

A Newsletter for the Members of the Kentucky Chapter



Daniel J. O'Brien, MD, FACEP
President

[Ashlee Melendez, MSPH, BSN](#)
Executive Director
Phone: 502.852.7874

Ryan Stanton MD, FACEP **Drive the Message**

I have always believed that you can tell your story or someone will tell it for you. Medicine has never been great at driving messages, correcting inaccuracies, or translating the complexities of our profession into relatable education for those without an advanced medical degree hooked to their name. Fortunately, we work in a specialty that is perfectly positioned to impact our patients and communities. We are the only specialty of medicine that has contact and context to almost every malady and misadventure of the human condition. In fact, most of us has a story or two about almost any medical topic that is

presented. This gives us an opportunity to truly impact the conversations and concerns of the lay public through real world experience and context. The good news is that I feel emergency physicians have done more in the past 10-20 years to engage both the profession and our patients through traditional media, podcasts, social media, and various other outlets.

With that being said, we need to be the watchdog for the information our patients receive. A good example that pulled me in recently was the annual media blitz on “dry drowning”. I have never seen a nonexistent medical condition that strikes fear in so many young families. The idea that a child will walk through a heavy rain and then suddenly die 4 days later from this “silent killer of swimmers” just boggles my mind. If you don’t know about this fictitious condition, google it. Basically, the term “dry drowning” was used 30+ years ago, along with terms like “delayed drowning” and “secondary drowning” to describe drowning conditions that happened after the initial episode. This was until we understood what actually happens. Since 2002 and the World Congress on Drowning, we have only three accepted terms for drowning...

- 1) Fatal Drowning
- 2) Nonfatal Drowning with Injury
- 3) Nonfatal Drowning without Injury

This Congress on Drowning clarified the definitions and basically summed up that you drown and are fine, injured, or die. All the processes that impair the respiratory function with regard to the phenomenon is summed up in those definitions. The problem is that none of these is as catchy as a term like “dry drowning”. Not only is it catchy, but it suggests a mythical quality like the boogie man or Sasquatch with fatal potential to the otherwise healthy appearing individual. This mythologic reaper of lives continues to be propagated by the media who are looking for a way to hook an audience and healthcare folks that don’t understand the current accepted medical condition.

The moral of this story isn’t specifically about the details of drowning, rather that the public is exposed to more and more bad medicine. If you want to call it “fake news”, then go for it, but either way, the desire for clicks, views, and a reaction are at the expense of truth and accuracy. The problem is that this fear baiting is not benign. People react to these stories in various ways, but in this case, bringing otherwise healthy children into the emergency department for an evaluation of a disease process that may be secretly brewing in their offspring. This results in unnecessary fear, ED volume, and costs. It also changes behaviors in a way that can actually increase risk, such as the anti-vax movement fueled by the false link to autism.

The moral of this story is about fighting back. We should not accept the volume of bad health/medical information that is impacting the public. We should be a voice for truth and science. We need to address fears with facts and context. Through these efforts, we can quell the fears and promote the health and safety of our fellow citizens. Whether it is through sharing an accurate article, debunking a bad one, or producing your own content based on the evidence, we can all do our part. As the specialty of emergency medicine continues to mature, we can also continue to grow our presence as the advocates for our patients, the public, and the information they receive.

Melissa Platt, MD, FACEP
Past President
Reimbursement Committee Chair

ONLY 5.5 PERCENT OF EMERGENCY VISITS ARE NONURGENT AND WAIT TIMES CONTINUE TO IMPROVE, CDC SAYS

[View the ACEP press release.](#)

Summary tables can be [accessed here](#).

Chris Pergrem, MD, FACEP
Governmental Affairs Committee Chair

Crack the Case

For this case presentation, details have been changed to protect the identity of the patient.

John James is in his mid-50s and presented to the emergency department because with difficulty breathing, generalized weakness, and malaise. Symptoms had started one to two days prior. He had just been released from the hospital after an uncomplicated endovascular stent repair for his 6cm abdominal aortic aneurysm. During his hospitalization, he had recovered uneventfully. There had been no reports of dyspnea, cough, chest pain or dependent edema while hospitalized. No fever had developed. Mr.

James labs had remained stable, with a hemoglobin of 11 and a hematocrit of 34.

