There I was...

Nathan Schlicher, MD, JD, St. Joseph Medical Center, Tacoma, WA, University of Washington Medical Center, Seattle, WA, Legislative Advisor

Like all good stories in the emergency department, mine began the same. There I was, in Washington, D.C., minding my own business, having just received a Leadership Award from the American Medical Association...when out of nowhere, I received a call inviting me to the White House! To say the least, I was stunned. I wondered if I was being pranked or if they had the wrong number. On the other end of the line though were credible sources from EMRA and ACEP.

The event for which we were invited – the President’s announcement to push forward with healthcare reform on March 3, 2010 – was a gathering of the leaders of medicine with the President in the East Room of the White House. After a year of working to have a seat at the table, ACEP was honored with four seats out of approximately 120 invitees. ACEP extended that honor to EMRA when they invited me to join them.

The other attendees to the event were Angela Gardner, MD, FACEP, President of ACEP, Sandra Schneider, MD, FACEP, President-Elect of ACEP, and Bruce Auerbach, MD, FACEP, member of the ACEP Federal Governmental Affairs Committee. Quite a distinguished delegation put together in under a day!

It is important to keep in perspective what this honor means to our specialty and the direct result of the hardwork of staff, leaders, and our membership. While our presence at the meeting was an endorsement of our position as an important stakeholder, it was not an endorsement or support of the legislation not passed or any specific piece of legislation. EMRA and ACEP will continue to advocate for our patients, access to care, and adequate educational opportunities for our membership. We need your help in these efforts. The best place to start is in Washington, D.C. at the ACEP Leadership and Advocacy Conference in May. Make the trek to D.C. and who knows, maybe the next call you receive will be an invitation to the White House!
AN ABOVE AVERAGE APP FOR THE ABOVE AVERAGE PHYSICIAN

EMRA Antibiotic Guide by Salibad the Sinner – Version 1.0.1 – Jan 22, 2010
“Excellent format and interface.”

Best of Class by Sardamann – Version 1.0.1 – March 23, 2010
“As an Infection Preventionist and a Microbiologist I find it an incredible source of information. Flow is very logical and essentials are readily available. Perfect work.”

Easier than Sanford by Geekstrap – Update
“It’s easier to navigate and the suggestions actually seem more in line with actual practice.”

EMRA ABX GUIDE iPhone App

Available on the App Store
or Download through your iTunes account on Apple.com
Upcoming events

April 6-10, 2010  ACOEP Spring Seminar
Scottsdale, AZ

April 12-14, 2010  ACEP Pediatric Emergency Medicine Assembly
New York, NY

April 15, 2010  EMRA Committee Application
Deadline

April 21, 2010  Resolutions for EMRA Representative Council Spring Meeting
Deadline

April 24-27, 2010  ABEM Spring Oral Certification Exam
Nationwide

April 30, 2010  ACEP 2010 Research Forum Abstract Submission
Nationwide

May 6, 2010  Representative Council Vote Allocation Cut-off
Deadline

May 6, 2010  EMRA Conference Committee Volunteer Application
Deadline

May 16-19, 2010  ACEP Leadership & Advocacy Conference
Washington, DC

May 16-22, 2010  EMS Week
Nationwide

May 26, 2010  Late Resolutions for EMRA Representative Council Spring Meeting
Deadline

June 3-6, 2010  SAEM Annual Meeting
Phoenix, AZ

June 5, 2010  EMRA Representative Council Meeting
Phoenix, AZ

June 12-16, 2010  AMA MSS / YPS / RFS and House of Delegates Meeting
Chicago, IL

July 7, 2010  Annals of Emergency Medicine Resident Editorial Board Fellowship Application
Deadline

July 15, 2010  EMRA/ACEP Health Policy Mini-Fellowship Application
Deadline

August 12-18, 2010  ACEP Teaching Fellowship
Dallas, TX

August 15, 2010  EMRA Travel Scholarship to ACEP Scientific Assembly Applications
Deadline

August 15, 2010  EMRA Fall Awards Application
Deadline

Advertising guidelines

Thank you very much for your interest in advertising with EM Resident. As the largest organization to represent the needs of the emergency medicine resident, we are able to reach a unique and important niche of our specialty. EMRA’s mission statement is to promote excellence in patient care through the education and development of emergency medicine residency-trained physicians. It is our belief that this provides the best patient care in an emergency department setting.

To support our mission and provide the greatest advantage to our residency-trained members searching for jobs, we welcome you to advertise in EM Resident, but require that all positions advertised in our publication be addressed only to board-certified/board-prepared, residency-trained emergency physicians.

For the sake of consistency, the use of the terms “ED,” “emergency department,” and “emergency physicians” are preferable to using “ER” or any such derivation.

Your support is very important to us, and we appreciate your compliance with these guidelines. Please respect this policy and reflect its sentiment in your advertisements. EM Resident has the right to refuse any advertisement that does not meet these guidelines.

Thank you again for advertising in EM Resident.

To place a classified or display ad in EM Resident, contact Leah Stefanini, 866.566.2492, ext. 3298, e-mail lstefanini@emra.org, or fax 972.580.2829. Information for advertisers can also be found at www.emra.org. EM Resident is published six times per year. Ads received by May 1 will appear in the June/July issue.

EM Resident subscriptions are available only to individuals and institutions that are not considered eligible for EMRA membership as per the EMRA bylaws. For information on how to subscribe please contact Leah Stefanini, 866-566-2492 ext. 3298 or e-mail lstefanini@emra.org.
Dear members,

The Texas Medical Board has recently authorized diplomates of the American Board of Physician Specialties (ABPS) to advertise themselves as “board certified” in emergency medicine. ABPS does not mandate that its diplomates complete an approved residency training program in emergency medicine. Physicians in primary care specialties and anesthesia may become “board certified” in emergency medicine by ABPS after gaining experience on the field. EMRA maintains that the only pathway to board certification is through an approved ACGME or AOA emergency medicine residency training program.

Here is our letter to the Texas Medical Board.

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**Emergency Medicine Residents’ Association**

March 26, 2010
Re: ABPS/BCEM Board Certification

Dear Texas Medical Board:

The Emergency Medicine Residents’ Association (EMRA) is the largest independent resident physician organization in the nation, promoting excellence in medical education and patient care since 1974. In representing over 90% of residents training in emergency medicine, we are deeply troubled by the recent decision allowing non-residency trained physicians in Texas to advertise themselves as “board certified” through the American Board of Physician Specialties (ABPS).

EMRA strongly believes that training in an accredited emergency medicine residency program is the only pathway to board certification. EMRA only recognizes the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM), both of which require residency training. The quality, caliber and depth of knowledge learned through a formal 3 to 4 year training program devoted to emergency medicine cannot be substituted by unsupervised experience on the field.

The ABPS, which is the governing body for the Board Certification of Emergency Medicine (BCEM), allows physicians trained in other specialties to represent themselves as “board certified” in emergency medicine to the public without completing an approved residency in the specialty. In a time when half a century of training skills have evolved into a specific, unparalleled and focused education the two are not comparable.

EMRA is greatly appreciative of the innumerable physicians who have helped staff hospitals nationwide for years and that began prior to the current availability of residency training programs. Nowadays, residency programs are widely available and have evolved significantly, going as far as producing subspecialties in emergency medical services (EMS), toxicology, emergency ultrasonography and disaster medicine to name a few. It is misleading to imply equivalency without residency training by asserting “board certification.”

Emergency medicine is one of the more competitive specialties. Given the critical nature and the rapid analytical decisions that must take place, medical student applicants currently rank among the highest in their class. Alternative pathways of board certification will compromise this by allowing medical students that did not successfully gain entry into an emergency medicine residency program to complete another training program and still practice as “board certified” emergency physicians, a fact to which the majority of the public will not be aware.

Pediatricians are trained in pediatric residency programs, surgeons in surgery residency programs, anesthesiologists in anesthesia residency programs. Emergency medicine is a highly specialized field that must also retain and protect its requirement for focused residency training. The concept that we can cross specialties by on the field experience undermines our medical education and the nature of medical residency training.

None of these concerns is greater than that of public misconception. The lay public is not privy to the differences between “board certified”, “board certified in ABPS” or “board certified in BCEM” and will assume that residency training in emergency medicine was achieved by the physician rendering care. This will prevent patients from making an informed decision regarding who they choose for their care.

We implore the Texas Medical Board to retract the position allowing ABPS-certified physicians to advertise themselves as “board certified”, “board certified in ABPS”, or “board certified in BCEM” for the reasons aforementioned. It would unknowingly be doing a great disservice to the thousands of physicians currently in emergency medicine residency training programs, the tens of thousands of residency trained physicians currently working in our communities and the millions of patients they serve.

Thank you for your consideration of this very important issue. Please feel free to contact us if you have any questions or need more information.

Respectfully,

Edwin Lopez, MD
President
Emergency Medicine Residents’ Association

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Emergency Medicine Residents’ Association

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Fax: 972.580.2829
www.emra.org
Board update

- **Calling all contributing authors!** The new EMRA blog EMPostCall.com is up and running! The perfect platform to share a terrific story, connect with other EM residents, or discuss topics and issues that are at the forefront of our specialty. Contact Alicia Hendricks for more information on how you can become a contributing author at ahendricks@emra.org.

- **2010 ACEP Leadership and Advocacy Conference (LAC)** will be held May 16-19th in Washington, D.C. This always-inspiring meeting will be more exciting than ever with discussions surrounding the latest in healthcare reform legislation. Be sure to ask your program or State Chapter if they’re participating in the “Chair’s Challenge,” a campaign to provide as many travel scholarships as possible for residents to attend the conference.

- **EMRA events at the 2010 SAEM Annual meeting in Phoenix!** Mark your calendar to join us in Phoenix, Arizona on June 3-6th. Your Representative Council will meet to vote on proposed resolutions. EMRA committee meetings are held to hammer out objectives for the coming academic year. Don’t miss the EMRA National EM Jeopardy Contest where six programs from around the country will battle it out for fabulous prizes. We will end the meeting with the acclaimed EMRA Party, THE place to be on Saturday night! Watch the Website for a full schedule of all EMRA activities.

- **Don’t roll the dice on your emergency medicine career!** For your sure bet, plan now to attend the EMRA activities at the 2010 ACEP Scientific Assembly this September in Las Vegas, Nevada! Your EMRA leaders and staff are hard at work creating the tools you need to succeed in all levels of your professional career as an emergency medicine physician. Watch the Website for more details.

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Consultant’s corner: Orthopedic observation

Dr. George Sutherland is an orthopedic sports fellow at The Hughston Sports Medicine Clinic in Columbus, Georgia.

Q: What physical exam findings do we [emergency medicine physicians] need to be more careful about?
A: The most common injury that I see emergency medicine residents/physicians miss is a posterior dislocation of the shoulder. The best physical exam finding for posterior dislocation is lack of external rotation; also look for a prominent coracoid process and a “fullness” at the posterior aspect of the joint. I know that you learn the classic mechanisms of seizure or electrical shock, but I see this injury often after motor-vehicle trauma, falls, and sports injuries. Always examine patients with their shirts off, and I recommend axillary views for nearly all shoulder injuries. Sometimes, this view is not taken because of fear of putting the patient in pain; however, 20 degrees of abduction should provide an adequate view and can generally be performed even by patients who have fractures.

Q: Talk to us about emergency physicians reducing a dislocated artificial hip joint.
A: Some surgeons feel that their risk is as much as yours in terms of separating the modular head from the stem. Some would prefer to do it themselves. Prolonged dislocation of a total hip replacement is much less dangerous than with a native hip, although sciatic injury can occur; however, the patient is usually in significant pain until the joint is reduced. Either way, get a complete series after reduction. A single view can look concentric and reduced, but the lateral view will show that the ball just hanging on the lip. Also, be sure to assess range of motion after any type of dislocation.

