-urgent visits. "I'm sorry, I don't want to hear it. Low-acuity patients have nothing to do with boarding," Dr. Kelen said. "Build a bigger ED?" he scoffed. "You can't cure constipation by building more colon."

Dr. Viccellio discussed how hospitals can adjust the way they work. "These solutions do not require that people work harder. They require that people work differently," he said.

One way ACEP is creating a path for progress is by working with agencies to strengthen regulatory requirements for hospitals related to boarding.

"Twenty years of data associates boarding with worse outcomes," said Dr. Pines. "Boarding is a fixable problem, but the incentives aren't there to fix it. It takes leadership, time, energy, and sustainability."

You Spoke, The Government Listened

A comprehensive, multi-year advocacy campaign to address the public health crisis of boarding escalated in 2022 with an ACEP letter to the White House that outlined significant concerns about the crisis and urging the President to convene a national summit.

CONTINUED *on page 8*

ACEP

Several ACEP members spoke as part of the AHRQ Boarding Summit, including ACEP President Dr. Alison Haddock (center).

BOARDING SUMMIT

CONTINUED FROM PAGE 7

ACEP collected hundreds of your troubling stories to highlight the urgent need for solutions, and we continued to sound the alarm with regulators, policymakers, and media.

In September 2023, ACEP organized and hosted the first National Stakeholder Summit on Boarding to analyze the causes of boarding, discuss barriers to overcome these causes, and identify priority areas to pursue in creating system-wide solutions. Representatives from 15 health care organizations, including the AHRQ, attended.

And during ACEP's 2023 Leadership and Advocacy Conference (LAC), hundreds of emergency physicians mobilized and took our concerns to Capitol Hill to urge elected officials to act.

ACEP members moved the needle—our advocacy secured the signatures of 44 elected officials on a letter from Congress to the Department of Health and Human Services (HHS), doubling down on the need to convene stakeholders and identify solutions.

Just a few months later, HHS announced its plans for what ultimately became the Summit in October.

Emergency physician leadership will be a critical part of any meaningful solution to the boarding crisis, and ACEP is making sure your voice continues to be heard.

"This community is not a bunch of emergency physicians pounding their fists on the table," Dr. Carr said at the Summit. "These are folks that can see the failed social policy and the chinks in the armor of the health care system and can help you (AHRQ) to find not a magical silver bullet—there is not one—but a matrixed number of incentives and structural changes and transparency that can get us to a place where we have a health care system that we are proud of." ⊕

How Did We Get Here? ACEP's Role

ACEP played an extensive role in bringing stakeholders together for the AHRQ "Summit to Address Emergency Department Boarding." Here's a recap of ACEP's work:

- ACEP started a comprehensive multiyear advocacy campaign to address this public health crisis in 2022 with a letter to the White House urging the President to convene a national, multi-stakeholder summit.
- The College collected hundreds of your troubling stories, keeping the pressure on as we mobilized Congress to amplify our request during ACEP's 2023 Leadership and Advocacy Conference (LAC).
- During LAC 2023, hundreds of emergency physicians went to Capitol Hill to urge elected officials to prompt action from the Department of Health and Human Services (HHS). ACEP members moved the needle. Our advocacy secured the signatures of more than 40 elected officials on a letter from Congress to HHS, doubling down on the urgent need to convene stakeholders and identify solutions. ⊕

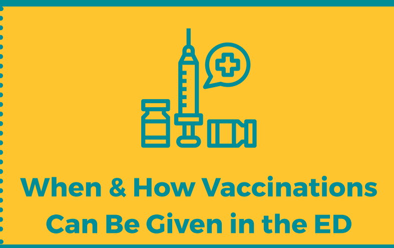
YOU CAN HELP CHILDREN CATCH UP ON THEIR VACCINATIONS & STAY HEALTHY

About 60% of children are behind in their routine vaccine schedule.

The ACEP Pediatric Emergency Department Vaccination Toolkit provides:

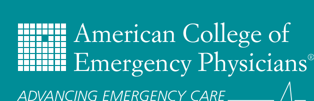
Ways to Identify Pediatric Vaccination Status

Best Practices to Encourage Vaccinations



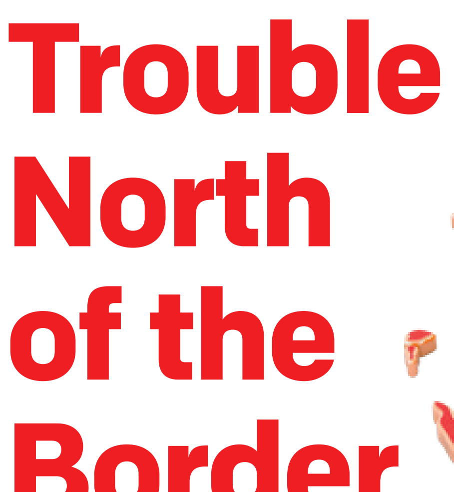
When & How Vaccinations Can Be Given in the ED

You can also find: Point of Care tools, Online Courses and More!



acep.org/vac

Vaccination grant: This project was funded in part by a cooperative agreement with the Centers for Disease Control and Prevention (grant number NU50CK000570). The Centers for Disease Control and Prevention is an agency within the Department of Health and Human Services (HHS). The contents of this resource center do not necessarily represent the policy of CDC or HHS and should not be considered an endorsement by the Federal Government.



Trouble North of the Border

ALEXLMX - STOCK.ADOBE.COM

ED closures plague Canada's emergency medical care

by LARRY BERESFORD

Across Canada, under a number of provincial health systems, a spate of closures of emergency departments (EDs)—whether for hours at a time, a day, several days, or indefinitely—raises serious questions about how the health care system is coping with an existential crisis and what can be done about it. Largely, but not exclusively, in hospitals serving small towns and remote rural communities, these closures sometimes get announced with a handwritten sign taped to the hospital's door, leaving patients and families who show up with emergencies to drive to the closest alternative facility.

Canadian EDs face many of the same overcrowding issues seen in the U.S. and other countries: long wait times and treatment delays; patients in need of emergency care piling up in waiting rooms; others boarding for days in ER bays—or hallways—often because there's no bed available upstairs; ambulances "ramping" in the parking lot, unable to unload patients or respond to other emergencies in their communities. But closing the ED entirely, even just for a day, as has happened thousands of times in Canada in recent years, reflects a serious breakdown of the system.

Canadian emergency medicine advocates say the problem has been brewing for a long time, with warning signs that went largely unheeded by the provincial health authorities responsible for planning and budgeting health services in Canada. Then the COVID-19 pandemic hit, making everything worse.

"It's a long-standing human resource problem that is now manifesting in what we could consider the most extreme form, which is ED closures in rural and remote areas of Canada, but also now in more suburban regions," said Catherine Varner, MD, an emergency physician in Toronto and deputy editor of the *Canadian Medical Association Journal*.[1]

Dr. Varner sees a confluence of issues coming to a head, presenting big challenges going forward. "We in emergency medicine on the ground are seeing the increasing complexity of our patient populations as they age," she said. Canada also has a large and growing number of patients who lack a primary care physician and thus look to the ED for their primary care.

"What's been surprising, both to people who work in health care, but also to the public, is that we're seeing these closures more frequently, in higher numbers, in all regions across Canada," she said. "Rural hospitals are saying, 'We don't have anybody to work tomorrow. We don't have the professionals to provide the emergency care.'"

What's Going On?

Examples of this epidemic of Canadian ED closures are not hard to find. Manitoba's rural EDs collectively closed for 80,000 hours in 2023, four of them indefinitely.[2] In that same year, Ontario reported 1,200 closures of hospital EDs and other departments due to staff shortages. The Ontario Health Coalition of community grassroots organizations has been working to mobilize physicians willing to travel to different sites in need.

In British Columbia, CTV News reported on June 6, some hospitals are offering qualified doctors bonuses of hundreds of dollars, up to $4,000—per shift—to pick up some extra ED shifts in hospitals that need it.[3] Northern British Columbia has been hit by ED service disruptions again this summer, prompting public rallies calling attention to the closures.[4]

A Domino Effect?

Ken Milne, MD, MSc, CCFP-EM, is a staff physician at Strathroy Middlesex General Hospital in Strathroy, Ontario, and the creator of a podcast called "The Skeptics' Guide to Emergency Medicine." He said every Canadian deserves timely and appropriate access to emergency medicine, but the system is not currently meeting that need.

"In Canada, most of our country is rural, and the ED closures are almost always in rural areas," Dr. Milne explained. If staff call in sick, there's no one to replace them. "But the closure of an ED can impact surrounding facilities, with their own fixed number of staff, turning into a domino effect and making it harder for people with emergency needs to get the help they need."

In addition, he said, physicians are getting older and withdrawing from night work and high-intensity shifts. Meanwhile, medicine has gotten more complex for general practitioners, and patients' expectations have also changed. "So how do we micro-allocate scarce resources? You'll always have a challenge in rural areas. But people coming into the field now rightly want a team-based work environment where they can also have a life away from work."

Emergency medicine is a heterogenous specialty in Canada. Some emergency physicians are board-certified after completing a five-year emergency medicine residency. Others do a one-year emergency medicine fellowship following family medicine training. And some family physicians in rural settings serve as generalists, combining clinic work, hospital wards, and ED shifts, possibly also doing anesthesiology and visiting patients in long-term care facilities. They may seek additional training in advanced trauma life support, advanced cardiac life support, pediatric advanced life support, and neonatal resuscitation, along with self-directed learning.

"I've been doing this work for 30 years," Dr. Milne said. "I love rural medicine. I was raised on a farm. I've worked in 30 rural Ontario hospitals via Health Force Ontario. I also love practicing up to the limit of my skill set," he said. "But the job certainly has changed. People are living longer, and medicine is much more complex. It's getting harder to stay up to date on all the advances."

What Are the Answers?

One solution to chronic staff shortages, Dr. Milne said, is to grow your own—drawing on people born and raised in the community. That involves decentralized training, ideally combining nurses and physicians together, and placing doctors-in-training back in their home communities. Northern Ontario School of Medicine University and the Centre for Rural Health Studies at Memorial University of Newfoundland have both developed programs aiming to entice more doctors to choose rural careers by exposing them to rural medical practice.

Other efforts have included provincial locums programs in Ontario and British Columbia to connect physicians with departments in need; the growing availability of on-demand virtual clinical support from remote physicians; and the greater use of nurse practitioners, physician assistants, and community paramedics in the ED. The Canadian Association of Emergency Physicians (CAEP)'s EM-POWER, a comprehensive task force report on the future of emergency care in Canada issued in March, proposes a roadmap to a redesigned, integrated framework for emergency care.[5]

A regionalization strategy for utilizing scarce rural emergency services, which has been explored by CAEP as well as by groups in Nova Scotia and Alberta, could link facilities and services in a more systematic way, pooling the resources of several rural hospitals located not too far from each other and struggling to stay open. Depending on driving distances, they could designate one as the center of excellence in emergency medicine for the region, said Alan Drummond, MD, a family physician who has practiced emergency medicine in Perth, Ontario (population: 6,000) for 40 years.

Dr. Drummond has been president and public affairs committee chair for CAEP, actively involved in provincial and national politics, and a widely published and outspoken voice trying to bring attention to this brewing crisis in Canadian emergency medicine. A decade ago, CAEP put out a position paper predicting a shortage of 1,500 emergency physicians in Canada by 2025, "if we didn't start planning for the near future, which is now on us," he said.[6] In Canadian politics, health care is a vote loser. "So, the alternative is keep doing what we're doing now, which is precisely nothing," he said.

"When I started this work, my vision for myself and my country was that every Canadian would not just have access to emergency medical care, but quality access. I dedicated 34 years of my life to that goal," Dr. Drummond said. "Let's declare this to be the crisis it is. Let's admit the obvious threat to services for millions of Canadians."