The only past medical history for John James included well-controlled hypertension on lisinopril. He had a 30- pack year cigarette history, but had stopped smoking prior to the AAA procedure. His hyperlipidemia was treated with simvastatin. There was no family history of AAA or of ACS.

Upon presentation, Mr. James was dyspneic with labored respirations. Respiratory rate was 26. He was hypoxic with room air saturations at 85%. Heart rate was 110. Blood pressure was 157/92. The patient was afebrile with an oral temperature of 37.3C. He was placed on a cardiac monitor, pulse oximeter, and oxygen at 4L by nasal cannula. An IV was established with labs being drawn. An ECG and chest radiograph were ordered.

Based upon the initial presentation, diagnoses considered included pneumonia, pulmonary embolism, stent complications, ACS, anemia, acute kidney injury, pulmonary edema, sepsis, and pericardial effusion. Bedside ultrasound was utilized to evaluate for intra-abdominal fluid and pericardial fluid. This was negative. The ECG was consistent with sinus tachycardia. There were no ischemic changes present. It was unchanged when compared to the pre-operative ECG. John James continued to be symptomatic. He did not respond to treatment.

The chest radiograph was unremarkable. No pneumonia, pulmonary edema, or cardiomegaly was noted. His labs were essentially unchanged from previous. A mild anemia was present with a hemoglobin of 10. The remainder of his chemistry panel, troponin, CBC, and BNP were normal. Mr. James was still symptomatic and CTA for pulmonary embolism was ordered. A CT of the abdomen and pelvis was also ordered. Both of which were non-diagnostic.

At this point, consideration was given to nSTEMI. Admission was planned. An ABG was ordered prior to calling the hospitalist and surgeon. After the blood gas was drawn, the respiratory therapist approached the physician. She commented that the blood appeared “really dark” and showed the sample to the physician. It was chocolate in color.

Upon further questioning of the patient, he admitted to using topical throat spray at home. After surgery, he had a sore throat he was told was related to intubation. Mr. James used a topical anesthetic for symptomatic relief.

After treatment in the emergency department was started, John James improved dramatically. His respiratory status improved. Hypoxia resolved. He began to feel better.

Once admitted, he had a stable course and was ultimately discharged home.

Methemoglobinemia is a condition caused by an elevation of methemoglobin in the blood. It contains ferric iron, which impairs the affinity of hemoglobin for oxygen. The oxygen hemoglobin dissociation curve is shifted left. Because the oxygen is not easily released, tissue hypoxia occurs. This condition can be precipitated by various medications including metoclopramide, topical anesthetics, sulfonamides, and other medications.

Treatment includes supportive measures and administration of methylene blue. Methylene blue is slowly pushed intravenously at 1-2 mg/kg. The response is usually rapid. Patients usually recover uneventfully.

Andy Barr, Rep. Greg Walden, Chairman of the House Energy and commerce Committee, and Ryan Stanton, MD at a fund raiser discussing Alternatives to Opioids (ALTO) in the Emergency Department Act, and HR 5176, Preventing Overdoses While in Emergency Rooms (POWER) Act.





Support Fair Insurance Coverage!

Help Fight to Protect Our Patients Against Anthem's Unlawful Practices

ACEP continues to keep the pressure on Anthem Blue Cross Blue Shield for denying coverage to emergency patients in six states with a [new video campaign](#). More will follow if this effort isn't stopped. Anthem's policy violates the prudent layperson standard, as well as 47 state laws. [Spread the word!](#) #FairCoverage #StopAnthemBCBS

Preparing to Give Testimony before State Legislators

Harry J. Monroe, Jr.

Director, Chapter and State Relations, ACEP

Over the years, I have worked with many lobbyists preparing for upcoming meetings. In some of those instances, the lobbyist would be gathering information to represent us himself in meetings of stakeholders or legislators or staff. In other instances, the legislator was preparing the client to give testimony at a legislative hearing.

In all of these circumstances, every good lobbyist I have worked with has required an answer to this question: what is the argument of the other side? What will our opponent say?

If you do not have a fair answer to that question, then you are not yet prepared to provide your testimony.

Because we tend to live in an environment in which we share our views with people who agree with them, too often we fail to think through the alternative point of view. Thus, insurers are against us, we often state, for example, because they are only in this for the money. They don't care about their "customers," our patients. The bottom line for their shareholders is their only concern.