Q: What do we do the most that bugs you (as consultants)?
A: Calling as a “head’s up” before all labs are available. Gather all your data first. A great example is joint fluid in a suspected hot joint; I need to know if there are crystals in the fluid, and I have to know the white count before I can decide if I am taking this person to the operating room to wash out his joint. Also, if there is gross deformity, reduction is best tried as soon as possible. A lot of emergency physicians are worried about “making things worse,” but iatrogenic injury during reduction is extremely rare and is less of a risk than the neurovascular complications from angulated, displaced, or dislocated bones.

The other side of the coin is that I really like it when emergency physicians call (during reasonable hours) to let me know of a problem that they have taken care of on my patient. If I am expecting Ms. Smith to see me for a wrist injury and she doesn’t show up the next day, I can call her at home and ask her to come in. When I do this for a patient, she knows that her emergency and orthopedic physicians work as a team and that we really care about her.

Q: What’s the deal with the Dr. Jekyll/Mr. Hyde consultant?
A: In the real world, consultants who treat emergency medicine physicians like crap don’t get called too often, and they pay for it in lost revenue. When you are a resident, do good work and stand up for yourself when someone gives you a hard time. On the other hand, if your workup is inadequate, if you don’t know something you should, or if you forgot something, own up to it, apologize, and take it when the consultant reams you out.

Q: Any final words of wisdom?
A: You never do a patient a favor by limiting your physical exam secondary to pain. It’s OK to treat their pain and come back for a re-examination when they have better pain control, but you must examine your patients. Missed injuries are bad news; you will miss an injury if you don’t look.
Dr. Carol Rivers’ EM Board Review

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Madam Speaker, I second the motion!

The notion of parliamentary procedures might make some individuals feel like they’ve been poisoned with a cholinergic drug. An individual may become diaphoretic, confused, and have a number of loose bowel movements. Despite the anxiety they cause, these guidelines make the world go around and are easier to learn than most people think.

Parliamentary procedures are not just part of governmental politics but also part of medicine. The American Medical Association (AMA), American College of Emergency Physicians (ACEP), and the Emergency Medicine Residents’ Association (EMRA) use parliamentary procedures to conduct business at their annual meetings. Program Representatives who attend EMRA’s bi-annual Representative Council meeting use these procedures to vote on important resolutions that affect the organization.

Parliamentary procedures are a body of rules that govern meetings and other operations of organizations or legislative bodies. The rules were developed in the 1800s to allow the majority to make decisions effectively and efficiently, while ensuring fairness towards the minority and giving each delegate the right to voice an opinion. At its heart is the will of the majority with respect for the minority. Multiple patterns of parliamentary procedures exist. EMRA uses the Sturgis Standard Code of Parliamentary Procedure. It’s a simpler and more streamlined version of Robert’s Rules of Order.

Have you ever been in a room with 100 doctors who all want to speak? We would never get anything done if everyone spoke at once or jumped from topic to topic. Parliamentary procedures keep us on track. The rules dictate how discussions and motions are brought to the floor. In addition, it details in what order the presiding officer should proceed through business. Application of parliamentary procedures increases the likelihood of a turning long, confrontational meeting into short, painless one.

So let’s get down to some examples. Below are common motions heard at meetings using parliamentary procedures. Get acquainted. At some point throughout your career, you may encounter them.

The bottom line is parliamentary procedures are as much a part of medicine as they are politics. To get yourself familiar try using a simplified version the next time you are in a decision making group, for example, with your friends or family planning an activity or event. If the idea of parliamentary procedures still brings on the classic SLUDGE symptoms of the cholinergic toxidrome, remember at the EMRA Representative Council meeting there will be a number of individuals and handouts to assist you through the meeting logistics. If that is not enough to ease your nerves, you can always attend our Town Hall, which takes place after each council meeting. There you can speak freely on whatever topic you like.

Kaedrea A. Jackson, MD, MPH
SUNY Downstate Medical Center
Brooklyn, NY
Speaker of the Council

“The bottom line is parliamentary procedures are as much a part of medicine as they are politics.”
Madame Speaker, I move to adjourn this article. Second. Any debate? I move to close debate. Second. We will now vote on closing debate. All those in favor raise your hand. All those against? Debate is closed. We will now vote on the main motion. All those in favor of adjourning the article raise your hand. All those against? The motion passes. Article adjourned.

Now that wasn’t so hard, was it?

Ways to get involved!

Make a difference in your specialty through EMRA

Write a resolution. A resolution is essentially a directive for EMRA to take a certain action or to form a policy. Resolutions for the EMRA Representative Council meeting to be held at Society for Academic Emergency Medicine (SAEM) Annual Meeting are due April 21, 2010. Visit the EMRA Website for more details, examples, and to submit your resolution online. You can always request more information from the Speaker of the Council at speaker@emra.org.

Become an EMRA Regional Representative

The purpose of the Regional Representative network is to identify and empower new leaders within our specialty, to write resolutions that influence our medical practice, to participate in the Representative Council, and to facilitate communication between the Program Representatives and the EMRA leadership. EMRA will begin collecting applications for Regional Representatives for the 2010-2011 academic year in June 2010. Interested parties please send your curriculum vitae and letter of intent to Angela Fusaro at vicespeaker@emra.org by June 18, 2010.

For more details on these and other ways to be involved in EMRA visit www.emra.org.

Forecast turnout for Council of Residency Directors (CORD) Academic Assembly

For those residents not familiar with the CORD Academic Assembly, the conference provides many fundamental skills to develop yourself as a professional educator and to kick-start your career in academics. Although much of Academic Assembly is tailored to established educators and junior faculty educators, residents gain much from participating in this premier educational conference in emergency medicine. A specific track organized for residents covered the topics of Transitioning to Junior Faculty, CV and Portfolio Building, Billing and Coding in addition to an interactive session on “Can’t Miss Cases.” Additionally, the familiar “Navigating the Academic Waters Track” launched a new three-year curriculum with workshops for developing skills in speaking, writing, and teaching.

Networking opportunities abound between the educational sessions, continental breakfasts, and catered lunches. New this year, EMRA sponsored a Resident/CORD Board of Directors Mixer that provided an additional opportunity to meet some of the biggest names in emergency medicine. EMRA provided three $500 scholarships to attend the CORD Academic Assembly as winners of the EMRA Faculty Development Award to senior residents aspiring to become medical educators. This year’s winners were: John Hougland, MD, Denver Health Medical Center, Carrie Cregar, MD, UMDNJ University Hospital, and William Goldenberg, MD, SUNY Brooklyn.

Mark your calendar for next years’ CORD Academic Assembly in San Diego March 2nd-5th, 2011. In addition to applying for EMRA’s scholarship, residents should look to attend in order to showcase their latest educational innovation or educational research at the CORD peer-reviewed academic poster session.
Currently in the 2009-2010 Academic Year there are 155 ACGME accredited emergency medicine programs of which 124 are three years in length and the other 32 are four years in length. Approximately 88 percent (4982 of 5675) of approved resident positions are filled. Of the 24 accredited Medical Toxicology Programs, 52 of the 88 approved positions are filled. In Pediatric emergency medicine, there are 63 of 75 positions filled in the 21 accredited programs. Sports Medicine has eight of eight positions filled in five programs. And lastly, seven of 12 positions are filled in the six Undersea and Hyperbaric Medicine programs.

Semiannually, the Residency Review Committee for Emergency Medicine (RRC-EM) meets to review both core emergency medicine and subspecialty programs. The purpose of the reviews is to ensure all residents graduating from an ACGME-accredited program receive equivalent and adequate training. Results from the February 2010 RRC-EM meeting in Santa Barbara, CA are as follows:

Five new Core EM (2), Medical Toxicology (2), and Undersea & Hyperbaric programs (1) were approved.

1. Staten Island University Hospital Emergency Medicine Residency Program
   Staten Island, NY (PGY1-3; 8 residents/yr)
   Program Director: Moshe Weizberg, MD

2. Baylor College of Medicine Emergency Medicine Residency Program
   Houston, TX (PGY1-3; 12 residents/yr)
   Program Director: Grish Bobby Kapur, MD

3. Texas Tech University Health Sciences Center / Paul L Foster School of Medicine Medical Toxicology Program
   El Paso, TX (2 fellows/yr)
   Program Director: Stephen Borron, MD

4. Washington University/B-JH/SLCH Consortium Medical Toxicology Program
   St. Louis, MO (2 fellows/yr)
   Program Director: Sarah Eliza Halcomb, MD

5. SUNY Upstate Medical University Undersea and Hyperbaric Medicine Program
   Syracuse, NY (1 fellow/yr)
   Program Director: John McCabe, MD

The next RRC-EM meeting will be held in Chicago, IL September 10-11, 2010. If you have any questions, please refer to the ACGME Website and the Emergency Medicine RRC newsletter which can be found on the ACGME Website (http://www.acgme.org/acWebsite/navPages/nav_110.asp). Congratulations and a great welcome to all the new programs!
On a daily basis, I hear the same story from my patients in the emergency department, and I’m sure many of your patients are telling you the same stories as well. “I have a GI referral, but the first appointment they have available is in three months,” or “I called my neurologist, but he can’t get me in for another month.” And let’s not forget “I’m scheduled for a MRI, but it’s not for three more months” or “I’m scheduled to have my tooth pulled…in four months.”

Every time I hear stories like these, I wonder what would happen if our patients were able to obtain these services sooner. Would they actually obtain timely outpatient care, instead of constantly relying on the emergency department to serve both their primary and long-term care needs?

Thanks to new legislation in the state of California, we may soon find out. In January, California adopted a set of health care access standards, becoming the first state to adopt such legislation. Governor Arnold Schwarzenegger stated that “timely access to comprehensive health care services is critical for both diagnosis and treatment, and these regulations will ensure nearly 21 million Californians can access physicians and other health services in a quick and appropriate manner.”

These regulations require HMO’s to ensure that they have enough providers to meet specific access time frames, which include:

- 10 business days for non-urgent primary care appointments
- 15 business days for non-urgent specialist appointments
- 10 business days for non-urgent mental health appointments
- 15 business days for non-urgent ancillary services
- 72 hours for urgent dental care
- 36 business days for non-urgent dental care
- 40 business days for preventive dental care

Set to take effect in January 2011, these regulations certainly provide food for thought. Based on my personal experiences as patient, parent, and concerned family member, I know how difficult it can often be to get a return phone call from a specialty provider within a reasonable time frame, let alone obtain an appointment without waiting for weeks or months. Even scheduling a routine health exam for my children requires at least a month of advanced planning. So I can certainly see the countless advantages these regulations could bring to the average patient.

There is still an entire year that will pass before these regulations take effect. And as we all know, the political machine is constantly producing new and “improved” rules, regulations, and policies. So these standards may change or even be revoked before being officially implemented. But it is my sincere hope that we are given the opportunity to see the results of this “experiment” in California. Perhaps our patients will truly have better access to care and ultimately better outcomes. Or perhaps despite better access there will not be any difference in outcomes. Only time will tell what, if any, benefit these regulations will demonstrate in the long run, but without being given the opportunity to fail, we will never know if they can succeed.
Disasters encourage technology development

Disasters force people to leverage their previous training and experiences to meet challenges with often inadequate resources and support. Volunteers must be more ingenious and innovative. I wanted to highlight some of the technological innovations developed and deployed during the Haiti Crisis, as well as some technologies on the horizon that may have a huge impact on future disasters. In many cases, these technologies were deployed remotely to aid responders on the ground.