The system has particularly failed to nurture its emergency medicine nurse colleagues, Dr. Drummond added. "We tell them to shut up and work, never paying a dime more than necessary, not treating emergency nursing as a specialty. If they get punched by a patient, we say: 'What did you do to deserve it?'" Historical wrongs like this have permeated nursing, he said, and then along came COVID-19. Nurses, realizing that they were just cogs in the wheel, said they were done with it and found other jobs. But Dr. Drummond believes they might come back if they sensed that their working conditions would be improved, because practicing emergency medicine can get in your blood.

LARRY BERESFORD is a freelance medical journalist based in Oakland, Calif., with a specialty in hospice and palliative care and thorough experience covering hospital medicine.

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CONTINUED FROM PAGE 1

a Past Chair of ACEP's Federal Government Affairs, State Legislative/Regulatory, and Membership Committees.

Dr. Cirillo previously served on the National Emergency Medicine PAC (NEMPAC) Board of Trustees. He is an ACEP representative on the ACEP/EDPMA Surprise Medical Billing Implementation Task Force Steering Committee.

In 2018, Dr. Cirillo received ACEP's Colin C. Rorrie, Jr., PhD Award for Excellence in Health Policy. He earned his medical degree at the University of Vermont College of Medicine in Burlington, Vt., and completed his residency in emergency medicine at UMASS Medical Center in Worcester, Mass.

Currently, Dr. Cirillo is the director of government affairs for US Acute Care Solutions and practices clinically in Advent Health system emergency departments in Colorado.

At the meeting, ACEP's Council also elected four members to the ACEP Board of Directors: Jennifer J. Casaletto, MD, FACEP, of North Carolina; C. Ryan Keay, MD, FACEP, of Washington; Heidi C. Knowles, MD, FACEP, (incumbent) of Texas; and Diana B. Nordlund, DO, JD, FACEP, of Michigan.

Nominated candidates are presented to the ACEP Council, a deliberative body made up of members representing ACEP's 53 chartered chapters, its 39 Sections of Membership, the Association of Academic Chairs of Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors (CORD), the Emergency Medicine Residents' Association (EMRA), and the Society for Academic Emergency Medicine (SAEM).

Each Chapter is represented by at least one councillor, and an additional councillor is allowed for each 100 members in the Chapter. Sections and other component bodies each have one voting councillor, except for EMRA, which has eight voting councillors. Each Chapter has its own process for how it elects or appoints its councillors.

Each year, the Council selects the ACEP President-Elect and members to the Board of Directors. Every other year, the Council elects the Council Speaker and Vice Speaker. Election by the Council ensures grassroots involvement in the democratic decision-making process of the College.

Alison J. Haddock, MD, FACEP, also began her ACEP presidency at the Council Meeting with an outline of her vision for the year, focusing on physician autonomy.

On the last day of ACEP24, ACEP's Board of Directors elected its new officers for 2024-25. Gabe Kelen, MD, FRCP(C), FACEP, is the Chair of the Board and Heidi C. Knowles, MD, FACEP, is the Secretary/Treasurer. Jeffrey M. Goodloe, MD, FACEP, is the Vice President–Communications and Kristin McCabe-Kline, MD, FACEP, is the Vice President–Membership.

PHOTOS: ACEP

Vegas a Winner for ACEP24

ACEP24 drew the largest attendance for an ACEP annual meeting in the post-COVID era. There were more than 8,300 physician, resident, medical student, nurse practitioner, physician assistant and other health care professionals in attendance, of which more than 6,100 were full four-day registrants. It is also estimated there were about 2,000 exhibitors at the Mandalay Bay Convention Center.

ACEP25 was originally planned for Dallas, but downtown convention center construction has forced ACEP to find a different city. Enter an exciting, lively locale and new, earlier timing.

Save the date and start making your plans now—**ACEP25 will be Sept. 7–10 in Salt Lake City!** Join the interest list today and book your hotel room (they are already going fast!) at acep.org/acep25.

Leadership Award Recipients Recognized

This year's recipients of the Leadership Awards, the College's most prestigious awards, were recognized during ACEP24, with video tributes and signage throughout the event:

- John G. Wiegenstein Leadership Award: **Debra G. Perina, MD, FACEP**
- James D. Mills Outstanding Contribution to Emergency Medicine Award: **Earl J. Reisdorff, MD, FACEP**
- John A. Rupke Legacy Award: **W. "Chip" Pettigrew, III, MD, FACEP**
- Pamela P. Bensen Trailblazer Award: **Arjun K. Venkatesh, MD, MBA, MHS, FACEP**
- Judith E. Tintinalli Award for Outstanding Contribution in Education: **Susan B. Promes, MD, MBA, FACEP**
- Award for Outstanding Contribution in Research: **Robert M. Rodriguez, MD**
- Outstanding Contribution in EMS Award: **Sabina A. Braithwaite, MD, MPH, FACEP, FAEMS**
- Colin C. Rorrie, Jr., PhD Award for Excellence in Health Policy: **Brendan G. Carr, MD, MA, MS, FACEP**
- Council Meritorious Service Award: **Thomas J. Sugarman, MD, FACEP**
- Policy Pioneer Award: **Michelle P. Lin, MD, MPH, MS, FACEP**
- Honorary Membership Award: **David A. McKenzie; Rick Murray, EMT-P, FAEMS;** and **James H. Slaughter, JD**
- Diane K. Bollman Chapter Advocate Award: **Tara Morrison, CAE, CMP**

There were also Council Awards, Section Awards, Faculty Teaching Awards, Junior Faculty Teaching Awards, and Excellence in Bedside Teaching Awards recognized during ACEP24, along with the new class of FACEPs, the prestigious Fellow designation in 2024.

See all the award recipients and their video tributes at acep.org/2024awards.

ACEP Council Tackles Key Issues During Las Vegas Meeting

The ACEP Council considered 70 resolutions during its meeting in Las Vegas, Sept 27–28, with many of them drawing considerable debate before 55 were ultimately adopted.

As the College's representative governing body, the Council meets annually to discuss and consider resolutions on issues impacting emergency physicians. Any member can submit a resolution if it is supported by at least one other ACEP member. If adopted by the Council and approved by a majority of the Board of Directors, the resolutions become official ACEP policy.

Of the resolutions considered, 55 were adopted, six were not adopted, one withdrawn, and nine referred to the Board of Directors. In addition to seven commendation resolutions and 11 memorial resolutions, the following resolutions were adopted:

Bylaws Resolutions

(Requires a two-thirds affirmative vote of the Board of Directors for adoption)

- 13 - Allocation of Councillors – Bylaws Amendment (as amended)
- 14 - College Parliamentary Authority – Bylaws Amendment (as amended)
- 16 - International Members Serving as Section Officers – Bylaws Amendment
- 17 - Removing Gendered Pronouns from ACEP's Bylaws – Bylaws Amendment

Non-Bylaws Resolutions

- 15 - College Parliamentary Authority - Council Standing Rules Amendment
- 22 - Support for the "Well Workplace" Policy Statement (first resolved statement)
- 24 - Address ED Boarding and the Medicare Three-Midnight Rule for Post-Acute Rehabilitation

OPPOSITE PAGE TOP: Newly elected ACEP Board members (L-R): Drs. Heidi Knowles (incumbent, Texas); Diana Nordlund (Michigan); Jennifer Casaletto (North Carolina), and Ryan Keay (Washington).

OPPOSITE PAGE BOTTOM LEFT: ACEP24 had the largest number of attendees in years, with a reimagined Exhibit Hall and lots of networking opportunities.

OPPOSITE PAGE BOTTOM RIGHT: Next year, ACEP25 will take place in Salt Lake City and will be earlier than usual—Sept. 7-10, 2025.

ABOVE: The ACEP Council meets each year to vote on how the College should address issues impacting emergency physicians and elect ACEP's leaders.

RIGHT: ACEP President Dr. Alison Haddock receives the gavel from Immediate Past President Dr. Aisha Terry.

PHOTOS: ACEP

- 25 - Boarding – Follow the Money
- 26 - Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events (as amended)
- 29 - Minimum Standards for Freestanding Emergency Departments (as substituted)
- 30 - Hospital Network Requirements for Emergency Physicians
- 32 - Preventing Harmful Health Care Deals (as amended)
- 33 - Promotion of Nursing in Emergency Medicine (as amended)
- 34 - Reimbursement for Emergency Physician Services Provided Out-of-Hospital
- 35 - Sharing of Protected Health Information
- 36 - Reform to Improve Patient Access to Necessary Care (as amended)
- 37 - Reinforcing EMTALA in Pregnan cy Related Emergency Medical Care
- 38 - Termination of Pregnancy (as substituted)
- 39 - Urgent Care Transparency on Available Resources and Credentials
- 41 - Workplace Violence (in lieu of resolutions 41 and 42 – as amended)
- 43 - Addressing Challenges Related to the New ABEM Oral Board Exam Format (as substituted ... resolved statements 2, 3, 4)
- 44 - Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations (as amended)
- 45 - Climate Change Research and Education in Emergency Medicine (as amended)
- 46 - Human Trafficking Training for All Emergency Medicine Residents (as amended)
- 47 - Human Trafficking is a Public Health Crisis (as amended)
- 48 - Alarm Fatigue (as amended)
- 49 - Centralized Repository of Credentialing Data (as amended)
- 50 - Communication to Established Patients Being Referred to the Emergency Department (as amended)
- 54 - Mandated Public Health Screening (as amended)
- 56 - Patient and Visitor Code of Conduct (as amended)
- 57 - Rationalizing Communication of Imaging Hazards to Improve Care (as amended)
- 58 - Reducing Waste in Our Emergency Departments (as amended)
- 59 - Tap Water is Sufficient
- 60 - Lethal Means Firearm Counseling (as amended)
- 61 - Safe Storage of Firearms (as amended)
- 62 - Stop the Bleed Education (as substituted)
- 70 - Reaffirming EMRA's Vital Relationship with ACEP

Interested in the work that happens after a resolution is approved? Visit acep.org/council to view actions taken on recent resolutions and track their progress.

MS. CALAWAY is ACEP's Senior Director of Communications.

Timely Council Resolution Encourages Using Tap Water for Wound Irrigation

by DARRIN SCHEID, CAE

One resolution adopted by the ACEP Council this year was particularly well-timed. As members in the southeastern states were faced with Hurricanes Helene and Milton during and after ACEP24, the Council approved a resolution for the College to advocate for the use of hospital tap water for wound irrigation.

Resolution 59 calls for health care professionals to:

- emphasize the importance of research and education within the emergency medicine community on the safety, efficacy, and potential cost savings of using hospital tap water for wound irrigation.
- urge U.S. policymakers and health care administrators to support initiatives, such as the use of hospital tap water for wound irrigation, that contribute to broader global efforts to enhance environmental sustainability and combat climate change in health care by decreasing the carbon footprint of emergency departments.

In the wake of Hurricane Helene, the Baxter International factory in North Carolina was flooded and shut down, preventing development and distribution of intravenous fluids around the country. The facility is one of the largest suppliers of IV fluids, the Food and Drug Administration has said. And at the time of this article going to press, Baxter still did not have a timeline for when the factory would be back up and running.

The American Society of Health-System Pharmacists (ASHP) issued a drug shortage alert for 0.9 percent sodium chloride irrigation on Oct. 4. ACEP and many hospitals nationwide were encouraging physicians to help conserve the supply, and establish protocols for reserving IV fluids for the most necessary use cases. Using tap water for wound irrigation was a common recommendation.

Resolution 59 pointed out that determining the efficacy of tap water compared to sterile saline in the United States would result in potential cost savings as 12.2 to 14.1 million people present to the ED for wound management. Assuming each one uses one bottle for irrigation, that would be 12.2 to 14.1 million bottles of plastic saved each year.

According to the background information provided with the Resolution, endorsing the use of tap water in the United States, instead of sterile saline solutions, can contribute to significant cost savings, reduce the carbon footprint of emergency departments, and advance efforts to mitigate climate change, all while maintaining high standards of patient care.