Within hours of the Haiti earthquake, developers launched a build of Ushahidi for Haiti. Ushahidi, Swahili for testimony, is a crisis incident management tool that aggregates and maps crisis intelligence. Originally developed for the post-election violence in Kenya, it has been deployed in South Africa, the Democratic Republic of Congo, India, and Pakistan.

The premise is simple. Crisis intelligence is best collected by the victims of a disaster. Crisis information is crowdsourced from text, Twitter, Facebook, and other sources. A network of volunteers then aggregates and enters the data into the Ushahidi system to become actionable data for disaster responders.

While disaster responders poured into Haiti, technology volunteers were busy around the world supporting their efforts.

Domain experts, developers, and first responders gathered at local events—called CrisisCamps—where they worked together to improve technology and practice for disaster relief. Under the CrisisCommons banner, they have accomplished a dizzying array of projects:

- The Sahana List was put together to catalog and map Non Governmental Organizations (NGO) personnel and to improve intra-organization communication

“While disaster responders poured into Haiti, technology volunteers were busy around the world supporting their efforts.”

Steven Horng, MD
Maimonides Medical Center
Brooklyn, NY
Technology Coordinator

The Life Saver System
water-filtration 750mL bottle unit.
The Person Finder application helps families reunite by searching for and cataloging missing person information.

The Open Street Maps project utilized volunteers to build an open source map of Port-au-Prince using satellite imagery, well before any other map provider.

The We Have, We Need Exchange is an online marketplace for the exchange of resources and services for NGO’s operating in Haiti.

CrisisCamps even produced a free iPhone app, a Creole to English translation mobile application.

There are also two emerging technologies I wanted to highlight. The Life Saver System is a new type of water-filtration unit that will revolutionize humanitarian aid. It is able to filter down to 15 nanometers, eliminating even the smallest viruses. It comes in two configurations—a 750 mL bottle, capable of filtering 4000 L of water, and a 18.5 L jerry can capable of filtering 10,000 L or 20,000 L, depending on which type of filter you use. This technology will allow disaster victims to return to their homes sooner, instead of clustering around potable water distribution points. By helping victims return to their homes sooner, it may also minimize the burden of infectious diseases that spread rapidly through clustered communities.

Another emerging technology—sustainable refrigeration—has always been difficult to introduce to developing countries. It is necessary for the storage of many vaccines and medications. Researchers at Stanford are working on a new type of Stirling engine, fueled by cooking fires, that will serve as a coolant device. The football-sized device is first heated over a fire for 30 minutes and then is able to refrigerate a 3-gallon tank for 24 hours. Even more impressive, this device can be used in perpetuity.

Technology will have a profound effect on future disasters. Ultimately, technology’s greatest contribution will not be sophisticated devices such as the Life Saver System but rather in helping to bring people together to work on a common cause—whether that means volunteers with a specialized skill set or even those with just a desire to help.
2010 ACEP Leadership and Advocacy Conference

May 16-19, 2010

Washington, D.C.

For complete conference schedule and registration, visit www.acep.org. Deadline: May 1, 2010

Be sure to ask your academic chair about participating in the EMRA Chair's Challenge.

EMRA/YPS Residents and First Timers Leadership and Advocacy Essentials

Sunday, May 16, 2010
12:30 pm – 12:40 pm  Welcome and Introduction
                            Edwin Lopez, MD, EMRA President and
                            Kathleen Cowling, DO, FACEP,
                            ACEP Vice President

12:40 pm – 1:20 pm  Introduction to Advocacy and
                    Healthcare Reform
                    Nathaniel Schlicher, MD, JD
                    EMRA Legislative Advisor

1:20 pm – 2:00 pm  Current Issues and Crises
                   Jennifer Wiler, MD, YPS Member

2:00 pm – 2:40 pm  Healthcare Economics
                   Ethan Booker, MD, YPS Member

2:50 pm – 3:50 pm  Roundtable Discussion

4:00 pm – 6:00 pm  Delivering Powerful Presentations
                   Learn to deliver powerful, effective presentations at a podium or in your hospital administrator's office; use effective strategies that convey enthusiasm and executive presence. Coaches offer critiques that are constructive and supportive to help improve your delivery, control and confidence.

6:00 pm – 7:00 pm  Resident and Young Physician Section Reception

Monday, May 17, 2010
7:00 pm – 7:50 am  Resident’s Welcome Breakfast
                   Edwin Lopez, MD, EMRA President

2010 Chair’s Challenge
Leadership and Advocacy Conference
Scholars Program

Support the development of our specialty’s future leaders and patient advocates

What the ACEP Leadership and Advocacy Conference does for Emergency Medicine Residents:

✓ Exposes them to the legislative process
✓ Fosters in them the advocacy spirit
✓ Teaches them the skills needed to effectively communicate issue-related messages
✓ Empowers them to actively use these skills as leaders

The experience culminates with the residents, along with the other conference attendees, meeting with their U.S. Senators and Representatives on Capitol Hill to discuss the most important health policy issues. For complete schedule and registration form, please visit www.acep.org.

Sponsorship commitment deadline: May 1, 2010

For more information and sponsorship form please visit www.emra.org
When I first sat down to write this article about healthcare reform it was late February, we had just seen the Senate lose its supermajority in the election of Scott Brown in Massachusetts, and the hope for healthcare reform seemed dashed. I had planned on analogizing our current situation to the time honored military terms of SNAFU and FUBAR. How had we gotten so hopelessly adrift after a year of work?

One month later we find ourselves in an about face. Healthcare legislation has passed relatively intact. The Republicans, once celebrating the defeat of healthcare legislation by Scott Brown’s election, are now screaming about revolution, repeal, and the political two step of reconciliation. Coverage will be extended to some 32 million Americans, pre-existing conditions are a thing of the past, “insurance abuses” are gone, fraud is under assault, and other major changes to the way we pay for healthcare is under way over the next four years.

Yet the legislation has not done as much to address many of the problems that exist in healthcare delivery, beyond providing coverage. If we can learn anything from the implementation from Massachusetts’ own healthcare legislation coverage five years ago, the system is not ready. We have too few primary care physicians who are paid too little and worked too hard by the current system. While some minor payment increases are foreseen and the “promises” of the Medical Home are touted, this is a glaring abyss within the legislative promises made. Where will all those patients who cannot get access to care (now with insurance) go to? Where else, their local emergency department and you. This was demonstrated by the ballooning numbers of patients seen in the emergency department after Massachusetts’ reform passed.

There is also the threat of new payment forms that will further hamper the emergency department. With Episode of Care (EOC) and Bundled Payments, there is growing risk that the fight will be between physicians and hospitals over reimbursement, not with CMS directly. These present a clear and present danger to every hospital based emergency physician. We will need to be working on these issues on the regulatory side to limit the scope and potential for abuse. There is also the ongoing issue of CMS reimbursement and SGR cuts that threaten to further push primary care physicians away from Medicare and Medicaid, drive down reimbursement, and threaten the recruitment of excellent medical students into our field. There is the inclusion of an independent oversight board in the regulation that risks putting SGR like cuts (or worse) in place down the road.

With the two thousands pages of legislation that has passed, now comes the true challenge. There will be constitutional challenges from many states under arguments of limiting federalism versus the broad reach of the commerce clause. There will be many special interests from within and outside of medicine that will be working to repeal part or all of the reform. The smallest lines of the reform will require pages of regulations and codification in the federal register. Comments will be needed as these regulations are published for review. Our work is only beginning, now comes the large challenges.

Regardless of the voluminous laws passed, there will be future bills, challenges to medicine, and ever-increasing need for physician involvement in advocacy. I hope that we will see many of you at the Leadership and Advocacy Conference in Washington, D.C. this May. Talk to your Chair today about having them sponsor you in support of the EMRA Chair’s Challenge. Help guide the future forward to successful!
**Clinical case**

**Going nuts over nuts**

**History and presentation**

Paramedics are in route with a 9-year-old male with a history of chronic persistent asthma who just finished a two-week taper of prednisone for an asthma flare. The boy had eaten a brownie about 30 minutes prior and started to have difficulty breathing and felt like he was choking.

Paramedics found the patient supine on the floor in severe respiratory distress with diffuse wheezing and poor air movement throughout his lungs. They attempted orotracheal intubation but the patient bit down on the blade. Paramedics initiated albuterol nebulizer treatments and gave methylprednisolone 50mg IV during transport.

**Physical exam**

On arrival to the emergency department, the patient was alert but having nasal flaring, sternal and inter-costal retractions. The boy was able to state his name but unable to complete a sentence. Vitals were temperature 94.6F, heart rate 143, blood pressure 111/40, respiratory rate 33, and weight 31kg with O2 saturation of 100 percent on 15L facemask. On skin exam, no rash was noted, and on HEENT exam, no oropharyngeal or lip swelling or edema was evident. The boy was still having significant inspiratory and expiratory wheezes with poor air movement. The rest of the physical exam was unremarkable.

**Differential diagnosis discussion**

Asthma exacerbations certainly present with the findings of diffuse wheezing and respiratory distress as was evident with this patient; however, the rapidity of onset and the relationship of the patient’s clinical deterioration with eating a brownie forces the astute clinician to consider other causes of this presentation. Foreign body aspiration with resultant stridor or wheezing is a definite consideration in pediatric patients with respiratory symptoms shortly after eating. Often the clinical history of an aspiration event is not readily apparent to parents or the physician and a high clinical suspicion is necessary in any pediatric patient presenting with a sudden onset of respiratory distress.

The lack of a rash or oropharyngeal swelling and the past medical history of asthma should not dissuade the savvy emergency practitioner that this presentation is likely a case of anaphylaxis. With additional history from the mother of the patient, the brownies were found to be made with pecans. Even though the patient had no known sensitivity to pecans, the proximity of the exposure with the rapid clinical deterioration of the patient clues us into the diagnosis. Food allergies in children, especially shellfish and tree nuts, have been reported to increase by 17 percent in the last ten years. Although the overall incidence of food allergies is increasing, the numbers of deaths related to anaphylaxis is relatively few. Less frequent than the uncommon death due to a lightning strike, sources report fewer than 150 anaphylactic fatalities per year.

**Initial management**

The patient was started on continuous albuterol nebulizer at 10mg/hr, given an IV bolus of terbutaline 10mcg/kg. Epinephrine (1:1000) 0.3mg IM was administered to this 30mg boy at a dose of 0.01mg/kg. The patient began giving a thumbs up to providers after these initial treatments but was still experiencing severe respiratory distress. A portable chest X-Ray failed to demonstrate a radiopaque foreign body or asymmetric hyperinflation. Diphenhydramine 30mg IV
at 1mg/kg was given along with a second dose of epinephrine IM and a terbutaline drip was started at 0.2 mcg/kg/min. Within 45 minutes of arriving to the emergency department, the patient was speaking full sentences and had a much-improved work of breathing.

Epinephrine is the treatment of choice and needs to be the first drug administered in the therapy of anaphylaxis. This has been confirmed by every guideline issued worldwide since 1973. Dosing and routes of administration should be committed to memory by emergency medicine practitioners. (See Table 1).

Although studies fail to demonstrate improved outcomes with various routes of administration, intramuscular administration is favored for initial treatments of epinephrine with intravenous administration reserved for refractory cases. Although both intravenous administration of histamine blockers and corticosteroids have been shown to improve outcomes for cases of anaphylaxis, they are largely ineffective in the first few hours of treatment. The addition of H-2 blockers, such as cimetidine or ranitidine, to diphenhydramine has shown to provide some modest improvements in patients and are reasonably warranted.

**Final thoughts**

The patient was admitted to the PICU and was on room air within three hours of admission. The patient was discharged two days later and ultimately diagnosed with an allergy to pecans and peanuts. Tree nuts, such as pecans, cashews, walnuts, and pistachios are common triggers for allergies in children. Peanuts, which are technically not nuts but instead legumes (like peas or lentils), are frequent “nut allergies” and have up to a 60 percent cross-reactivity with tree nuts. Even though three million Americans (one percent of the total population) have been reported to have an allergy to tree nuts, most will never have more than mild reactions to the ingestion of or exposure to nuts.