Several studies have endeavored to compare the use of tap water versus normal saline for wound cleansing. A 2021 *Cochrane Review* by Fernandez, et al., included 13 randomized controlled trials that compared wound cleansing with tap water, distilled water, cooled boiled water, or saline with each other or with no cleansing on wound infection, wound healing, reduction in wound size, rate of wound healing, costs, pain, and patient satisfaction.

For all wounds, eight trials found the effect of cleansing with tap water compared with normal saline was uncertain: very low-certainty evidence. Regarding cost, two trials examined in the systematic review reported cost analyses, but the cost-effectiveness of tap water compared with the use of normal saline was uncertain: very low-certainty evidence. A relevant paper published after the *Cochrane Review* is a literature review by Monika Holman published in the *Journal of Wound Care*.

Of the seven studies included in the literature review, six studies demonstrated that use of tap water had no significant influence on wound infection rates when compared to normal saline; one study demonstrated that tap water did not increase wound contamination; and four studies established that tap water was cost-effective compared to normal saline.

MR. SCHEID is ACEP's Communications Director.

A Chat with Native American Emergency Physicians

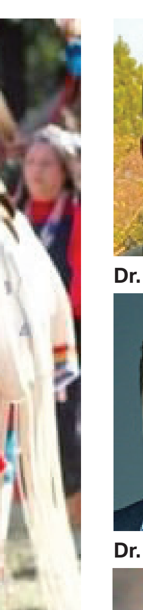
In honor of Native American heritage month

by ACEP NOW

Native American emergency physicians make up 0.1 percent of physicians in U.S. emergency departments, according to research published in 2020 in *Annals of Emergency Medicine*. Three Native American emergency physicians in Oklahoma—three of five in the state—discussed with *ACEP Now* their approach to health care and how their careers in medicine began. Brent O. Hale, MD, (Creek), Oklahoma ACEP President James R. Kennedye, MD, MPH, FACEP, (Kiowa), and Brandon Postoak, DO, (Chickasaw), also talked about how they recognize Native American Heritage Month each November.

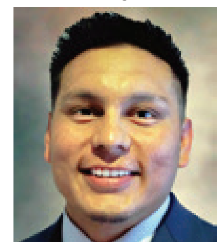
KJ'S FLASHED AND PHOTOGRAPHY

Jennifer Turner (left), Welana Queton, and Ivy Kennedye, the 8-year-old daughter of Oklahoma ACEP Chapter President James Kennedye, are shown at the 2024 Kiowa Black Leggings (Ton Kon Gyat) Ceremonial on Oct. 12–13 in Anadarko, Okla. More than 200 years old, this event honors those who currently serve or have served in the military.



Dr. Hale

Dr. Kennedye



Dr. Postoak

***ACEP Now:* What got you into medicine and why emergency medicine?**

DR. POSTOAK: I didn't always know I was going to go into medicine. I'm a little nontraditional. I didn't get into medical school until I was about 25. Before that, I wasn't sure what I wanted to do. I had a lot of different experiences before finally getting into science. Once I started learning about medicine, things fell into place, and I realized it was my path. You know, growing up, I didn't see many Native doctors, so I didn't think it was something I could do. But when I looked back at my family history, I saw we had a lot of medicine men and women, so it was kind of in my blood. Pursuing medicine felt like it was the right thing to do.

It's an honor to come back and serve my community, but even now, my direction in medicine keeps evolving every six months or so. I think that's part of the journey.

DR. HALE: I was nontraditional, too. I didn't go to med school until I was 30. I grew up in Okmulgee, on the Muskogee reservation. Like Brandon, I didn't know what I was going to do for a long time. I tried a lot of different things—served in the Army, worked as a cook. I got married young and had kids, so I had responsibilities. I finally realized that if I was going to do something meaningful with my life, I needed to take a big step. I always knew I was good at math, but I didn't know how to apply that skill until I saw an article in the *Kansas City Star* about an ER physician's weekend. It was written like a diary, detailing what he did during a weekend shift: codes, traumas, you name it. I thought, "That's what I want to do."

I quit my job, went to KU for undergrad, and then went to med school. I did my residency in the ER program at OU. From the beginning, I knew I wanted to be an ER physician. But, like Brandon, there weren't many Native American doctors to look up to. We had one: Don Bowen, a Muskogee physician who worked for the tribe. I always admired him. He passed away when I was young, but he left a big impact on me. When I graduated from medical school, we honored him by giving his widow and daughter a beaded belt. It was our way of saying thank you for the example he set.

Editor's Note:* *Adoniram (Don) Van Bowen, MD, was the first American Indian doctor to gradate from Harvard Medical School.

DR. KENNEDYE: Like a lot of Native kids, I didn't have doctors or other professionals in my family to look up to. In my tribe, the Kiowa, we didn't start sending people to college until the 1920s, and our first doctor didn't come until the 1950s. By the 1970s, there were only a handful of college graduates. That's a big difference from other groups that have generations of professionals to encourage them. Growing up without those role models, it's easy for Native kids to feel lost, especially in reservation or rural areas where poverty and other issues are prevalent.

I didn't grow up on a reservation, but I did grow up in a poor area, and my parents didn't go to college. I was good at math and science, but I didn't think I was "doctor smart." I wanted to be a Navy pilot at first, but life happened. I had a kid, and my plans changed. I joined the Navy. It took me two years into college before I realized I wanted to be a doctor. I had a mentor from my tribe, Dr. Everett Rhodes, the first Native American director of the Indian Health Service. He helped me learn about pioneers like Charles Eastman, the first male Native American physician, and he gave me the confidence to pursue medicine.

***ACEP Now:* Native Americans were the first to practice healing arts in America, yet they make up just 0.4 percent of physicians and 0.1 percent of emergency physicians. Does it surprise you that the number is so low?**

DR. HALE: It's extremely low, but it doesn't surprise me. All three of us have the same story. There was nobody around to show us the way, maybe one person if we were lucky. I know most of the Native ER doctors in the country because there are so few of us. We're just such a small population to begin with, so it makes sense that there aren't many Native physicians.

***ACEP Now:* When it comes to patient care, what do you take from your heritage into the emergency department?**

DR. POSTOAK: I think back to when I was younger. My grandma and great grandma would take herbs or jars from the back of the house when someone was sick. They'd not only give medicine, but also sit down and talk, trying to figure out what was really going on. That's something I try to carry into the ER—looking beyond just the immediate complaint and seeing the whole person. A lot of times, especially for Native patients, the ER is their primary care because they can't access other services. We're not always the best fit for those issues, but we do our best to help, to figure out what's really going on. It's tough when you see your own people come in. Some are homeless or dealing with addiction, and it hurts to hear their stories. It's a blessing to be able to treat them, but it's also heavy.

DR. HALE: Yeah, we see a decent number of Native patients, and it's always a different feeling. It's special to be able to treat your own people, but it can also be heartbreaking because you know the deeper context behind their struggles.

***ACEP Now:* Why did you choose emergency medicine over other specialties?**

DR. POSTOAK: I feel like emergency medicine found me. I was doing rotations, and when I tried emergency medicine, I loved it. I realized I could be functional in any setting: at a ball game, in the wilderness, wherever someone needed help. I wanted to be that jack of all trades. My dad was a mechanic, and he always had an answer when something went wrong. I wanted to be like that—a resource in any scenario.

***ACEP Now:* Native American physicians in Oklahoma are working to reverse some of the cultural, social, and health issues caused by years of marginalization. What are some of those challenges?**

DR. KENNEDYE: There's a deep historical context to keep in mind. Native people have been here for about 25,000 years, but in the last few hundred years, we've been marginalized and pushed to the edges. My tribe, the Kiowa, were roaming free until about 1872, and we weren't made citizens until 1924. That's not ancient history; it was relatively recent, and the trauma from those events are still reverberating today. The damage wasn't just physical; it was cultural. We were told we couldn't speak our language, wear our traditional clothing, or practice our customs. That kind of deep cultural loss doesn't go away in a generation or two. It's still affecting our communities today, and you can see it in the social determinants of health: poverty, education gaps, and health care access.

I do public health and policy work, and we focus a lot on social determinants of health. It's hard to address those in a busy emergency room, but it's crucial because if you don't, you're just putting a Band-Aid on a much bigger issue.

***ACEP Now:* As leaders in your community, how do you recognize Native American Heritage Month?**

DR. HALE: I celebrate Indigenous culture every day, whether it's speaking my language, attending ceremonies, or even having conversations like this. But I'd like to see people stop celebrating Columbus Day. Celebrating what he did is an abomination.

DR. KENNEDYE: I participate in the Black Leggings Ceremony every year. It's one of the last remaining Native American warrior societies, and it's been part of our tribe for centuries. We honor our veterans and our warriors. It's a big cultural event with songs, dances, and ceremonies passed down through generations. It was banned twice in our history but revived by World War II veterans, and we've kept it going ever since. It's a visual spectacle, and it's about remembering our past and honoring our people. My brother is a documentary filmmaker, and we filmed the ceremony last year. It'll air on PBS soon, so more people can see it.

DR. POSTOAK: I'm honored to learn from leaders like Dr. Hale and Dr. Kennedye. I also watch my dad, who's in the Chickasaw Honor Society, and it reminds me of our warrior spirit. It's a blessing to carry forward those traditions and continue growing in my heritage. Working alongside these two doctors, especially treating Native patients, is one of the most rewarding parts of my job. ⊕

NEONATAL RESUSCITATION

From initial to advanced care of your youngest patients

by MATTHEW TURNER, MD; AND STEPHEN SANDELICH, MD

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A gravid woman presents to your emergency department (ED). Before you can obtain any history, she gives birth in your waiting room. The neonate is apneic and has a heart rate of 48. How do you stabilize this patient?

Neonatal resuscitation is common; 10 percent of the four million newborns in the U.S. each year will require at least some intervention.[1] However, one percent of births will require advanced interventions, including chest compressions, intubation, and medications.[2] These rare scenarios are difficult to prepare for; resuscitation guidelines are not strictly followed in more than 90 percent of cases.[2] Physicians may experience skill atrophy in these scenarios within two months, underscoring the need for regular review of current guidelines.[2]

Initial Resuscitation

All necessary personnel and equipment needed for advanced pediatric resuscitation should be present before delivery.[4] Immediately after birth, the neonate should be assessed for appearance, pulse, grimace, activity, and respiration (APGAR).[5] Cord clamping may be delayed for at least 30 seconds in preterm and term neonates.[3] If the neonate is term and has normal tone and breathing and/or crying, they should be placed skin to skin with the mother. Most newborns do not require resuscitative efforts.[3]

Within 30 seconds, if the newborn has any evidence of apnea, cyanosis, or difficulty breathing, they should be taken to the warmer to maintain a temperature between 36.5–37.5 degrees Celsius and undergo tactile stimulation through drying and rubbing of the back and soles.[3,4] Secretions may be cleared and the airway repositioned.[3]

Advanced Resuscitation

Within 30 seconds of the initial intervention and 60 seconds from birth, the neonate should be reassessed. If the neonate has a heart rate (HR) below 100 or is apneic and gasping, positive pressure ventilation (PPV) should be provided immediately.[3] PPV is *the* most critical step in neonatal resuscitation.[2] For every 30 seconds that PPV is delayed, the risk of prolonged admission or death increases by 16 percent.[4] A rise in HR is the most important indicator of effective resuscitation. Term infants should initially receive an FiO_2 of 0.21 while preterm infants should be started between 0.21 and 0.3, with oxygen titrated based on pulse oximetry. Routine airway suctioning is not recommended. However, if a neonate is delivered through meconium-stained fluid and is showing signs of obstruction during PPV, intubation and tracheal suction can be beneficial.[3]

PPV is often done incorrectly (Table 1). Two-thirds of cases of continued respiratory depression after resuscitation begins are due to ineffective PPV.[2]

One team member should auscultate HR during the first 15 seconds of PPV. A rising HR is the best indication of effective PPV.[3] If there is no increase in HR, PPV may be corrected with the MR. SOPA pneumonic (Table 2).