For those patients refractory to intramuscular epinephrine, intravenous epinephrine can be used. An epinephrine infusion can be created by injecting epinephrine (1:1000) 1mg into 250ml of normal saline. This infusion can be run in at 2-4ml/min to maintain acceptable blood pressures and treatment effect. In a pathway similar to that involved in beta-blocker overdose, glucagon can be considered as an adjunctive medication to those patients, particularly patients on beta-blockers, who are refractory epinephrine treatments. Administration of glucagon in doses of 2-5mg IV will be necessary.

**References**

Back to basics: Emergency medicine residents rekindle their passion for medicine in Haiti

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Is your procedure log up to date? How many patient follow-ups have you completed? Did you finish your journal club assignment this month? As residents in the middle of a grueling academic year, we are easily overtaken and distracted by the ever-mounting tasks expected of us. Unfortunately, many of us let these responsibilities take away the joy and excitement we once had for the practice of medicine. However, it is imperative that we occasionally remind ourselves of the excitement we felt back in July, when we first started our academic year. This past month, several emergency medicine residents rediscovered their passion for medicine after providing relief work in Haiti.

In January, a devastating earthquake killed thousands of people and destroyed much of the infrastructure in the country of Haiti. After the earthquake, countries from around the world quickly came to the aid of Haiti, with much of their focus on the capital city of Port-au-Prince. However, the widespread devastation also hit the southern region of the island, including the small town of Petit-Goave, located 42 miles southwest of Port-au-Prince. This town of 12,000 was the site of a temporary clinic established by the Wesleyan Church, existing only until the local hospital became fully operational. However, with that goal almost two years away, the clinic now serves as a local emergency department and trauma center.

I had the privilege of spending ten days in the clinic serving as a co-medical director with two other emergency medicine residents. During this experience, we quickly realized how well we were trained as we took care of patients without the luxury of radiology, labs or specialty back-up. Our second night, we treated four patients injured in a motorcycle accident, three burn victims with 20 to 30 percent TBSA wounds and one seizing, eclampsia patient. By the end of the night, we had stabilized each patient and transferred them safely to definitive care. However, our feelings of triumph were quickly replaced by defeat the next night when a patient in labor presented with fetal distress. By the time an obstetrician arrived, the baby had already died. Despite that loss, we knew our involvement had helped save the mother’s life.

During our short stay, we helped organize the new “emergency department” in Petit-Goave by developing a triage system, an ambulance transport system and even a small ICU. Teams of three to four physicians will continue to rotate through in approximately two-week cycles. By providing a medical safety net for patients left helpless, we were reminded again of why we chose to devote our lives to the practice of medicine.

All the physicians who worked in Haiti gained an experience that will stay with them throughout their careers. Although not every emergency medicine resident will have that same experience, each one can have equally inspiring shifts at their home hospitals. So the next Saturday night you run five Level I traumas, take care of that septic patient, resuscitate that medical code and deliver that baby in the hallway, just remember how fortunate and privileged you are to be an emergency medicine physician.
Case
A 16-year-old female with no past medical history presented to the emergency department with a chief complaint of seizure. Three hours prior to arrival, the patient had got into an argument with her father. Her mother went to check on her and witnessed the patient having a seizure. On arrival to the emergency department, the patient’s vitals were as follows: blood pressure, 80/50 mmHg; heart rate, 120 beats/min; respiratory rate, 15 breaths/min; oxygen saturation, 99 percent on room air; and capillary glucose, 110 mg/dL. An ECG was obtained as seen in Figure 1.

Discussion
When a patient presents to the emergency department with a history of suspected overdose, a “tox” panel is often sent. This usually consists of a complete blood count, a chemistry panel, urine screen for drugs of abuse, and a serum acetaminophen/salicylate concentration. While some institutions also add a measured osmolality and serum lactate, perhaps one of the most critical tests to obtain is an ECG.

In addition to evaluating for ischemia, an ECG can reveal evidence of sodium channel and potassium channel blockade in the setting of suspected overdose. Sodium channel blockade is often evident as prolongation of the QRS interval, defined as greater than 100 msec. Additional evidence of sodium channel blockade is a $R_{avr} \geq 3$ mm, especially in tricyclic antidepressant (TCA) overdose. While TCAs are classically associated with sodium channel blockade, there are many other drugs with similar properties, often described as a “quinidine-like” effect. These drugs are listed in Table 1.

Table 1. Drugs with type IA sodium channel blockade

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effect</th>
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<tr>
<td>Amantadine</td>
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<tr>
<td>Carbamazepine</td>
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<td>Cocaine</td>
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<td>Diphenhydramine</td>
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<tr>
<td>Encaïnide</td>
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<td>Flecaïnide</td>
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<td>Procainamide</td>
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<tr>
<td>Propranolol</td>
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<tr>
<td>Quinidine</td>
<td></td>
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<tr>
<td>Quinine</td>
<td></td>
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<tr>
<td>Thioridazine</td>
<td></td>
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<tr>
<td>Tricyclic antidepressants</td>
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The mechanism by which sodium channel blockade occurs is the same regardless of the pharmacologic agent. Drugs that exert this "quinidine-like" effect block the fast-acting sodium channels in cells of the His-Purkinje system. This prolongs phase 0 of depolarization and manifests as a widened QRS on the ECG. This conduction delay can also manifest as a right axis deviation due its greater effect on the right-side of the conduction system.

Management focuses on recognition of these potentially fatal complications and treatment. Alkalization with hypertonic sodium bicarbonate is the cornerstone of therapy for sodium channel blockade. While the efficacy of this therapy is well-demonstrated in experimental models for cyclic antidepressant cardiotoxicity, it is also recommended for other agents causing sodium channel blockade.

References
I can’t find potato gun on the algorithm for trauma activation. Is it in the same category as a GSW or is there a separate listing for homemade vegetable missile?” These were the thoughts (with some artistic embellishment) in my head during a shift in a rural emergency department in Colorado. Apparently, a potato, a piece of PVC piping, and a can of hairspray can be quite dangerous when in the hands of enthusiastic teenage boys (these implements would also be dangerous in the hands of an enthusiastic medical student, and this author takes no responsibility should one choose to assemble the aforementioned products). During the summer between my first and second year of medical school, I spent one month in a small town (population 7,000) living and working with physicians in a six-bed emergency department through an externship program. I experienced firsthand some of the challenges and rewards facing rural emergency physicians. I felt the pressure of minimal subspecialty consult resources and long transfers – I even learned all about “mutton-busting” (imagine a small child clinging for dear life onto the back of an angry sheep).

Emergency medicine can be difficult in rural areas. While the emergency department isn’t always busy and the volume of patients is low in comparison to other settings, the chance for any type of pathology still exists. As such, the rural emergency physicians must be able to make complex medical decisions with minimal resources and backup, such as deciding whether or not to administer tPA in an acute stroke without neurology in house or even in the same county. Rural providers must maintain their skills without the benefit of daily exposure, and they are often faced with difficult decisions about transfer times or appropriation of limited resources; they must be adequately trained.

In a recent study, Ginde et al. illustrate some of the issues surrounding the emergency physician work force, including the shortage of emergency medicine trained physicians practicing in rural areas. In small, rural areas only 35 percent of physicians who practice emergency medicine are board certified in emergency medicine. Additionally, only 21 percent of these rural practitioners completed an emergency medicine residency. This shortage may continue to worsen as only one percent of residency graduates in the past five years practice in small, rural areas, as opposed to five percent of graduates who finished training 20 years ago.¹

In order to best serve our patients in these areas, we should seek to improve these numbers. The American College of Emergency Physicians’ goal is to have all new physicians who practice emergency medicine in the 21st century complete an emergency medicine residency and be eligible for board certification.² Although this aim may not be practical in the near future, there may be steps that we can take with this goal in mind. Exposure to rural practice in both medical school and residency may encourage graduates to practice, at least part time, in smaller towns. Broadening loan repayment programs, such as the National Health Service Corps, to include emergency medicine physicians may increase rural numbers, especially with young physicians. Encouraging groups to include rural hospitals in their staffing, i.e., having urban physicians spend one or two shifts a month in a rural site, may also be feasible as many rural areas are within a few hours drive of urban centers and most use 24 hour shifts.

As we bring the entire specialty of emergency medicine into the 21st century, we can hopefully address these issues with practical solutions. As you begin thinking about your own career and future in emergency medicine, consider an elective at a rural emergency department. You will undoubtedly be challenged and find many rewards. Who knows, you may even leave with your own potato gun.

References
Tips for a successful EMIG

For those medical students interested in emergency medicine, there are precious few ways to get involved in the department. This makes involvement in an Emergency Medicine Interest Group (EMIG) an invaluable experience. Not sure whether or not you like emergency medicine? Become involved in a shadowing program! Considering residency in emergency medicine? You’ll build relationships for future recommendations. Want to improve your clinical skills? Attend a clinical skills lab! EMIGs are often the only link between interested first and second years and the specialty, so having a successful organization becomes crucial. Here are some tips for running a successful EMIG:

1. **Fundraising:** Use that first year anatomy class as a way to fundraise! Providing an easy and affordable way to purchase scrubs is a lucrative way to raise funds.

2. **Lunch talks:** Aim to have four talks per semester, and always keep the exam schedule in mind when organizing the event. Balance lectures that introduce students to the specialty with lectures covering issues such as advocacy, the future of emergency medicine, and overcrowding. Reserve the room in advance, and ask for the AV equipment your presenter needs. Try to have speakers set at least a month in advance; remind them as the event gets closer, and send them a thank you immediately after the event. Don’t forget to change the lectures each year to keep event attendance high.

3. **Labs:** There is a multitude of labs you can offer—including ultrasound, phlebotomy, EKG reading, and suturing. Try to coordinate with other groups such as the Surgical Interest Group to defray costs. Residents are often willing to help teach. Either a lottery system or first come, first serve are acceptable ways to fill popular labs.

4. **Shadowing:** There are two ways to manage this. One is to match students up with a resident or an attending and let them coordinate shadowing on their own. Although this allows students to build a relationship, inevitably some students will be unable to set up a shadowing time and may lose out on this experience. Another option is to have prearranged three-hour-shadowing shifts in the emergency department. By not having a set person to shadow going into the experience, the student can follow whoever has the most interesting cases that day. The downfall is that students whose schedules do not work with the prearranged shadowing shifts will potentially miss out. A combination of both approaches will ensure that students have the best experiences shadowing in the department.

5. **Mentoring:** Ask your EMIG faculty advisor to provide a list of attendings willing to interact with students on a one-on-one basis and offer guidance for a career in the emergency medicine. This opportunity might be best for those second years who have investigated the field of emergency medicine (such as through the EMIG in their first year) and thus have a genuine interest in the field. This can become a fantastic resource for students to meet faculty and become involved in the department early in their medical school career.

6. **Additional events:** Considering hosting a blood drive, starting an ambulance ride-along program, teaching CPR classes, or holding a fundraiser for students to attend a scientific assembly. The more opportunities you can offer for students to become involved in emergency medicine the better. Don’t forget to advertise summer research and externship opportunities in emergency medicine!

I hope that these tips help you either improve upon an existing EMIG or provide you with the tools to start one in your school. Good Luck!

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Baltimore, MD
EMIG Vice-President

Sign up for the EMRA Mentorship Program at www.emra.org and select the Get Involved tab.
Going abroad

Have you considered rotating abroad? An international rotation will leave a lasting mark on you, both as a person and as a physician. You will learn to see things differently in medicine and your everyday life. The scope of diagnosing and curing disease varies dramatically from country to country, and you will have a firsthand opportunity to incorporate the best ideas from around the globe into your future practice. In addition, you will see the differences in health care systems; the way insurance is provided, how hospitals are organized, and what culture exists within them. Lastly, many program directors will appreciate an international rotation on your CV.

Working in a hospital is probably one of the best and most direct ways of immersing yourself into another culture. How does society treat its sick? How do the people react to illness? How is the doctor-patient relationship different? Is there universal health care? Also, this kind of work will expose you to people of all levels of society, patients and co-workers alike; you would never learn so much about a country and its people as a tourist. Mastering the new environment and learning all the medical issues can be challenging at times, but isn’t adaptability to unfamiliar situations a key characteristic of a good emergency physician?

Start by deciding what type of setting you would like to work in. Are you more interested in rural, low budget medicine and tropical disease, or would you prefer a country with top-notch facilities and lots of resources? Do you speak a foreign language? In many countries, English is widely spoken among medical professionals, but keep in mind that some may require you to be able to communicate in the local language.

Once you have decided where you want to go, there are many resources available to help make it happen. Your medical school may have partnerships with foreign universities, so start by asking around. The International Federation of Medical Student Associations has a Standing Committee on Professional Exchange (SCOPE) that offers many international electives. Often food and lodging are included, and a social program will get you in touch with the local students. Finally, EMRA’s Medical Student Council partners with Emergency Medicine Interest Groups (EMIG) in countries all over the globe, from Rwanda to New Zealand, from the Philippines to Germany to help students find international rotations.

Our international EMRA EMIG representatives will be glad to assist you with information on rotations in their country – please feel free to contact us if you are interested at MSCIntl@emra.org. Having worked and studied in five different countries, I can assure you that an international rotation will be a phenomenal and exciting experience that will shape your future life and career.
Choosing an away rotation

The specialty of emergency medicine is becoming increasingly competitive. Program directors not only wish to see outstanding performance in the emergency department at the applicant’s home institution, but also at another program as well. As such, away rotations are becoming an essential piece to the process of applying to residency in emergency medicine.

The Standardized Letter of Recommendation (SLOR) is the tool used to evaluate your performance on a fourth-year-emergency-medicine rotation. Your application is much stronger with two of these letters in your file—one from your home institution and one from an away rotation. If your medical school does not have an emergency medicine residency, it is helpful to complete two rotations at established residency programs that interest you.

There are many advantages to doing an away rotation. Spending four weeks with a residency program will tell you first-hand if that residency is for you. You will work with the faculty, interact with the residents, eat in the cafeteria, and attend conferences. By the end of the month, you will know if this program is a top choice for you. You may even be able to interview during the rotation, which will save time and money later during the interview season. Most importantly, spending time at another institution will help you to experience the different settings in which emergency medicine is practiced. Emergency department volume, percentage of trauma patients, patient demographics, autonomy of residents, and length of shifts are all different factors you will experience during an away rotation.

There are two schools of thought on how to choose an away rotation. One approach is to apply to the program of your dreams. If the program is highly competitive and your scores mediocre, outstanding performance during your month may show the program that you are worth considering. In addition, spending a month at your top choice residency will either reaffirm your choice or change your mind.

The other approach is to select a program that is entirely different than your home institution. If your local residency is an academic, community program, go to an urban, county program. The practice and style of emergency medicine varies dramatically depending on the setting, and exposure to different places will help you find a match that fits your unique personality. Choosing between academic and county programs is important when applying for interviews, so finding out what you like early will save a large amount of travel and expense down the road.

There is a potential downside to away rotations. It is a four week long interview. You will interact with dozens of faculty and residents, and as a student, you will make mistakes. Bad interactions can hurt your chances of matching at that program. However, if you are enthusiastic, work hard, and play nice with others, you will be highly regarded. Program directors may choose someone with a strong work ethic and social skills, rather than take a risk on an applicant they do not know.

Applying for an away rotation used to involve contacting programs individually and filling out many separate applications. The Visiting Student Application Service (VSAS) program, available on the AAMC Website, is an on-line application that many residences now utilize. Using this program is much more efficient and may even be required by the program with which you wish to rotate. Beware that this system is relatively new and programs may not receive your application materials before deadlines. I recommend contacting the program coordinator to follow-up after applying electronically. Keep in mind that competitive programs often fill their available spots early in the spring or summer. Apply early, and have a current CV ready. Lastly, remember your professional reputation in emergency medicine is molded with every interaction. Be polite in your communications. Do not miss deadlines, and decline back-up away rotations as soon as you receive confirmation from your desired program.

In summary, an away rotation can significantly strengthen your application and provide useful insight into your residency goals. It will be an experience you will not forget. Good luck!
Sepsis affects approximately 750,000 people annually in the United States, with its associated mortality approaching 25 percent. Over the past decade, there has been a movement towards early goal-directed therapy. Having specific endpoints for resuscitation has proven to significantly influence survival rates. Indices of macrocirculation such as systolic blood pressure and urine output have traditionally been utilized within the emergency department to target therapy for septic patients. Current trends, however, are shifting to include other objective measurements of tissue hypoperfusion and microcirculatory changes that can be present despite no signs of overt shock.

Lactate has long been identified as a marker of energy failure and tissue hypoxia; however, its production is one of many critical adaptive mechanisms utilized by the body during states of oxygen deprivation. According to the Pasteur effect, under anaerobic conditions, pyruvate generated through glycolysis is shunted to produce lactate rather than entering the Krebs’ cycle via acetyl-coA to produce energy. This mechanism occurs during states of low oxygen tension within cells. Lactate produced via this pathway can then be utilized by the liver for gluconeogenesis allowing cells to produce some energy under states of relative oxygen deprivation.

Many of these adaptive mechanisms are time-sensitive—including the cell’s ability to utilize lactate as an energy source. If the hypoxic insult continues, a threshold is reached where energy supply no longer meets demand, and lactate diffuses into the circulatory system becoming an objective measurement of disease progression.

Elevated lactate levels in patients with septic shock clearly provide the physician an indication that the patient has reached their threshold of adaptation and have progressed to a state of tissue hypoperfusion. Generally accepted criteria for aggressive, early resuscitation includes either a systolic blood pressure less than 90 despite a fluid bolus or an initial lactate level greater than four.

After identification of the shock state, it is critical to begin resuscitation with specific goals designed to ensure optimization of tissue perfusion. Currently, in accordance with the Surviving Sepsis Campaign revised in 2008, those include CVP between 8-12, MAP 65 or higher, urine output at least 0.5 ml/kg/hour and cSvO2 or mSvO2 at least 70 or 65 percent, respectively.

If goal venous oxygen saturation is not achieved, then further fluid should be considered in addition to transfusion of packed red blood cells to achieve a hematocrit of at least 30 percent and/or the addition of dopamine at a maximum dose of 20 ug/kg/min. It is this early goal-directed therapy that has proven to reduce mortality among patients with severe sepsis and septic shock.

Despite the success of early goal-directed therapy within the emergency department, there are still approximately 215,000 deaths each year secondary to sepsis. Research continues to investigate ways in which we can further reduce these numbers with lactate being a specific area of interest.
In a recent cohort study, an association was found between elevated serum lactate levels and increased mortality independent of signs of organ failure and shock. Interestingly, patients within their study with intermediate lactate levels between two and four mmol/L—which would not typically prompt aggressive resuscitation—experienced almost twice the mortality as patients with lactate levels less than two. This raises a new subgroup of patients with sepsis who could potentially benefit from goal-directed therapy.

Several investigators have evaluated not only patient’s initial lactate levels, but lactate clearance. Lactate clearance is defined in these studies as at least ten percent decrease in initial lactate levels compared to six hours after resuscitation. Nguyen et al found a significant decrease in mortality as well as decreased fluid and vasopressor requirements in those patients with high lactate clearance.

A similar study conducted by Arnold et al evaluating lactate clearance in septic patients found similar results, with decreased mortality from 60 percent among lactate non-clearers to 19 percent among lactate clearers. In addition, they found discordance between cSvO2 optimization and lactate clearance suggesting the need to incorporate lactate clearance as a distinct end point of early resuscitation.

Sepsis continues to be one of the most costly and devastating disease processes affecting thousands of patients on a daily basis. With the majority of these patients presenting to the emergency department, it is critical for emergency medicine physicians to diagnose and initiate aggressive resuscitation. Having specific end points has already changed practice within the emergency department at many facilities.

Mortality remains significant among these patients, however, with continued search for areas of improvement within the accepted resuscitation goals. Elevated lactate in septic patients is clearly a measurement of tissue hypoperfusion, even without overt signs of shock. With the study of lactate clearance showing promising results, it is likely to be incorporated as a goal of resuscitation in the emergency department, further decreasing mortality among these patients.

References

Infantile diabetic ketoacidosis presenting as respiratory distress

Case

A 13-month-old male presents to the emergency department with difficulty breathing. This was preceded by two days of intractable vomiting and one day of decreased urine output. There is no report of recent fever, trauma, or sick contacts. The patient was born full-term without complications. He has no chronic medical problems and no prior hospitalizations or surgeries. Immunizations are up to date.

On arrival, the patient’s eyes open spontaneously. He has a weak cry, and he withdraws from pain. Initial vital signs are: T 37.4°C, pulse 143, respirations 48, and SaO2 92 percent. On exam, the patient has increased work of breathing with retractions and grunting, dry mucous membranes, peripheral cyanosis, and a small forehead hematoma. Lungs are clear with good air movement and no wheezes or crackles.

Initial interventions include intraosseous line placement after failed peripheral venipuncture. Despite a 40 mL/kg NS bolus and one nebulized albuterol treatment, rapid sequence intubation is performed due to a worsening respiratory status. A confirmatory chest x-ray shows good ETT position, normal cardiac silhouette, and no signs of infection or edema. A head computed tomography (CT) scan is negative for abnormalities. Transfer is arranged to an affiliated hospital with a pediatric intensive care unit.

Initial labs include a venous blood gas with a pH of 6.98 and bicarbonate of 15. Half an amp of IV bicarbonate is given. A finger-stick blood glucose reads “too high” on the glucometer. Eventual laboratory results demonstrated a metabolic panel with a serum glucose of 797 mg/dL, an anion gap of 32, and a urinalysis positive for glucose and ketones thus confirming the diagnosis of diabetic ketoacidosis.

Discussion

This case demonstrates that not all respiratory distress stems from a primary pulmonary problem. The diagnosis of diabetic ketoacidosis was eventually made but was clearly not high on the differential as demonstrated by the lateness in obtaining the serum glucose measurement. Even though this patient presented with significant respiratory symptoms during respiratory syncytial virus (RSV) season, non-pulmonary causes of respiratory distress should always be considered.

Since definitive treatment requires insulin replacement to halt ketogenesis, an early diagnosis is crucial to ensuring a good outcome. Cerebral edema and deep venous thrombosis (DVT) are serious complications to be avoided as these patients are managed. The remainder of this article offers some clinical pearls on the management of DKA in infants.

The bicarbonate controversy

Uncorrected acidosis can depress both cardiac contractility and respiratory drive. This may result in worsening acidosis, cardiac instability, and ultimate demise of the patient. Although counter-intuitive, the administration of sodium bicarbonate is rarely indicated to correct acidosis in the treatment of DKA. Instead, intravenous hydration and insulin are the mainstays of management. They reverse ketogenesis—
allowing for the oxidation of ketoacids and regeneration of bicarbonate.