After 30 seconds of effective PPV, the patient should be reassessed. If HR is 60–99, the MR. SOPA algorithm should be repeated for proper PPV.[1] If HR is below 60, chest compressions should be started and an ECG placed.[3] The two-hand technique is the most effective. Compressions should be delivered at a ratio of three compressions to one ventilation, for 90 compressions and 30 inflations in one minute.[3] Vascular access through an umbilical vein catheter (UVC) should be obtained, although intraosseous (IO) access is acceptable.[3]

The patient should have an endotracheal (ET) tube placed. ET tube size should be 2.5 mm for neonates under 1,000 grams, 3.0 mm for 1,000–2,000 grams, and 3.5 for neonates over 2,000 grams.[1] ET depth is generally "6 + the weight in kilograms," so a three kg infant would have an ET tube be nine cm at the lip.[1] Intubation is difficult; a laryngeal mask airway (LMA) is a useful alternative.[2]

If the patient is bradycardic after 60 seconds of compressions and ventilations, initiate medications. 0.01–0.03 mg/kg IV epinephrine, or 0.05–0.1 mg/kg through the ET tube, should be given every three to five minutes.[3] Volume resuscitation with normal saline or blood may be given at 10 cc/kg over five to 10 minutes in infants with concerns for blood loss.[3]

In the post-resuscitative state, the patient should be transferred to a higher level of care, where they can be monitored for further complications and undergo therapeutic hypothermia.[4] If all steps of resuscitation have been completed and HR remains undetectable 20 minutes after birth, goals of care should be discussed and termination of resuscitation considered.[3]

Table 1. PPV Guidelines in Neonatal Resuscitation

40-60 ventilations per minute[4]
Peak pressures of 30 cm H_2O in term neonates; 20-25 cm H_2O in preterm neonates[4]
Neonates born after 35 weeks should receive 21 percent oxygen[4]
Neonates born before 35 weeks should receive 21-30 percent oxygen[4]
100 percent oxygen should *not* be used due to risk of excess mortality[3]

Table 2. MR. SOPA for correcting PPV

Mask – reapply
Reposition head
Suction airway with bulb syringe
Open mouth
Increase PIP to maximum of 40 cm H_2O
Place alternative airway

DR. TURNER, originally trained at the Medical University of South Carolina, is an EM intern at Hershey Medical Center in Hershey, Pa.

DR. SANDELICH is a pediatric emergency physician at Hershey Medical Center in Hershey, Pa.

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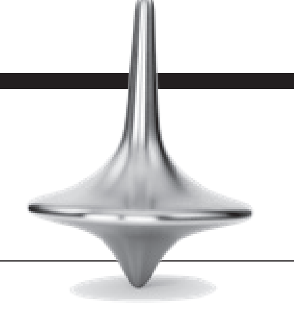
OPINIONS FROM EMERGENCY MEDICINE

OPINION



CPR for the Professional Rescuer

Two respected organizations offer training and certification in life support, and both should be universally accepted

by ARTHUR L. KELLERMANN MD, MPH; AND THOMAS D. KIRSCH, MD, MPH

For decades, only one major organization—the American Heart Association (AHA)—provided standardized training and certifications in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). This changed in 2019 when the American Red Cross rolled out a suite of courses that teach the same science and skills in a more learner-centered way. Despite the broad acceptance of Red Cross certifications by national accrediting bodies, state agencies, and thousands of hospitals and clinics, some medical centers, nursing schools, and community colleges have policies that do not recognize both organizations' certifications. This imposes an undue burden on new hires and rotating trainees who are certified by one organization but cannot start work before they are recertified by the other.

Background

From its founding in 1881 to today, the American Red Cross has taught tens of millions of Americans first aid and other lifesaving skills, including CPR. It also offers a comprehensive "CPR for the Professional Rescuer" course. In 2015, it introduced Basic Life Support (BLS) training and certification for EMS personnel. Their response was so enthusiastic that the Red Cross expanded its offerings.

After three years of curriculum development and testing, the Red Cross launched a package of courses that includes BLS, ALS, and PALS training with certification in 2019. All three leverage the latest educational methodologies.

Scientific Rigor

Red Cross resuscitation courses closely align with the International Liaison Committee on Resuscitation (ILCOR) recommendations. Major resuscitation organizations worldwide meet in this forum to share knowledge and best practices. Each year, ILCOR issues "Consensus on Science with Treatment Recommendations" (CoSTR) to its member organizations, including the International Federation of the Red Cross (IFRC) and the AHA. Because both organizations base their curricula and periodic updates on ILCOR guidance, they convey the same concepts and practice standards.

The Red Cross Scientific Advisory Council

Red Cross courses are regularly reviewed and updated by a Scientific Advisory Council (SAC) comprising 60+ nationally and internationally recognized experts from a wide range of disciplines. In addition to analyzing ILCOR updates, the SAC members consider guidance issued by the ACEP, the American Academy of Pediatrics, the Society of Critical Care Medicine, and other leading groups. Their findings are summarized in periodic releases entitled *Focused Updates and Guidelines*.

Learner-Centered Education

Red Cross training programs are designed to actively engage adult learners, reduce training time, and minimize training costs. Educational advances include the following:

- Besides instructor-led training, the Red Cross offers a blended learning option. This allows participants to access course content through their smartphone or personal computer to learn at a pace, place, and times of their choosing.
- Because the Red Cross' online content is *adaptive*, participants can test out of content they already know and tailor their learning path. This can reduce an individual's training time by up to 50 percent with no decrement in learning.
- Instead of actors, Red Cross training videos use actual physicians, nurses, and support staff to demonstrate clinical decision making and teamwork. This makes the material more relevant to health professionals.

Initial Rollout

America's Military Health System (MHS) was the first major organization to adopt Red Cross ALS and PALS training. Initially, following an initial "beta test" with military medical students and faculty at the Uniformed Services University in Bethesda, Md., the Defense Health Agency (DHA) convened a team of subject matter experts to systematically compare the guidance conveyed in the Red Cross curricula to that offered by the AHA. When they confirmed equivalence, the MHS formally adopted Red Cross BLS, ALS, and PALS training for relevant military and civilian personnel. The transition began in January 2019.

At a recent meeting at Red Cross headquarters, a DHA leader reported that their decision to switch saved the MHS more than $23 million in 2022 and $25 million in 2023. Even more important, the transition saved 830,000 student and instructor training hours in 2022 and nearly one million hours in 2023.

National Recognition

Red Cross resuscitation certifications are accepted by:

- The Joint Commission
- The Accreditation Council for Continuing Medical Education (ACCME)
- The American Nurses Credentialing Center (ANCC)
- Commission on Accreditation for Prehospital Continuing Education (CAPCE)
- The National Registry of Emergency Medical Technicians (NREMT)
- The EMS agencies of all 50 states
- The Veterans Healthcare Administration (VHA)
- The DHA and MHS

More than three million Red Cross BLS, ALS, and PALS certifications have been issued to health care personnel working in thousands of facilities, including some of the largest governmental, nonprofit, and for-profit health care systems in the U.S.

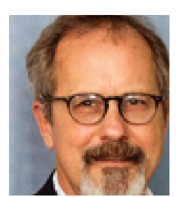
Benefits of Dual Acceptance

Health systems and educational institutions have every right to train their staff using the curricula they like best. Still, all academic programs and health care organizations should recognize both American Red Cross and AHA certifications. Those that do can onboard new hires without requiring them to retake time-consuming coursework. Dual acceptance allows health systems to "test drive" the other organization's approach without conflicting with their policies or creating confusion at the bedside. When it comes time to renew a training contract, those who accept both organizations' certifications are in a stronger negotiating position than those who do not.

The Bottom Line

Red Cross BLS, ALS, and PALS courses convey the same clinical and scientific content as those of the AHA. Health system experience suggests that Red Cross blended and adaptive learning is less costly and burdensome with no decrement in clinical performance. Health care systems can choose which organization they want to work with, but all should recognize both organizations' certifications.

DR. KELLERMANN is an emergency physician, former medical school dean, and former academic health system CEO.



DR. KIRSCH is an emergency physician and expert in disaster medicine who previously served on the Red Cross Scientific Advisory Council.

Both advise the American Red Cross on a part-time basis. Their views are their own.

ACEP POLICY NOTE

ACEP Believes You Exceed the Need for Short Course Merit Badges, Offers Cards

ACEP believes that certification by ABEM or AOBEM supersedes the need for so-called "merit badge" short courses. Such courses are generally designed for a broad spectrum of clinicians including non-emergency physicians and non-physicians. These are sometimes required for medical staff privileges.

Many credentialing bodies, however, still require emergency physicians to produce evidence of completion of the short courses.

For emergency physicians required to have a card, ACEP offers its members a set of personalized cards online, which attest that they are currently Board Certified by ABEM or AOBEM and have expertise in Procedural Sedation, Cardiac Resuscitation, and Trauma.

ONLINE EXCLUSIVES

Scan the QR Codes to access the full stories.

Intervening on a Crisis

A potential solution to America's psychiatric boarding crisis

by MAURA KELLY

Dr. Elizabeth Wharff was the director of emergency psychiatry at Boston's Children's Hospital in the late 1990's when she became concerned about what was, then, a new problem. The emergency department (ED) was frequently overwhelmed by suicidal adolescents who needed inpatient psychiatric treatment but couldn't be admitted, because the hospital had no free beds. "They would wait in the halls, in exam rooms—wherever we could find space for them," said Dr. Wharff. "Sometimes they waited for hours; other times, for days and weeks." ⊕

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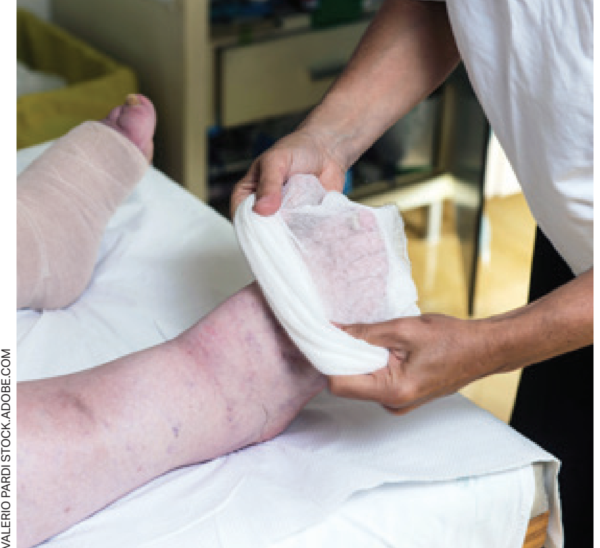


VALERIO PARDI STOCK.ADOBE.COM

Chronic Wounds in Acute Care

How to best inspect, protect, and dress wounds in the ED

by HOWARD LEVITIN, MD, FACEP

This is the second visit in two weeks for an elderly gentleman who is concerned about his legs being red and swollen. During the first visit, he was diagnosed with cellulitis and placed on cephalexin. Today, he notes worsening swelling and a blister forming near his left ankle. The pain makes it difficult for him to ambulate unassisted through his home.