Administration of bicarbonate has been identified as a risk factor for developing cerebral edema because it indirectly increases the osmolarity of brain tissue and causes cerebral hypoxia. Early recognition and avoidance of cerebral edema is paramount as it accounts for the majority of case fatalities in DKA patients. It frequently presents with an insidious onset and subtle symptoms including mental status changes, decreased heart rate, and age-inappropriate incontinence. If cerebral edema is suspected, it should be treated immediately by reducing fluid replacement rates and administering either mannitol or hypertonic saline. Additionally, alkalosis resulting from bicarbonate administration can exacerbate hypokalemia by accelerating potassium entry into cells. This is of particular concern as potassium levels are already expected to fall as a result of rehydration, renal excretion, and insulin administration. In general, bicarbonate administration should be reserved for cases of severe acidosis refractory to fluid hydration and insulin therapy.

The risk for DVT
Studies have shown that children presenting in DKA may be at increased risk for deep venous thrombosis. One retrospective cohort study suggests that central access may increase the complication rate of DVT in children with DKA.

Hospital course
Upon transfer to the PICU, the patient received fluid replacement and IV insulin therapy for two days. He was subsequently extubated and converted to subcutaneous insulin. A left central venous femoral line resulted in a deep venous thrombosis requiring anticoagulation therapy with enoxaparin. Over several days, the patient’s symptoms gradually resolved, and he was discharged from the hospital.

**DKA pearls**
1) Obtain finger stick glucose immediately in a child with altered mental status.
2) Intubation may be needed due to respiratory distress (from acidosis) and/or mental status changes (from cerebral edema).
3) Gradually replace fluid losses with isotonic saline (10-20 ml/kg) for the first hour prior to insulin drip.
4) Avoid use of bicarbonate therapy for correction of acidosis in DKA.
5) Use central venous access as a last resort in DKA patients.

**References**
7) Woolridge, D., Boesen, K., EMRA Pediatric Qwic Card.
“Imagine obtaining a history, doing a shoulder exam, or administering medications while looking at the backdrop of the Himalayan Mountains!”

I arrived at New Delhi’s Indira Gandhi Airport in the early morning after an overnight flight. I was immediately impressed by the multitude of people running about. Instead of orderly lines, there was a crowded mass of people busier than at Penn Station’s rush hour. After collecting my bags, I took a taxi to the center of town where cows stopping in the middle of a major roadway had caused a traffic jam.

After a few days exploring the city on my own, I arrived at our team’s hotel. It was a nice establishment down a narrow side street populated with stray dogs and motorized rickshaws. Our team—consisting of people from US, Canada, Europe, and even Australia—met early the next morning to catch a northbound train.

We arrived in the state of Himachal Pradesh after a train ride straight out a scene from The Darjeeling Limited. There, we met the organizers of Himalayan Health Exchange. After the introductions were made, we piled into five Jeeps driven by hired locals who also served as our translators for the mission. As we climbed the steep mountainside, the area was so remote I wondered if a car had ever been on that road.

Our mission went to the outer Himalayas in Himachal Pradesh. The population of Himachal is just over six million and made up of various cultures including Hindus, Muslims, Sikhs, and Buddhists. We had over fourteen clinics at seven different sites in the northern province of India. The clinics sites—set up in local schools, Buddhist monasteries, or the mountain areas—were breathtaking.

Working side-by-side with local healthcare providers, we administered general medical and dental care in addition to providing medication to the local patient population. In the monasteries, we also provided care to the monks. Throughout our time there we saw over 2,500 people. What a great experience!

The mission’s success was largely due to the planning of the Himalayan Health Exchange. I heard the story of its founding one night as we sat around a campfire drinking chai. The organization began over a decade ago when two trekkers, Ravi Singh and Hem Singh Thakur, were exploring the foothills of the Himalayan Mountains. While hiking, they came upon another mountain climber who had become ill with chest pain. One of them had an aspirin and gave it to the sick climber. When they awoke the next day, there was a line of people outside their tent seeking medical attention. Neither Singh nor Thakur were medically trained, but they recognized at that moment the area’s medical need.

Soon after, in 1996, Ravi Singh founded the Himalayan Health Exchange. The mission of the Himalayan Health
Exchange is to provide medical and dental care to the underserved people living in remote regions of the Indian and Nepal Himalayas. The organization also helps support two orphanages located in the north Indian state of Himachal Pradesh.

All of the care we provided during our mission was free of charge, and our donations for the trip also went to support the two orphanages. The people we treated were so thankful that on two occasions the local paper printed articles praising our efforts. We were also honored with traditional dances or ceremonies in many other places.

I was floored seeing how spending just a few minutes with the natives could make such a big impact. Many of these people traveled for hours, and some for days, to get to the camps, yet they were so thankful for even the short amount of time we devoted to them. The chronic conditions we found in their history and physical could not be cured in that one day we were there, but the education about their diseases could help them deal with, prevent further decline, and perhaps control their condition. Though we spoke through translators, the smiles on their faces and the sincere gratitude in their eyes let us know beyond words how much they appreciated what little we could do for them.

All this brings a new focus to how we might treat someone who walks through the door into the emergency department. Even though it may be a brief encounter, our sincere effort to help, and more importantly, the education we give them might empower them to take charge of their own healthcare more than any medication we can dispense.
### Board of Directors
- **Thursday, June 3, 2010**
  - 1:00pm-5:00pm: EMRA Board of Directors Meeting
- **Friday, June 4, 2010**
  - 8:30am-11:30am: EMRA Board of Directors Meeting
  - 3:00pm-5:00pm: EMRA Board of Directors Meeting
- **Saturday, June 5, 2010**
  - 3:00pm-5:00pm: EMRA Board of Directors Meeting

### Representative Council
- **Friday, June 4, 2010**
  - 1:00pm-2:00pm: Regional Representative Meeting
  - 2:00pm-3:00pm: EMRA Conference Committee Orientation
  - 3:00pm-4:00pm: EMRA Reference Committee Public Hearing
  - 4:00pm-5:00pm: Reference Committee Work Meeting
- **Saturday, June 5, 2010**
  - 8:30am-9:00am: EMRA Representative Council Welcome Breakfast & Registration
  - 9:00am-12:30pm: EMRA Representative Council Meeting/Town Hall
  - 12:30pm-1:30pm: EMRA Representative Council & Resident Luncheon

### Committees
- **Friday, June 4, 2010**
  - 1:00pm-1:30pm: EMRA Committee Chair Orientation
  - 1:00pm-3:00pm: EMRA Medical Student Governing Council Meeting
  - 1:30pm-3:00pm: EMRA Committee Meetings
  - Health Policy Committee
  - Technology Committee
  - International Committee
  - Critical Care Committee
  - Research Committee
  - EM Resident Advisory Committee

### Other Fun Stuff
- **Friday, June 4, 2010**
  - 4:00pm-5:00pm: EMRA Spring Awards Reception
  - 5:30pm-6:30pm: EMRA Resident SIMWars
  - 1:00pm-5:00pm: EMRA National EM Jeopardy Contest

- **Saturday, June 5, 2010**
  - 5:30pm-7:00pm: EMRA Party
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<tr>
<td>Programs with 100% EMRA membership among their residents. EMRA would like to thank these programs and residents for their continued support.</td>
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- Beth Israel Medical Center
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- Brigham & Women's Hospital
- Brody School of Medicine/East Carolina University
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Disability insurance for emergency physicians: The 2010 scoop

This time of year always brings about discussion regarding the importance of disability insurance and income protection. Emergency physicians are no strangers to disabling injuries, as they often witness them firsthand. In the first 20 years of practice, your disability program is one of the most vital components of your financial plan.

A recurring question among residents is how to purchase appropriate disability insurance. This article is a “nuts and bolts” explanation of disability terms and conditions. An understanding of these terms will enable you to make informed purchasing decisions.

The disability marketplace continues to be competitive for emergency physicians. Some of the recent developments that impact you specifically are:

• There are now four individual disability contracts (in most states) with own occupation (specialty specific) language for the life of the contract.
• Premium costs overall have decreased recently due to an increasingly competitive market.
• A graduating resident can now obtain up to $6,500 per month in benefit in some situations (prior to signing a contract).

Following are the terms and conditions that I find myself advising on frequently.

Own occupation (specialty specific) wording

The own occupation period is the length of time that you will be eligible to receive FULL benefits under your contract, as long as you cannot practice emergency medicine. Be aware that there are less comprehensive variations of own occupation. Some of the most common are:

• Own Occupation and Not Working
• Own Occupation and Any Reasonable Occupation
• Transitional Own Occupation

Understand that with a true own occupation contract, you could conceivably be working outside of emergency medicine and still receive the full benefits under your contract!

Residual disability

This is as important as own occupation. Imagine you become injured and you are out of the emergency department for eight months. If you wish to return to the emergency department as soon as possible, you need to understand the residual definition in your contract. The residual clause will determine how much money you receive, the duration of the payments and when you can return to work as an emergency physician. Understand this benefit, how long it will pay and if there are any clauses such as time or earnings that could discontinue payments.

Guaranteed purchase option

An option to purchase simply gives you
“As EMRA members, you can obtain a personal analysis and apply for benefits by visiting www.integratedwealthcare.com/education/ and clicking on the EMRA link.”

the right to potentially increase your benefits in the future, if your income will justify it. It ensures that any future medical history will not impact your ability to increase your benefit. It does not guarantee, however, that you can purchase more protection. Given the often transitory nature of emergency medicine, I recommend this option. If you will be an independent contractor and currently have a clean medical history, this is a must have.

Cost of living
Every individual contract should have a cost of living (COLA) feature. This increases your benefit every year that you remain disabled and on claim, protecting your income from the rising cost of inflation over time. I recommend this to be a compound increase, rather than a simple increase.

Monthly benefit amount
As a resident, you can protect future earnings by purchasing disability coverage before you finish your training. You can purchase up to $6,500 per month of tax-free benefit while still in training as either a resident or fellow. This opportunity expires the day you complete your program. If you bring this into practice and have 60 percent of your income covered by your employer, your two programs now stack on top of each other. This allows you to protect a higher proportion of your income than if you waited until after residency. You can also purchase another $9,500 of future income protection. This allows you to ensure $350,000 of future income! A competent disability advisor will be able to compare multiple contracts, design an appropriate strategy and negotiate the terms of the contract(s) if there are any medical complications.

As EMRA members, you can obtain a personal analysis and apply for benefits by visiting www.integratedwealthcare.com/education/ and clicking on the EMRA link. You can also view two educational videos on the topic, further explaining this opportunity.

An adequate disability income program will provide you with the confidence of knowing that your time and effort is fully insured and that your family’s financial security is protected from any unexpected loss of income.

Shayne Ruffing, CLU, ChFC, AEP is the creator of the Confident Transition Plan™ for medical residents, the Physician Disability Income Analyzer™ and the Physician’s Financial Navigator™. Shayne specializes in executive benefit planning for physicians and medical practices. He can be reached at 800.225.7174, or via e-mail at shayne@mybpginc.com or on the web at www.IntegratedWealthCare.com.

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When Congress passed the College Cost Reduction and Access Act of 2007, much of the focus by resident advocacy groups was on the elimination of the 20/220 rule. For those unaware, the 20/220 rule stipulated that you could defer your Subsidized Stafford Loans if:

• Your debt burden was greater than 20 percent of your income AND
• Your income minus your debt burden was less than 220 percent of the federal poverty level

Lost in all of this were two essential things

• The 20/220 rule only allowed deferment of federal SUBSIDIZED Stafford Loans (roughly $8,500 per year); the remaining UNSUBSIDIZED Stafford Loans and Graduate Loans (by far the largest portion of total medical school debt) have never been able to be deferred and thus have always accrued interest
• The creation of the Public Service Loan Forgiveness Program.