Nearly 10 million Medicare beneficiaries suffer from chronic wounds at an annual cost of almost $25 billion, a number that will likely grow as the population ages. About three percent of emergency department (ED) visits are due to skin and soft tissue infections, but data are lacking on the contribution of chronic wounds to this number. The impact of early-stage wounds, including those at risk of progression, is also poorly studied and may go unnoticed. This lack of awareness is unfortunate given that such skin findings are often precursors of chronic disease that, if recognized and appropriately cared for, can offset future morbidity. ⊕

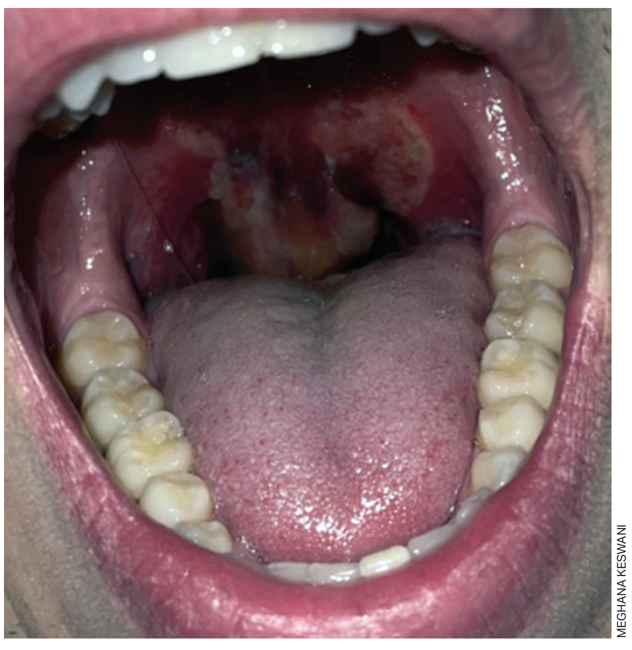
CASE REPORT

The Silent Swell

Recognizing uvulitis in the context of inhalational drug use

by MEGHANA KESWANI, MD; M. KATHRYN MUTTER, MD, MPH; AND MOIRA E. SMITH, MD, MPH

A healthy 20-year-old male presented with one day of a progressively worsening sore throat with difficulty swallowing, increased secretions, and increased work of breathing. He had no history of allergies, anaphylaxis, or recent dental procedures or infection. He endorsed daily inhalational marijuana usage. ⊕



MEGHANA KESWANI

CASE REPORT

Foot Amputation

Performing a field amputation is an extremely rare and heroic procedure

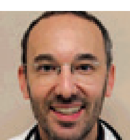
by TODD BURGBACHER, DO, FACEP

EMS and Fire are called to a new development construction site for a 22-year-old male who is possibly entrapped in a concrete machine. Prior to arrival, a bystander placed a belt on the patient's legs as a makeshift tourniquet. Upon arrival, they find a young male partially standing up inside the hopper of a concrete curb laying machine. Further investigation reveals his right leg was stuck in the auger of this machine with his mangled food sticking out of the chute at the bottom. The fire crew requested a heavy rescue for additional resources. The EMS crew placed a second tourniquet, began two large bore IVs, and started IV fluids. Additionally, they called for an EMS helicopter for transport. ⊕

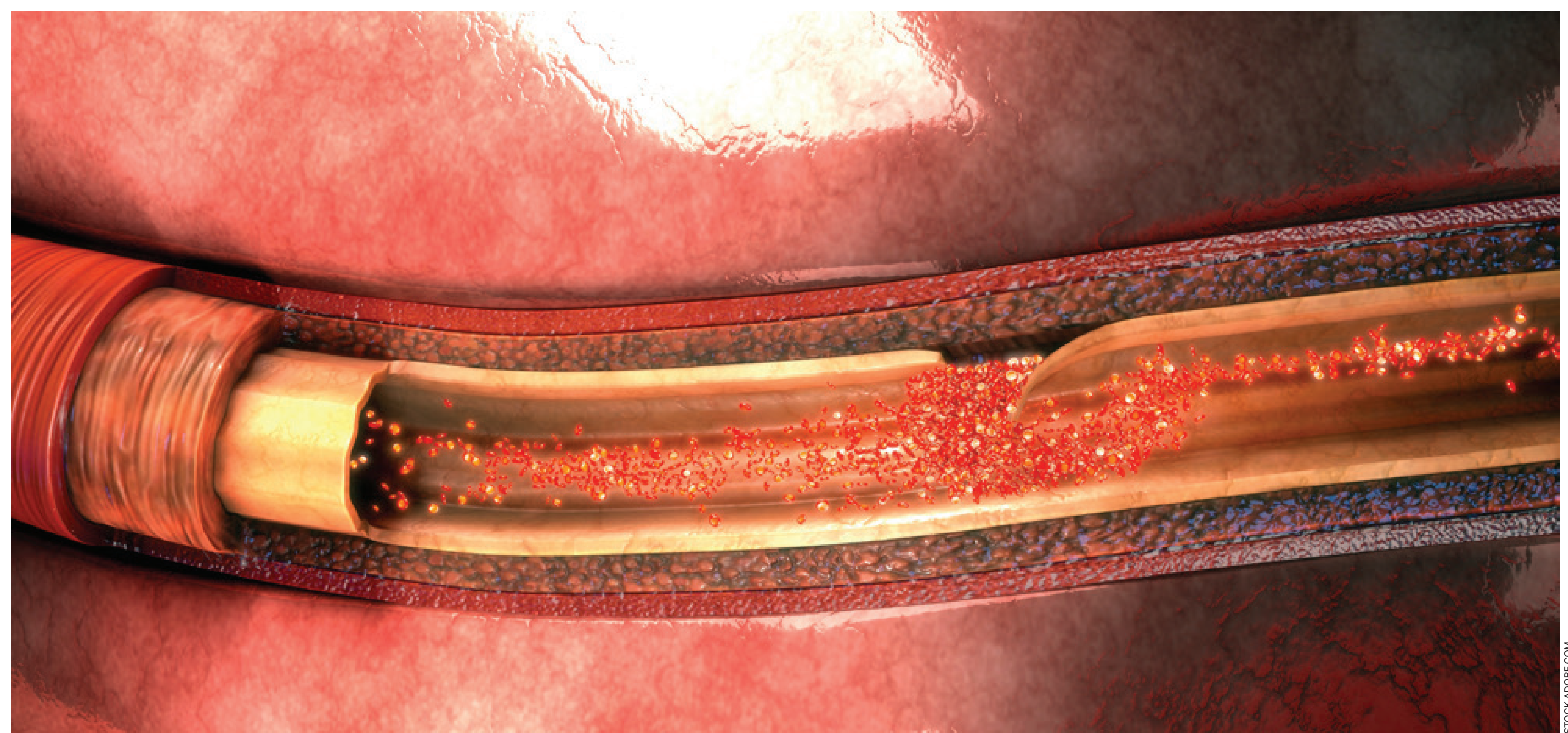
HOWARD LEVITIN

BRINGING YOU CANADA'S BRIGHTEST MINDS IN EM

EM CASES



DR. HELMAN is an emergency physician at North York General Hospital in Toronto. He is an assistant professor at the University of Toronto, Division of Emergency Medicine, and the education innovation lead at the Schwartz/Reisman Emergency Medicine Institute. He is the founder and host of Emergency Medicine Cases podcast and website (www.emergencymedicinecases.com).



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Traumatic Coronary Artery Dissection

A rare, potentially life-threatening diagnosis

by ANTON HELMAN, MD, CCFP(EM), FCFP

While many of us are familiar with spontaneous coronary artery dissection (SCAD) as a common cause of myocardial ischemia in young people, traumatic coronary artery dissection (TCAD) is a rare, potentially life-threatening diagnosis that is challenging to diagnose and often missed in the emergency department (ED), as the clinical features overlap with more common diagnoses that result from blunt chest trauma.[1] It is important to pick up this diagnosis early, as emergency treatment with percutaneous coronary intervention (PCI) to restore blood from to the heart can be lifesaving. In this *ACEP Now* column, I hope to elucidate some of the key clinical clues of TCAD to maximize your chances of picking it up in your blunt chest trauma patients.

TCAD occurs as a result of rapid deceleration, which increases shear forces on the endothelium of the coronary artery. The stress of the traumatic event causes an acute increase in blood pressure. The combination of shear forces on the coronary artery endothelium and sudden increase in blood pressure results in TCAD. The dissection of the coronary artery that occurs in TCAD may lead to thrombus and/or vasospasm resulting in myocardial infarction and all of its potential complications, including death. Aortic dissection as a result of blunt trauma is often immediately fatal, and if patients do survive to be transported to the ED, it can be difficult to diagnose. By contrast, traumatic aortic dissection does not cause cardiac ischemia like TCAD typically does.

There are several reasons TCAD is often missed in the ED besides it being a rare entity with an incidence of only 0.1 percent.[2] First, TCAD may result from a relatively low energy mechanism such as a seemingly innocuous blow to the chest in sport. Second, it is predominately diagnosed in young people; 82 percent of patients with acute myocardial infarction after chest trauma are under 45 years of age.[3] Another reason TCAD is easily missed in the ED is that the most common cause of TCAD is a motor vehicle crash caused by deceleration and traction or direct impact, and concurrent traumatic injuries in these cases often overshadow the diagnosis.[4] Patients may present with altered mental status, rendering them unable to convey symptoms of cardiac ischemia. Generalized chest pain has a broad differential diagnosis in the polytrauma patient. Other cardiac injuries are often considered first, such as cardiac contusion, dysrhythmias, and cardiac tamponade. Finally, symptoms of TCAD may not present for several hours, days, or weeks after the inciting traumatic event, as the rate of expansion of the false lumen may vary considerably.[5]

When Should We Consider the Diagnosis?

Given how easy it is to miss TCAD and how rare it is, when should we consider the diagnosis? TCAD should be considered in a young person with a history of recent chest trauma followed hours to weeks later with anginal symptoms plus any combination of ischemic ECG changes, troponin elevation, or wall motion abnormalities on point-of-care ultrasound (PoCUS). Typical angina symptoms after trauma in a young patient without traditional cardiac risk factors warrant a work-up for TCAD. Patients complaining of chest pain after sustaining blunt chest trauma should undergo a prompt cardiovascular work-up with ECG and serial troponins to screen for cardiac contusion, dysrhythmias, and for cardiac ischemia as a result of TCAD. The Eastern Association for the Surgery of Trauma (EAST) recommends that an ECG and cardiac biomarkers be obtained for all patients in whom blunt cardiac injury is suspected.[6] A key pitfall in patients who have recently sustained trauma to the chest is assuming that a borderline ECG and positive troponin are due only to cardiac contusion, which does not warrant activation of the cardiac catheterization lab. Similarly, patients with multiple rib fractures, a risk factor for TCAD, may have their chest pain attributed solely to the fractures, and the diagnosis of TCAD may be overlooked. Patients with angina-type symptoms, ongoing dyspnea after initial treatment of other traumatic injuries, cardiac dysrhythmia, and/or elevated troponin should be considered for CT angiography of the coronary arteries and/or angiography in the cath lab. Even a borderline ischemic-appearing ECG and positive troponin should trigger the provider to consider the diagnosis of TCAD and discuss this possibility with an interventional cardiologist for consideration of emergency coronary angiography.

PCI is the most common treatment done to repair the coronary artery dissection in patients who have sustained a myocardial infarction. In the very rare case of left main coronary artery dissection, coronary artery bypass grafting (CABG) is the treatment of choice. In those patients with TCAD who are stable without evidence of coronary ischemia, the treatment of choice is often conservative, with observation and repeat angiography.[6]

It is my hope that increasing awareness of TCAD by emergency providers will improve the diagnostic yield and improve morbidity and mortality in these patients. If we consider TCAD in young people with a history of recent chest trauma followed hours to weeks later with anginal symptoms plus any combination of ECG changes, troponin elevation, or ischemic PoCUS findings, the emergency medicine community will save many lives! ⊕

A special thanks to Dr. Ian Chernoff, the guest expert on the EM Cases podcast that inspired this column.