The Public Service Loan Forgiveness Program was created as part of the College Cost Reduction and Access Act to encourage individuals to work in public service jobs. According to the Department of Education, “borrowers may qualify for forgiveness of the remaining balance due on their eligible federal student loans after they have made 120 payments on those loans under certain repayment plans while employed full-time by public service employers.”

While you can read the aforementioned reference to answer most questions, we can briefly take a look at the eligibility requirements:

• Any Federal Direct Loan is eligible. Note, however, that if you had previously taken out loans under the Federal Family Education Loan (FFEL) program, you can consolidate your loans under the Direct Loan program if you intend to apply for forgiveness.
• You must make 120 on-time payments under one of the following repayment plans: Income Based Repayment (IBR), Income Contingent Repayment, Standard Repayment over a ten-year period.
• You must be employed full-time by a public service organization for the duration of 120 payments and until loans are forgiven. These include: federal, state or local government/agency, any 501(c) (3) non-profit organization, or any private organization that is not a for-profit business that provides a public service (ie., health professionals).

One important thing to note is the employment requirement. As an EM resident, joining a for-profit group or becoming an employee at a for-profit hospital would automatically exclude you from this program.

Let’s take a look, though, at how this might benefit you if you took out student loans. Say you’re starting four-year residency this year at $45,000 per year, do not have a spouse or children, and have a student loan debt of $150,000 after college and medical school. According to IBR info, your calculated Income Based Payment would be $360 per month. (Another quick note – more income would increase the IBR, whereas dependents would decrease the IBR.) We will assume that when you finish residency, you start a job at $200,000 per year.

With an IBR of $360 per month for four years of residency, followed by full payments of $1,617 per month for six years, at the end of ten years, you would still have a balance of neatly $85,000 that the government would forgive. In addition, making IBR payments during a longer residency or added fellowship would further increase the amount the government will forgive.

One other aside – if you have a spouse, currently the federal government adds their income in considering the IBR amount, however, it does not take into account your spouse’s student loan burden. This creates higher IBR payments without accounting for the payments you make on both loans. The Department of Education has agreed to look into this, but it has yet to act on it.

Regardless, most are unaware of the potential for loan forgiveness offered by the Public Service Loan Forgiveness Program. Although it does require Income Based Repayment to be made throughout the course of residency, it offers significant financial incentive in the long run. Please consider it when making decisions in regards to your student loans.

References
1. A 40-year-old man is brought in by ambulance from the local steel mill. His coworkers had noticed that he was confused and acting inappropriately while working at his station pouring molten steel. The EMTs state that the patient was diaphoretic, hypotensive, and felt warm to touch. Family members are contacted and disclose that the patient is in good health and had visited his psychiatrist 2 weeks earlier for a medication adjustment. There are no known allergies, and he is otherwise healthy. On examination, the patient is agitated and does not respond appropriately. He is noted to be tachycardic, diaphoretic, hypotensive, febrile to 38.5°C (101.5°F), and has generalized rigidity. What is the most likely diagnosis?
   A. Delirium tremens
   B. Heat stroke
   C. Malignant hyperthermia
   D. Meningitis
   E. Neuroleptic malignant syndrome

2. A 38-year-old woman presents because she began vomiting blood that evening. Medical history is significant for alcohol abuse and occasional smoking. She has been in the United States for 6 months and has been homeless since her arrival. Vital signs are stable, and she is in no acute distress. Cardiac, pulmonary, and abdominal examinations are unremarkable. What is the most appropriate next step in management?
   A. Abdominal CT with contrast
   B. CBC and type and crossmatch
   C. Chest radiograph
   D. Complete physical examination
   E. Nasogastric lavage with administration of an H2 blocker

3. A 45-year-old homeless man presents with hemoptysis, weight loss, and fever. He admits to smoking 2 packs of cigarettes per day and drinking whenever he is able to find alcohol. He has lost 20 to 30 pounds over the past month and has been coughing up “cupfuls” of blood over the past 1 to 2 days. He says he has been experiencing night sweats for several months. Vital signs are blood pressure 90/60, pulse rate 110, and temperature 37°C (98.6°F). Physical examination reveals coarse breath sounds, no cardiac murmurs, and clubbing. Which of the following studies is most likely to lead to the correct diagnosis?
   A. Bronchoscopy
   B. Chest CT
   C. Chest radiograph
   D. Echocardiography
   E. Tuberculin skin testing

4. A 55-year-old man presents complaining of abdominal pain of several days’ duration. He was in good health until he developed fever and chills, malaise, and myalgias. He got scared when his coworkers told him that his eyes were yellow. Past medical history is unremarkable. He denies any history of alcohol abuse, intravenous drug abuse, or blood transfusion. Vital signs include blood pressure 100/70, pulse rate 110, and temperature 38.8°C (101.8°F). Physical examination reveals scleral icterus and a tender right upper quadrant. What is the most likely diagnosis?
   A. Acute cholangitis
   B. Cholelithiasis
   C. Hepatic metastasis
   D. Pancreatic carcinoma
   E. Viral hepatitis

5. A 45-year-old woman presents with chills and abdominal discomfort that have been present for the past 2 to 3 days. Her husband says that her abdomen is getting progressively larger and that she appears to have gained weight over the past 2 weeks. Past medical history is significant for hypertension and renal insufficiency. On examination, the patient is in mild discomfort, with blood pressure 100/70, pulse rate 110, respiratory rate 22, and temperature 38.5°C (101.4°F). Spider angiomata are noted on the trunk, and examination of the abdomen reveals moderate distention, a fluid wave, and an enlarged liver. Ultrasonography-guided paracentesis is performed; the aspirate is somewhat cloudy, and the cell count is 300 neutrophils/mm3. What is the most appropriate management?
   A. Admit the patient and await culture results before starting antibiotic treatment
   B. Admit the patient and await results of the Gram stain
   C. Admit the patient and start antibiotic treatment in the emergency department
   D. Admit the patient for observation and repeat the paracentesis in 24 hours
   E. Discharge the patient with outpatient followup
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Questions should be directed to Nancy Medina, CAE, Editorial Director, Annals of Emergency Medicine, at 800-803-1403, ext. 3221, or by e-mail to nmedina@acep.org.

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Emergency Medicine Advocacy Handbook
Nathaniel R. Schlichter, MD, JD
In this clear, well-thought-out handbook, Dr. Schlichter and the chapter authors outline the essential advocacy issues surrounding emergency medicine today. Not just for the politically-minded, this resource is useful for the student, resident, physician, healthcare worker, patient or concerned citizen to help understand the important issues affecting all aspects of emergency care.

Brian J. Levine, MD
A quick reference guide to antibiotic use in the emergency department. Organized alphabetically by organism, followed by sections on “Special Topics” to make reference quick and easy for a particular disease process. Color coded.

Career Planning Guide for Emergency Medicine, 2nd Edition
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Get help organizing and understanding the many complex issues concerning emergency medicine careers. Topics include career possibilities, CV’s, interview tips, contract negotiations, benefits & more. Reviewed by Ann Emerg Med 2009; 53: 292

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EMERGENCY MEDICINE RESIDENTS’ ASSOCIATION
1. “This child can’t have a migraine. She has a bilateral frontal headache.”
Pediatric migraine headaches have many different facets that are not comparable to adult migraine headache – one of which is location. A large percentage of pediatric migraine headaches are bilateral (especially younger patients) – a distribution that is infrequent in adult migraine headache.

2. “I know my 8-year-old patient has a headache, but it can’t be a migraine. He’s too young.”
Migraine headaches can affect very young children. The mean age of onset of migraine headaches is 7 years for boys and 11 years for girls, and the gender ratio shifts in adolescence.

3. “My patient says she has a severe migraine, but she looks too comfortable to really hurt that badly.”
Misinterpreting headache severity is a common occurrence by nurses and physicians. Migraineurs who suffer frequent headache episodes are often able to tolerate pain at a much higher level, making these patients appear in minimal distress. The use of standardized pain scales [Visual Analog Scale (VAS), Faces Pain Scale-Revised (FPS-R)] is essential to track the patient’s initial pain score as well as to track improvement of his/her symptoms.

4. “I’m starting an IV for medications in my patient with migraine headache. I better get a CBC, electrolytes, and a liver function series to make sure they are normal.”
The utility of laboratory evaluation in primary headache patients (like migraine) is limited at best.

5. “I need to obtain a CT scan of the head in all pediatric patients with a debilitating headache, even those with a history of migraine.”
If the patient has a history of migraines, neuroimaging is not warranted unless the patient has an abnormal (focal) neurological examination, a seizure associated with the headache, or a migraine that significantly differs from his/her previous migraine headaches.

6. “My patient has a history of migraines. I’m sure that her current occipital headache with an abnormal gait is not too concerning and does not require additional work-up.”
In a patient with a history of migraine headaches, a change in the type of migraine is concerning enough to warrant advanced neuroimaging (CT, MRI). In addition, a headache patient with a focal neurological examination (like abnormal gait) warrants neuroimaging.

7. “My migraine patient hasn’t responded to acetaminophen or ibuprofen. I’m going to order some fentanyl or morphine for her migraine headache”
Narcotic pain medications, although useful for many pathologic causes of pain, have no indication in a pediatric migraine patient.

8. “My headache patient doesn’t have nausea, so anti-emetics won’t be useful in her treatment.”
Anti-emetic medications (prochlorperazine, metoclopramide, promethazine) have demonstrated efficacy in the treatment of pediatric migraine headache, even in the absence of frank nausea and/or vomiting.

9. “My patient’s migraine headache has not gotten better in the ED, but she just needs to go home – she’ll feel better with rest at home.”
Lack of significant improvement despite aggressive ED management of pediatric migraine requires continued headache treatment as an inpatient by the appropriate medical service (Neurology, Pain Management, etc).

10. “This is my patient’s third ED visit in the past 3 months for migraine headache. Why can’t she take care of this at home?”
If a pediatric patient is having frequent, debilitating migraine headaches requiring abortive therapies, he/she may need prophylactic migraine medications. It is imperative that these patients contact a primary care physician, neurologist, or headache specialist for further management, including daily medications to decrease migraine frequency.
Risk management pitfalls for oncologic emergencies

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1. “Even though the patient whom I just diagnosed with malignant spinal cord compression wasn’t able to walk into the ED, I’m going to tell the family that he should be all right once treatment is initiated.”

The neurologic status of patients before treatment for ESCC is the most important prognostic factor for neurologic status after treatment. Understanding the significant prognostic implications of the patient’s presenting neurologic status should help guide your discussions with patients and their families.

2. “This lady has ESCC. She needs to get radiation now!”

Radiation therapy is not indicated in all patients. Its greatest benefits are seen in the following situations: recurrences following surgical decompression, no spinal compression or instability, subclinical cord compression, radiosensitive tumors, or in patients who are not candidates for surgery.

3. “He said his back has been hurting for 2 months, making it difficult for him to walk, but he appeared fine to me in the ED and had a normal x-ray.”

A new diagnosis of an underlying malignancy is made in 20% of patients who present with ESCC, so clinical suspicion must always remain high for any patient with relevant symptoms. Back pain is the first symptom in 95% of patients with ESCC, and it usually predates all other symptoms by up to 2 months.

4. “I know he had lung cancer, but his back pain doesn’t seem too bad. I’ll just get an x-ray and send him home with some acetaminophen if it’s normal.”

Not seriously considering ESCC in the differential diagnosis in any cancer patient with back pain is a recipe for disaster. Also, relying on a plain radiograph alone for the diagnosis of ESCC is inadequate. Since plain radiography is only 75% sensitive for ESCC even when vertebral collapse is evident, MRI is the study of choice.

5. “I couldn’t tell the patient’s face was swollen. I’ve never seen him before and I thought he always looked like that.”