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EM LITERATURE OF NOTE

PEARLS FROM THE MEDICAL LITERATURE

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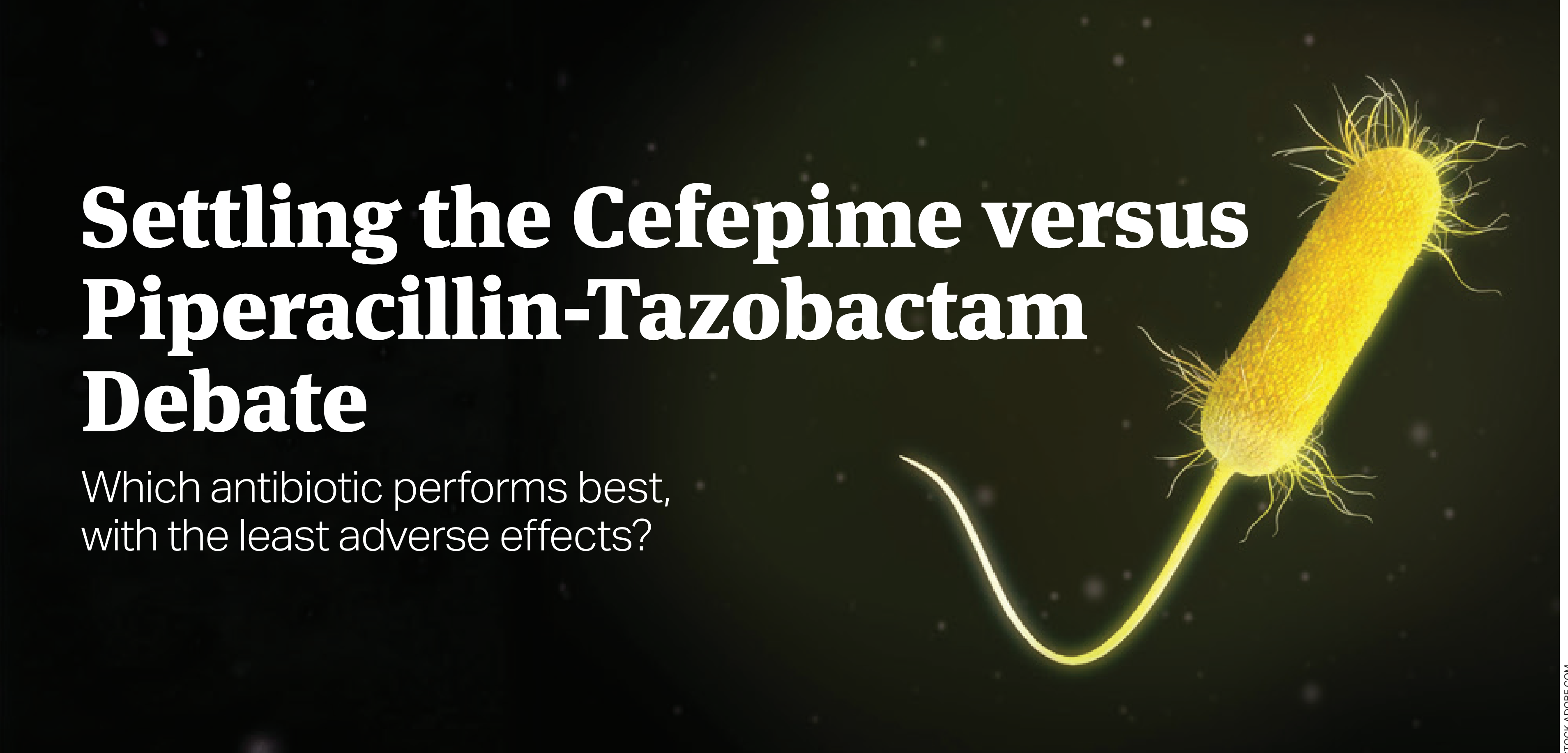

Settling the Cefepime versus Piperacillin-Tazobactam Debate

Which antibiotic performs best, with the least adverse effects?

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by RYAN RADECKI, MD, MS

If you work in the emergency department, you're out there in the trenches "suspecting sepsis" on a daily basis. Adhering to guideline recommendations, considered by some hand in hand with "quality," requires prudent empiric antibiotic coverage. Vancomycin remains the typical straightforward choice for patients in whom methicillin-resistant *Staphylococcus aureus* coverage is indicated. However, the choice for antipseudomonal coverage is muddier; the split between cefepime and piperacillin-tazobactam is more or less equal in current practice.[1]

Surely, these two differing antibiotic formulations cannot possibly be interchangeable? There must be a difference favoring one over the other? These are among the questions at the forefront in the exciting world of infectious disease.

The opening volley in the debate came from the Antibiotic Choice On ReNal outcomes (ACORN) trial, which tested these two antibiotics against a primary outcome of acute kidney injury (AKI) or death by day 14 of treatment.[2] A secondary prespecified outcome included measures of days alive and free of delirium and coma, a nod to the observed increase in neurotoxicity suspected with cefepime.

Nearly 95 percent of the 2,511 patients included in this trial were enrolled in the emergency department, with the most common sources of infection suspected to be intra-abdominal or pulmonary. Most patients received the antibiotic as per randomization, though the number of patients receiving the study antibiotic dropped steadily through the first three days. By study day four, fewer than 40 percent of the original cohorts were still hospitalized and receiving the antibiotic exposures of interest.

Grossly speaking, the results were a wash. Small differences, not reaching statistical significance, favor piperacillin-tazobactam, including renal outcomes, neurotoxicity, and death. It is probably not reliable to focus on these small differences in renal outcomes and mortality, as there are differences in the baseline characteristics of patients enrolled that potentially contributed to the skew. Most prominently, there was a two percent absolute excess of intensive care unit patients and mechanically ventilated patients randomized into the cefepime. Without further parsing through baseline characteristics, this is enough of an indicator that the non-significant excess mortality should not be emphasized. By any stretch, however, there are no clear signals of harm associated with piperacillin-tazobactam.

Unfortunately, the suspected association of cefepime with neurotoxicity was likely confirmed. While the measure of days "alive and free of delirium and coma" was skewed by the increased mortality seen in the cefepime cohort, further analyses still demonstrate an excess of delirium and coma. These various post-hoc analyses required accounting for receipt of sedation and varying alternative definitions of delirium and coma, but do little to refute the prevailing notion of increased neurotoxicity relating to cefepime.

Upending these results entirely comes a subsequent study whose conclusions are completely different.[3] In this alternative study, the authors took advantage of a sort of "natural experiment," a 15-month national piperacillin-tazobactam shortage. Preceding and following the period of shortage, piperacillin-tazobactam was the clear primary option at the authors' institution. During the shortage period, the prevailing anti-pseudomonal antibiotic coverage for their institution switched, by necessity, to cefepime. The authors make an argument that the shortage exists as a random exogenous factor creating the conditions necessary to interpret their results as a sort of emulated clinical trial.

The results of this emulated clinical trial are starkly different. In their study, comprising over 7,500 patients, these authors demonstrated an opposite, and larger, absolute effect on mortality. Rather than the non-significant difference observed at 14 days in ACORN, here the mortality outcome at 90 days demonstrated a 5.0 percent absolute advantage to cefepime. The authors ultimately conclude, when not otherwise indicated, the use of piperacillin-tazobactam results in potentially "thousands of additional fatalities each year."

Any conclusion providing evidence of "thousands of additional fatalities" ought give any clinician pause. Clearly, it is always prudent to narrow the spectrum of antibiotic coverage as clinically appropriate. However, each of these antibiotics has historically been used interchangeably for empiric coverage of gram-negative organisms.

There are, of course, concerns regarding the magnitude of this observed effect size. Firstly, and most prominently, this remains a retrospective analysis prone to the effects of uncontrolled biases and confounding. Even a so-called "natural experiment" such as this remains limited in its ability to isolate a causal effect. Of note, despite the proposed disadvantage of piperacillin-tazobactam, crude mortality was unchanged, rather than improved, during its absence. Most of the observed mortality advantage favoring cefepime emerged following statistical adjustments.

In particular, one specific adjustment, for metronidazole exposure, is suspected to have been problematic. Patients who received metronidazole as extended anaerobic coverage were generally more unwell, leading to commentary suggesting the observations from this analysis are subject to collider bias.[4] Collider bias is a type of confounding in which an unobserved feature is associated with both an outcome and a covariate used for adjustment. In this case, the concern voiced is high-risk clinical factors independently influence both mortality and metronidazole use, and an adjustment solely for metronidazole neglects this "collider." The net effect of this adjustment generates an over-correction, after a fashion, bestowing an exaggerated advantage upon cefepime.

All controversy aside, however, these observations favoring cefepime must be respected because they are consistent with other observational data. The unavoidable fact remains that these data have the fundamental limitations of all retroactive or observational studies. The only true method to settle the question remains a prospective, randomized trial designed specifically to address medium-term mortality, rather than short-term renal outcomes. Considering the wide usage of these antibiotics in the current approach to sepsis, an urgent answer ought be sought.

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Q&A ABOUT OUR LITTLEST PATIENTS

KIDS KORNER

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When Do VP Shunts Fail?

Most shunts will be okay after the first year

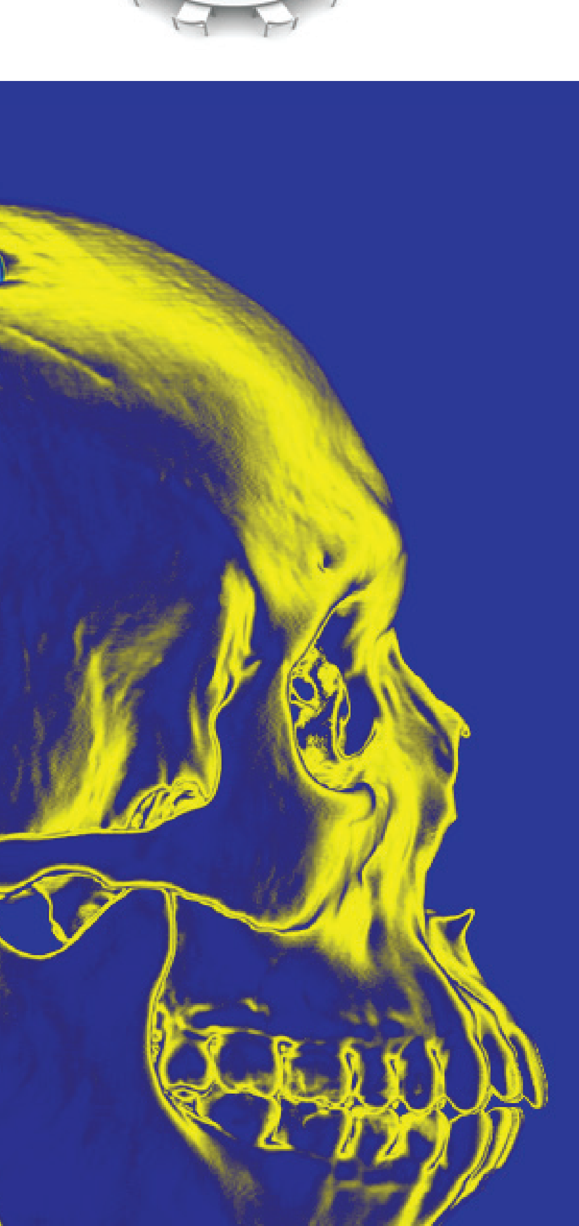
by LANDON JONES, MD, AND RICHARD M. CANTOR, MD, FAAP, FACEP

The best questions often stem from the inquisitive learner. As educators, we love—and are always humbled—by those moments when we get to say "I don't know." For some of these questions, you may already know the answers. For others, you may never have thought to ask the question. For all, questions, comments, concerns, and critiques are encouraged. Welcome to the Kids Korner.

In children with ventriculoperitoneal (VP) shunts, when is the most common time for the shunt to fail?

Children with and without VP shunts get sick. When a child with a VP shunt develops a fever or feels unwell, the voice in the back of our heads asks, "Is it the shunt?" Sometimes it is; most often it's not. While we often evaluate the shunt for malfunction, is there a particular time window where shunt malfunction is more common?