Although facial swelling is often obvious, it can be overlooked by one who is not familiar with the patient’s usual appearance. The emergency clinician must obtain a thorough history to elicit important clues, such as worsening of the swelling in the morning or a sense of facial fullness when bending down. Consider involving family or friends for their opinion or look at a patient’s driver’s license for comparison.

6. “I knew that the patient had SVCS, but it was subacute and I thought that she could follow up with her oncologist to take care of it. I didn’t know that it could progress to stridor or cerebral edema.”

Their exact incidence is not known, but the 2 most feared complications of this syndrome are upper-airway obstruction and cerebral edema, both of which are attributable to diminished venous return to the head and neck. Even if the presentation is subacute, treatment should be provided promptly to avoid these complications. Given the coordination required among multiple disciplines, it is reasonable to admit most patients with SVCS.

7. “There is no facial edema and the chest film is normal — this patient doesn’t have SVCS.”

About 20% of patients with SVCS have no facial or neck edema, and about 20% have normal chest films. When abnormal radiographic findings are present, they usually include evidence of lung masses. Further imaging is warranted if SVCS continues to be suspected.

8. “A chest x-ray without an enlarged cardiac silhouette essentially rules out a pericardial effusion.”

In the case of malignant pericardial effusion, the effusion is usually large in volume, owing to the subacute nature of the fluid accumulation. The classic “water-bottle” heart on chest x-ray certainly alerts physicians to the possibility of this diagnosis, but the lack of this finding is insufficient to rule out the diagnosis.

9. “After the pericardiocentesis, my patient was doing so well. He said he could follow up with his oncologist a week later, so I let him go home. I didn’t realize that fluid could reaccumulate that quickly!”

When pericardiocentesis is the sole treatment modality for a malignant pericardial effusion, it can recur at a rate of 56%, often within 24 to 48 hours. Patients should be admitted for close observation and a repeat echocardiogram. In cases of recurrent malignant pericardial effusions, more definitive treatment, such as a subxiphoid pericardial window, should be considered in consultation with the cardiothoracic surgery team.

10. “But the patient initially had a stable blood pressure. Nobody would have suspected cardiac tamponade.”

Initially, many patients with nontraumatic cardiac tamponade present with preserved blood pressure; however, they can deteriorate quickly because of the “last drop” phenomenon. Beck’s triad is rarely present in such patients. For any patient with a pulmonary malignancy (primary tumor or metastasis) who presents with heart failure-like symptoms, cardiac tamponade is often detected only by emergency clinicians who are alert for this possible diagnosis.
Resident’s Appreciation Day

The University of Michigan/Saint Joseph Mercy Hospital Emergency Medicine Residency Program celebrated EM Residents’ Appreciation Day by playing Whirly Ball, a combination of basketball and Jai-Alai (using bumper cars and whiffle ball slingers)! No injuries this time around!

PHOTO COURTESY OF ANNA LIESE PEFFER, GME PROGRAM COORDINATOR, UNIVERSITY OF MICHIGAN/SAIN T JOSEPH MERCY HOSPITAL DEPARTMENT OF EMERGENCY MEDICINE

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great team support. Contact Molly Smith: (800) 877-5520 ext. 6301; msmith@hppartners.com or visit www.hppartners.com/emra.

**Illinois, Chicago area and Kankakee:** EMP manages EDs at 4 community teaching hospitals seeing 30,000 – 50,000+ pts./yr. with Level I and Level II trauma center designation and EM residency teaching options. We are an exclusively physician owned/managed group with open books, equal voting, equal profit sharing, equity ownership, funded pension, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

**Illinois, Kankakee:** EM position available at Riverside Medical Center. The 40,000 annual visit ED is located 60 miles south of Chicago and has 36 hours of physician coverage per day/11 hours mid-level FastTrack coverage. Candidates must be BC/BP EM. EPMG offers paid family medical benefits, paid malpractice, incentive bonus system, flexible scheduling, and much more. Contact Andy Roy at 800-466-3764, x329 or aroy@epmgpc.com.

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Michigan, Battle Creek: BC Emergency Medicine physician sought for democratic group in 50,000 volume ED. Excellent package offers shareholder status at one year with no buy-in! Benefits include pension, family medical plan, CME, incentive income, malpractice, more. Stable group with outstanding physician retention record. Contact Kim Rooney, Premier Health Care Services, (800)726-3627, ext. 3674, krooney@phcsday.com, fax (937)312-3675.

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Nebraska, Omaha: BP/BC EM physician sought for stable group at suburban ED. Excellent package with shareholder opportunity at one year plus family medical plan, employer-funded pension, malpractice, expense account and more. As Nebraska’s largest city, Omaha provides both metropolitan amenities and friendly, Midwestern charm. Contact Kim Rooney, Premier Health Care Services, (800)726-3627, ext. 3674; e-mail krooney@phcsday.com; fax (937)312-3675.

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Gundersen Lutheran is a dynamic top-rated healthcare organization based in scenic La Crosse, Wis. At Gundersen Lutheran, we serve residents of western Wisconsin, southeastern Minnesota and northeastern Iowa. Our healthcare system is anchored by one of the largest multi-specialty group practices and a teaching hospital with Level II Trauma Center. Specialty outreach, telemedicine, distance learning, digital imaging and other services link Gundersen Lutheran with regional clinics, hospital affiliates and practitioners in a 19-county service area.

La Crosse is a historic, vibrant city of more than 50,000 people nestled between bluffs and the legendary Mississippi River. La Crosse boasts a historic downtown and riverfront, a host of festivals and annual celebrations, some of the best outdoor recreation, excellent schools including three universities, affordable housing in safe neighborhoods, an endless variety of live entertainment and breathtaking beauty, making this a great place to call home.

Contact Jon Nevala, manager, medical staff recruitment, at (800) 362-9567, ext. 54224, or email jnevala@gundluth.org. Visit online at gundluth.org.

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North Carolina, Charlotte: EMP is partnered with 6 community hospitals in Charlotte, Lincolnton, Pineville and Statesville. A variety of partnership opportunities are available in urban, suburban and smaller town settings with EDs seeing 8,000-70,000+ pts./yr. EMP is an exclusively physician owned/managed group with open books, equal voting, equal profit sharing, equity ownership, funded pension, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

North Carolina, Kinston: Located in the center of eastern North Carolina, Kinston is less than 60 miles to the east are some of the most beautiful beaches of the Carolina coast and 35 miles from Greenville. 200-bed full-service community hospital treats 39,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD, (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

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**Ohio, Barberton:** SUMMA Health System-Barberton is a full-service community hospital in southern suburban Akron with 38,000 ED visits/yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

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**Ohio, Cambridge:** Southeastern Ohio Regional Medical Center is a 177-bed, full-service facility and Level III Trauma Center treating 34,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

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**Ohio, Lima:** Outstanding package with democratic group. Level II, 57K volume ED has separate pediatric ED and hospitalist support. Features shareholder status without buy-in, loan repayment, pension, family medical, more. Full benefits included and not deducted from outstanding clinical compensation. Contact Kim Avalos Rooney, Premier Health Care Services, (800) 726-3627, ext 3674, krooney@phcsday.com, fax (937) 312-3675.

**Ohio, Lodi:** Fully accredited 30-bed hospital with acute and skilled care facilities is part of the Akron General Health System. Brand new 12-bed ED has 12 private rooms including cardiac and trauma. 10,000 ED pts./yr. with 12 and 24 hr. shifts. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

**Ohio, Toledo:** Opportunity for solid EM physician within democratic group. This Level III facility has an annual volume of 42,660 visits with outstanding physician coverage plus PA coverage. Appealing package includes equity ownership, employer-funded pension, family medical plan, malpractice CME and more. Contact Amy Spegal, Premier Health Care Services, (800)726-3627, ext. 3682, e-mail aspegal@phcsday.com, fax: (937) 312-3683.

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Virginia, Blacksburg: Seeking full-time BC/BE EM physician for 26,000 visit ED located just 40 miles south of Roanoke. Level III trauma center. Great work environment. EPMG offers paid family medical benefits, incentive bonus system, paid malpractice, 401(k), flexible scheduling, and much more. Please contact Ruth Ann Sheets at 800-466-3764, x332 or rsheets@epmgpc.com.

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**Exciting Academic EM Opportunity, Get in on the Ground Floor!**

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**West Virginia, Wheeling:** Wheeling Medical Center is a 250-bed community teaching hospital with a brand new ED under construction. AOA approved Osteopathic EM and EM/IM residency program. Enjoy teaching opportunities, full-specialty back up, active EMS, and two campuses seeing 26,000 and 22,000 pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD, (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

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**West Virginia, Eau Claire:** Luther Midelfort-Mayo Health System, in Eau Claire, Wisconsin, is seeking an 11th and 12th BC/BP Emergency Medicine physician to work in our Level II trauma center. ACLS, ATLS, and PALS required. Ultrasound certification required once on staff. 130 hours/month clinical time. Five different eight and nine hour shifts are covered. EMR and PACS. Department has 18 ED rooms, two large trauma resuscitation rooms and a fast-track program. The Mayo One helicopter, with a rooftop touch down pad, provides transportation from outlying areas to Luther, and an immediate transport system for patients that need to go from Luther to another major referral center. Annual volume greater than 26,000. Luther Midelfort is a physician directed, 240-physician multispecialty clinic and integrated hospital owned by Mayo Clinic. Contact Cyndi Edwards; 800-573-2580; edwards.cyndi@mayo.edu; fax 715-838-6192; www.luthermidelfort.org.

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**West Virginia, Cheyenne:** Join a dynamic emergency physician team in beautiful, historic Cheyenne, Wyoming. Frontier Emergency Physicians (FEP) is seeking an energetic and enthusiastic team member, a physician who is board certified/board prepared in emergency medicine. He or she would fill a position at Cheyenne Regional Medical Center, which hosts a level II trauma center, operated by FEP, that sees about 35,500 patients a year. FEP offers a competitive salary, benefits, and partnership opportunities. Interested physicians should send a cover letter and a copy of their curriculum vitae by email to tlong@seriolc.com or by mail to SERIO Physician Management, Attention: Teresa Long, 1241 W. Mineral Ave., Suite 100, Littleton, CO 80120. Or, call Dr. Mike Means at (307) 633-7550.
Moving tips

- **Change your address ahead of time** at https://moversguide.usps.com. You can enter a future move date. Keep us updated too: You can change your EMRA and ACEP contact info at the same time by visiting either www.emra.org or www.acep.org and logging in as a member.

- **Purchase renter’s insurance** if you’re renting and don’t already have it. Renter’s insurance doesn’t just cover your property if there’s a fire, it protects all of your belongings, including theft-prone items like laptops and cell phones, even when you’re away from home.

- **Be cautious if choosing a mover** to help you, especially if you will be traveling across state lines. Ensure that you have a binding delivery date and a written contract, including a set price, to protect yourself against scams. Visit www.movingscam.com for a few tips.

- **Make a list.** The more specific the better – instead of “Misc. Kitchen,” write “serving bowls, mugs and cooking utensils.” You’ll thank yourself later.

- **Pack infrequently used items ahead of time.** Decorative items, books, and seasonal items that can be packed early will save you time and energy later.

- **Keep important papers and valuable items with you.** Don’t let movers take your files, secure information, or valuables – take them in your own vehicle.

“Don’t cry because it’s over, Smile because it happened!”

**Dr. Seuss**

Activities that burn about 100 calories

- Lift weights for 13 minutes.
- Play caddy (carrying a heavy bag!) for 2 holes of golf.
- Drink four ice-cold glasses of water throughout the day.
- Play the piano for thirty minutes.
- Clean house for 30 minutes
- Play tennis for 9 minutes
- Paint a room for 16 minutes.
- Mow the lawn (push mower, not riding!) for 14 minutes
- Change 52 diapers.
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PHCS Regional Medical Director
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