To begin, a 2012 prospective pediatric study found a failure rate of 16.9 percent.[1] It was a five-year prospective study at a single institution and followed 236 children under 12 years of age who received VP shunts—40 children (16.9 percent) required shunt revision. In these 40 children, there were 48 shunt revisions, meaning some children had more than a single shunt revision. The most common complications leading to shunt revision were peritoneal end malfunction (n=18), shunt/shunt tract infection (n=7), extrusion of peritoneal catheter through the anus (n=5), ventricular end malfunction (n=4), and cerebrospinal (CSF) leak from the abdominal wound (n=4). In these children requiring shunt revision, 38 (79 percent) occurred within six months of previous surgery and 28 (58 percent) occurred within three months of the previous surgery. There were four (8 percent) who required revision within six–12 months and six children (12.5 percent) required revision after one year of prior surgery. While a shunt complication can occur at any time period, the majority of VP shunt malfunctions requiring revision occurred within the first six months following placement. A 10-year retrospective observational study by the same author again evaluated children younger than 12 years of age who had received VP shunts.[2] This was a different group of children evaluated at a later time period at the same institution. The author found the VP shunt revision rate to be 11.9 percent (40 of 336 children). Similarly, 70 percent of VP revisions occurred within the first six months after surgery.


SCIENCE SOURCE

A 2016 multicenter prospective study evaluated 1,036 pediatric patients for shunt failure who received CSF shunts over a four-year period.[3] This study was conducted at six institutions in the Hydrocephalus Clinical Research Network. Inclusion criteria included children younger than 19 years of age undergoing their first insertion of a CSF shunt for the treatment of hydrocephalus. Nearly all shunts were VP shunts. The majority of patients were younger than six months of age at time of initial shunt placement (55.7 percent) for hydrocephalus. During that study period, 344 (33 percent) shunts failed. Risk factors associated with shunt failure were: patient age younger than six months (adjusted HR 1.4; 95 percent CI 1.1–2.1); cardiac comorbidity (adjusted HR 1.4; 95 percent CI 1.0–2.1); and interoperative use of the endoscope (adjusted HR 1.9; 95 percent CI 1.2–2.9). Specifically, regarding shunt failure, the mean time of failure was 344 days (range 1–932 days). While the authors do not specifically state the highest risk time for failure, the mean and range suggest that the majority of these cases failed within the first year after being placed.

While most of the literature suggests a higher VP shunt failure rate in children younger than one year of age, a very small amount of literature argues differently. For example, one 11-year retrospective study looked at 137 children who received VP shunts for hydrocephalus.[4] Ages ranged from 1.5 months to 8.5 years with an average age of 20.7 months. The incidence of VP shunt complication requiring revision was only 27 percent (n=37), and only 24 percent (n=9) of the total revisions presented within the first six months. Eighteen of the VP shunt revisions (49 percent) occurred more than 24 months after the initial placement. The patient population receiving the initial shunt, though, appeared to be older than most other studies and may have contributed to these variable findings.

Overall, the literature suggests that most VP shunt malfunctions requiring revision probably occur within the first year of placement.

Summary

While VP shunt malfunctions can occur at any time in children, the majority of VP shunt malfunctions requiring revision appear to occur within the first year after placement. ⊕

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DOING THE MATH TO BENEFIT OUR SPECIALTY

EQUITY EQUATION

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Creating a Compassionate Space

Caring for neurodivergent patients in the emergency department

by JAYNE KENDALL, MD, MBA, FACEP, CPE

The quick-moving, high-stress practice of emergency medicine means health care professionals need to be prepared for anything. Among emergency physicians' diverse patient populations, neurodivergent individuals represent a unique group with distinct challenges and requirements. Neurodivergence is an umbrella term that refers to a variety of neurological differences (not deficits), including autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and dyslexia, among others.[2] These conditions are prevalent and frequently misunderstood, leading to gaps in care and communication.

Why is this important to emergency physicians? First, research suggests a higher number of emergency department visits among individuals with ASD. About 30 percent of children with ASD need treatment in an emergency department, and this number increases to nearly 70 percent for those aged 15–18.[7] Second, diagnosed adults have twice the number of emergency department encounters compared to those without these diagnoses.[7] Thus, understanding neurodivergence is crucial for emergency physicians, who often serve as the first point of contact for these patients when they are in crisis. Knowing how to recognize and respond appropriately can significantly impact the quality of care provided, ensuring that all patients receive compassionate and effective care.

But what exactly are neurodivergence and neurodiversity? Neurodivergence refers to the unique way in which an individual's brain processes and responds to certain information, differing from the typical or average brain.[9] Neurodiversity refers to the diversity in human brain functioning and encompasses a range of neurological differences that affect how individuals think, learn, and interact with the world.[9] As Stowers points out in his article debunking neurodiversity myths: Consider that some individuals are auditory learners, while others prefer visual methods.[12] Each person has their unique approach to learning and understanding, and we adapt and use techniques that suit us best. So, it shouldn't be surprising that people perceive the world in diverse ways too and that their thinking, learning processes, and traits don't conform to a one-size-fits-all model.[12] The term "neurodiversity" represents a shift from viewing these conditions as "deficits" or "abnormalities" to recognizing them as human thinking and behavior variations.[9] Here are some of the key conditions that are considered neurodivergent and that emergency physicians are likely to encounter:

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1. **Autism Spectrum Disorder (ASD):** Although the definition of autism has changed over time, in general, it refers to a group of complex developmental brain disorders.[3,4] The spectrum nature of autism means that symptoms and their severity can vary widely among individuals. Some people with ASD may have exceptional abilities in specific areas, such as math or art; others may need considerable support in daily living tasks.[2,3,4,6]
2. **Attention Deficit Hyperactivity Disorder (ADHD):** ADHD is a neurodevelopmental disorder marked by more severe patterns of inattention, hyperactivity, and impulsivity than are typically observed in individuals at a similar developmental level. Individuals with ADHD may struggle with organizing tasks, following instructions, or remaining still for extended periods, leading to difficulties in various settings, including the fast-paced environment of an emergency department.[1]
3. **Dyslexia:** Dyslexia is a specific learning condition that primarily affects reading and language processing. People with dyslexia often struggle with phonological processing, spelling, and quick verbal responses; however, many of them have strong problem-solving skills and creative thinking abilities.[14]
4. **A variety of others:** Dyscalculia, dyspraxia, sensory processing disorder, and Tourette's are some of the other diagnoses that belong under the neurodiversity umbrella.[6]

According to a 2022 survey of 1,000 people across multiple organizations, 91 percent of respondents do not know how common neurodivergent conditions are.[13] In fact, many people are working alongside or interacting with neurodivergent individuals regularly and may not know it.[13] According to the Centers for Disease Control and Prevention, approximately one in 35 children in the United States is diagnosed with ASD. ADHD affects around seven million children aged three to 17 years, and dyslexia impacts approximately 15–20 percent of the population.[3,14] These statistics highlight the importance of emergency physicians being prepared to encounter and support neurodivergent individuals.

Several myths and misconceptions about neurodivergence can affect care in emergency settings. One common myth is that neurodivergent individuals are intellectually disabled or incapable of understanding complex information. But many individuals with neurodivergence are knowledgeable and capable when given the appropriate support.[2] As previously stated, given that there is no one "right way" to think or learn, neurodivergence is just a difference—not a deficit.[2]

Another misconception is that neurodivergent behaviors are always disruptive or intentional. For example, a person with ADHD may appear restless, fidgety, or inattentive, but this is often not due to defiance or disrespect. These behaviors spring from differences in their brain that are part of the condition.[15] Understanding these nuances is critical for emergency physicians, enabling them to approach neurodivergent patients with empathy and tailored strategies that accommodate their unique needs. Emergency physicians can significantly enhance the quality of care they provide by dispelling myths and adopting an informed perspective on neurodivergence.

Effective Communication Strategies to Aid in the ED

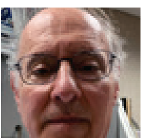
When working with neurodivergent patients, emergency physicians can use the following communication strategies to create a positive and respectful experience:

1. **Active Listening:** Take the time to listen to the patient's concerns and needs. Show empathy and understanding for their experiences. It's also important to include caregivers, as they may notice changes and subtle differences in the patient's behavior.[5]
2. **Clear and Concise Language:** Use clear and straightforward language when providing information or instructions. Avoid jargon or ambiguous terms that may confuse or overwhelm the patient (e.g., "bandwidth" and "deep dive"). Also avoid using idioms and metaphors, as these are often misunderstood (e.g., "a piece of cake" or "feeling down in the dumps").[8,11]
3. **Visual Aids:** Use diagrams, charts, or illustrations to improve communication and help those who understand information better through visuals. One simple visual aid, a "now and next board," is a board with the word "now" on the left and the word "next" on the right. Below those words is space for words, pictures, or even symbols that will let patients know what is going to happen.[8] Using a board like this in the emergency department can create trust and decrease fear in neurodivergent patients.
4. **Create a Calmer Environment:** The emergency department can be overwhelming due to noise, crowds, and unfamiliar surroundings.[8]

   To help alleviate stress:
   - **Identify specific triggers:** Ask the patient what makes them feel uncomfortable or anxious. This could be loud noises, crowds, or certain types of lighting.[8] Knowing this information can help clinicians and staff tailor the environment to the specific needs of that patient.
   - **Provide a quiet space:** If possible, offer a quieter area for patients to wait.
   - **Consider noise-canceling devices:** Keeping some ear defenders (noise reduction earmuffs) on hand that can be lent out can significantly reduce noise-related distress.[8]
   - **Adjust lighting:** Be mindful of lighting preferences. Some patients may require bright lighting, while others may prefer a darker environment.[8]
5. **Allow for Processing Time:** Understand that neurodivergent individuals may need extra time to process information and respond. Be patient and give them pauses during the conversation.[5]
6. **Pain Assessment:** Keep an open mind when assessing pain, especially in children with complex needs. Just because a child can't express their pain verbally doesn't mean they aren't experiencing it. Use a pain assessment tool that considers their developmental stage, parents' observations of pain, and any information from the child.[8]

Ultimately, emergency physicians can improve care for neurodivergent patients and create a welcoming environment to all seeking medical assistance by implementing effective communication strategies while promoting acceptance and respect. Every patient deserves care that meets their individual needs, and by embracing neurodiversity, emergency physicians can provide truly patient-centered care in the emergency department.

The references can be found online.



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Extraglottic Airway Devices

Current prehospital practices and current commercial devices

by AUSTIN HILLMAN, MD; SCOTT POWERS, MD; JEREMIAH ESCAJEDA, MD, FACEP, FAEMS; JONATHAN GLAUSER, MD, MBA, FACEP

Airway management remains a fundamental skill for all emergency physicians. Extraglottic airway devices (EGAs) have become a widely accepted means of airway management along with rescue airway devices. We aim to clarify the role of these devices in the prehospital setting and discuss considerations surrounding the most frequently used devices in current practice. Although we discuss the benefits of various commercial products, none of the authors endorse any individual device detailed below.

Historically, the endotracheal tube (ETT) has been considered the definitive airway of choice in both the prehospital and in-hospital setting. Emergency medical services (EMS) scope of practice is governed by the state, but national scope of practice guidelines are available for the four different EMS provider levels. The guidelines, updated most recently in 2019, note that endotracheal intubation is reserved for paramedics. Extraglottic devices, however, are in the scope of practice for both advanced emergency medical technicians (AEMTs) and paramedics, making the devices more widely applicable.[1] Prehospital endotracheal intubation and EGAs are typically placed without paralytics and are reserved for unconscious, apneic, and out-of-hospital cardiac arrest patients. With more recent studies such as the AIRWAYS-2 and PART trials showing no significant benefit to using ETTs over EGAs and even possible evidence of benefit with EGAs, the role of the prehospital ETT may be further restricted in the coming years.[2,3,4] With the current prehospital emphasis on EGAs, it is important for emergency physicians to understand which current extraglottic devices are commercially available and the role each plays in the management of the compromised airway in the prehospital setting.

Proposed benefits to EGAs include ease and speed of placement, reduced need for training, reduced need for sedation and paralytic medications to facilitate placement, and reduced risk of complications during the procedure.[5] Due to these benefits, many protocols (both prehospital and hospital-based) list EGAs as a key step in both standard and failed airway management; however, potential risks come with using EGAs in lieu of ETTs. Because EGAs do not isolate the trachea as the ETT does, the risk of aspiration events increases, and due to the blind placement of many of these devices, unidentified airway occlusion can occur.[6] Additionally, EGAs are not generally considered to be "definitive" airways and are typically exchanged for an ETT at patient hospital presentation, although they can be used with mechanical ventilation for up to 24 hours.[7]

Laryngeal Mask Airway (LMA)

Developed in the 1980s and first introduced into the prehospital setting in 1992, the LMA spearheaded the broader introduction of extraglottic devices into prehospital practice.[8] Initially developed as a surgical adjunct, the LMA proved to be easily adaptable to the less controlled environments of the prehospital setting.[9] LMAs use an inflatable mask expanded using a similar technique to the endotracheal tube cuff. LMAs are intended to cover the laryngeal inlet, thus isolating the airway from the esophagus. These devices are currently manufactured by several companies and have multiple variants, including the LMA Supreme (manufactured by The Laryngeal Mask Company Ltd) and the LMA-Proseal and LMA-Fastrach (manufactured by LMA North America), which aim to improve certain aspects of the LMA device, such as ease of placement or improved isolation of the respiratory tract.[6] Because LMAs require inflation to function

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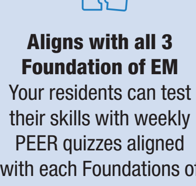

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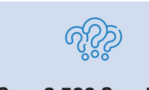

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appropriately, they are at risk of balloon rupture or loss of seal pressure. While not unique to LMAs, the potential risk of airway occlusion is higher than it is for other EGAs.[7]

Esophageal-Tracheal Combitube

The Esophageal-Tracheal Combitube (manufactured by Covidien-Nellcor in Colorado), a device designed to be inserted blindly, was created to be used with less prerequisite training. The Combitube features two lumens, proximal and distal, with two associated cuffs that allow for ventilation of the patient regardless of esophageal or tracheal insertion. If the distal lumen is placed in the esophagus, the patient is ventilated via the proximal lumen. If the Combitube is inserted and breath sounds are heard when ventilating through the distal lumen, the distal lumen was likely inserted into the trachea. Similar to the LMA, the Combitube can be used without significant neck manipulation in patients who require C-spine precautions. It has the added advantages of aspiration risk reduction and stomach decompression given its two cuffs and lumens.[10] The Combitube is contraindicated in patients with upper esophageal abnormalities, such as esophageal varices, or caustic ingestions.[11] As with LMAs, Combitubes are at risk of balloon rupture as well, and attention is needed to avoid damaging the inflating sections of the device both while in storage and during placement. The variation in using the two lumen can also cause confusion.

Laryngeal Tube/King Airway

First invented in Europe in 1999, laryngeal tubes were popularized in the United States by King Systems and are commonly referred to as King airways.[8] The King LT has distal and proximal cuffs that function to seal the esophagus and hypopharynx, respectively, with a ventilatory lumen located between these cuffs. In contrast to the Combitube, the King LT utilizes one line to inflate both cuffs. The benefits of a King LT include lower inflation pressure and soft distal end, which decrease trauma during insertion and use.[11] Due to the presence of inflatable sections, balloon rupture and degradation remain a potential complication, similar to LMAs and the Combitube.

I-Gel

The i-gel was designed in the UK in 2003 and features a gel-style cuff that surrounds the larynx.[8] Constructed with thermoplastic material, it can take the shape of the patient's larynx, a design intended to optimize ventilation and minimize aspiration.[11] The i-gel features a smaller, secondary lumen running the length of the device, through which a nasogastric tube can be passed. Commonly used in prehospital and hospital settings, the i-gel can facilitate endotracheal intubation and bronchoscopy given its large unobstructed main lumen.[11] First-pass success rates are similar when compared to cLMAs and pLMAs and better when compared to the King airway.[12] As a result, the i-gel has found itself in the hands of many prehospital and hospital workers, both in initial and difficult airway management. As there is no inflation step in the placement of i-gel devices, balloon rupture is not a concern and syringes are not required to place the device.

Conclusion

EGAs offer multiple benefits in managing patient airways and have found generally wide acceptance in the protocols of numerous EMS provider levels. Regardless of the device used, continuous ventilation and oxygenation assessment must be performed, because EGAs constitute only one aspect of airway management. Frequent training and skill verification are needed to ensure that these devices are utilized appropriately, regardless of the care setting. While each EGA device type features proposed benefits, ultimately, the greatest predictor of success is likely to be the thoughtful incorporation of these devices into protocolized care structures and emphasis on both initial and ongoing personnel training. ⊕

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Answer

The correct answer is:

D. Optic neuritis

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Patients with idiopathic acute optic neuritis typically present with pain and unilateral visual loss over days without systemic or neurological symptoms. Pain is present in more than 90 percent of cases and often worsens with eye movements. One-third of cases of optic neuritis involve swelling of the optic disc, while most cases have a normal funduscopic examination with retrobulbar optic nerve involvement. As optic neuritis is usually unilateral, an afferent pupillary defect is usually present.

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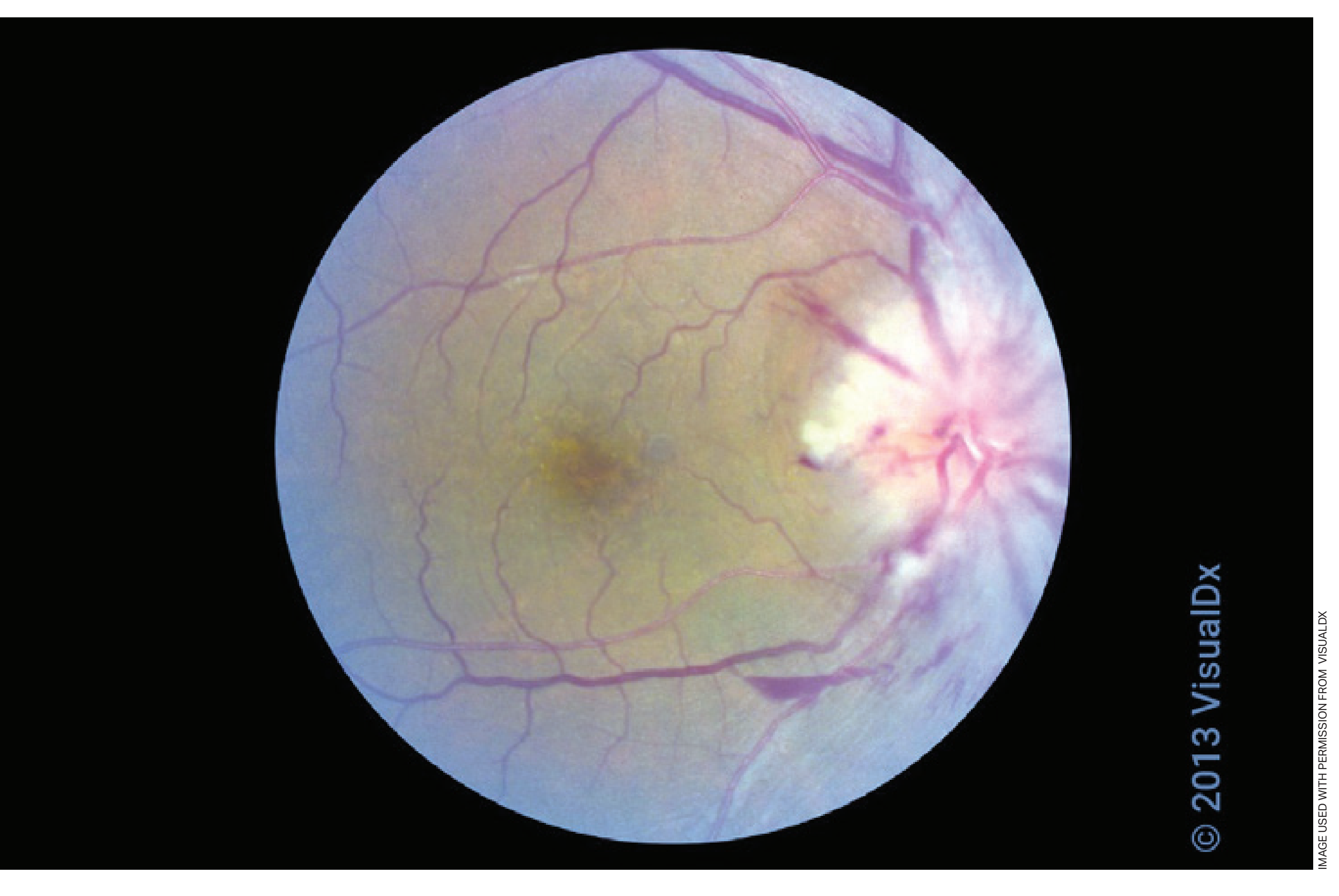

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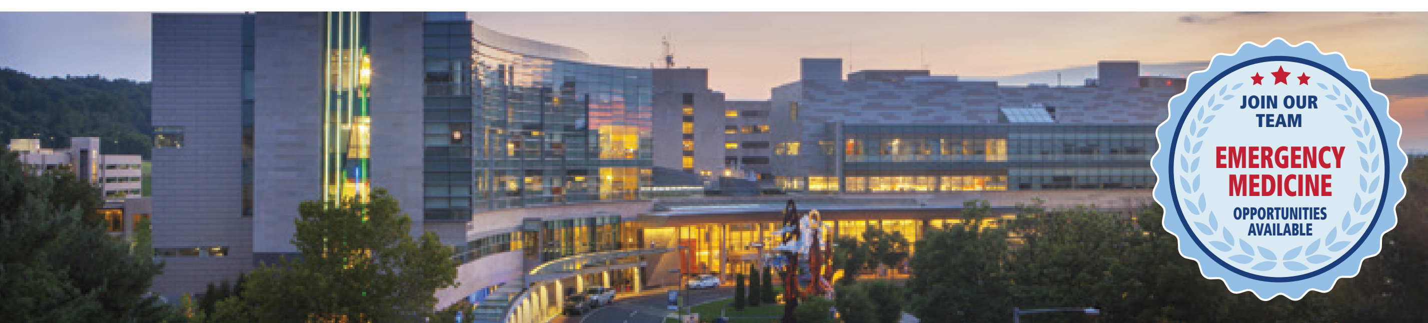

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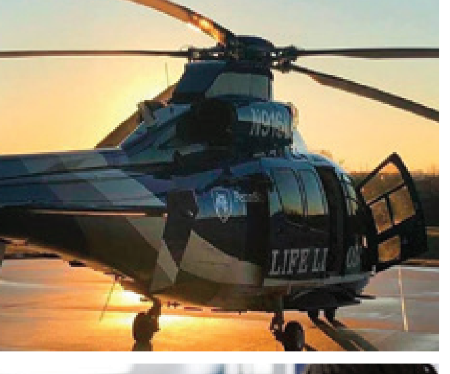

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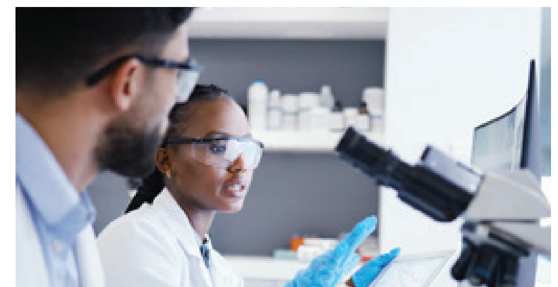

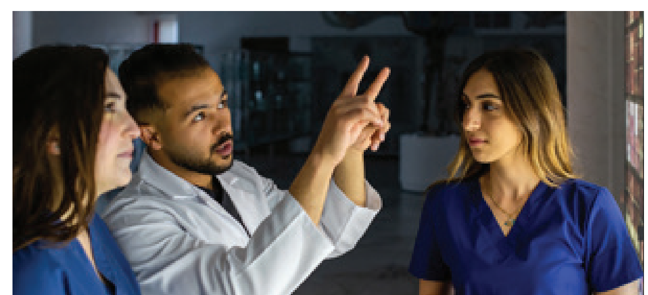

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