My point is not that there is not a point to this. However, no insurer is going to arrive at a hearing to explain that, you know, we caught him. He doesn't care about anything but making a buck.

There are no Perry Mason endings at legislative hearings. Insurers don't confess.

The truth is that insurers, wrongly I think most of the time, have their own story, their own rationale, for their policy. We have to understand that story so that we are sure to be able to counter it – and to avoid walking into traps as we tell our own story.

None of this to say that we should have a need to fully explain or defend the insurer's point of view. Quite the contrary, a more typical approach, as appropriate, would be to briefly summarize the opposition's position before pivoting to an explanation as to why it is wrong and how we have a better solution to the problem that the policy maker wants to solve.

That sort of response is a way of showing ourselves to be fair minded and solutions oriented. It is a crucial part of effective state advocacy.

Articles of Interest in *Annals of Emergency Medicine*

Sam Shahid, MBBS, MPH
Practice Management Manager, ACEP

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

Kellogg K, Fairbanks RJ.

Approaching Fatigue and Error in Emergency Medicine: Narrowing the Gap Between Work as Imagined and Work as Really Done.

Annals of Emergency Medicine – April 2018 ([Epub ahead of print](#))

This is an editorial commenting on an article by Nicolas Perisco and colleagues, “Influence of Shift Duration on Cognitive Performances of Emergency Physicians: A Prospective Cross-Sectional Study.” The article reports that there was significant cognitive decline after a 24 hour emergency shift, though not one after a 14 hour shift. The editorial goes on to describe some of the consequences of their finding, for example the fact that any cognitive decline likely also occurs in all emergency workers. They suggest we repeat the study using 8 and 12 hours shifts which are more common in the US.

Hall MK, Burns K, Carius M, Erickson M, Hall J, Venkatesh A.

State of the National Emergency Department Workforce: Who Provides Care Where?

This is a cross-sectional study that analyzed the Centers for Medicare and Medicaid Services’ (CMS) 2014 Provider Utilization and Payment Data Physician and Other Supplier Public Use Files and found that of 58,641 unique EM clinicians, 61.1% were classified as EM physicians, 14.3% as non-EM physicians, and 24.5% as advanced

practice providers. Among non-EM physicians categorized as EM clinicians, Family Practice and Internal Medicine predominated. They also found that urban counties had a higher portion of EM physicians compared to rural counties.

Stiell IG, Clement C M, Lowe M, Sheehan C, Miller J, Armstrong S, Bailey B, Posselwhite K, Langlais J, Ruddy K, Thorne S, Armstrong A, Dain C, Perry JJ, Vaillancourt C.

Multicentre Program to Implement the Canadian C-Spine Rule by Emergency Department Triage Nurses.

This multicentre two-phase study demonstrated that with training and certification, ED triage nurses can successfully implement the Canadian C-Spine Rule, as reflected by more rapid management of patients, and no missed clinically important spinal injuries.

Lumba-Brown A, Wright DW, Sarmiento K, Houry D.

Emergency Department Implementation of the Centers for Disease Control and Prevention Pediatric Mild Traumatic Brain Injury Guideline Recommendations.

These are the Centers for Disease Control and Prevention's (CDC) 2018 "Guideline on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children," published in JAMA Pediatrics. As the Emergency Department clinicians may be the first healthcare provider to evaluate an injured child they play an important role in the recognition and management of mild traumatic brain injury. The key practice-changing takeaways in these new guidelines include: using validated and age-appropriate post-concussion symptom rating scales to aid in diagnosis and prognosis; and incorporating specific recommendations for counseling at the time of ED discharge.

New Resources from ACEP

The following **policy statements** were recently revised and approved by the ACEP Board of Directors:

- Alcohol Advertising
- Trauma Care Systems

Four **information papers and one resource** were recently created by several ACEP committees:

- Disparities in Emergency Care – Public Health and Injury Prevention Committee
- Empiric and Descriptive Analysis of ACEP Charges of Ethical Violations and Other Misconduct – Ethics Committee
- Fostering Diversity in Emergency Medicine through Mentorship, Sponsorship, and Coaching – Academic Affairs Committee
- The Single Accreditation System – Academic Affairs Committee
- Resources: Opioid Counseling in the Emergency Department – Emergency Medicine Practice Committee

These resources will be available on the new ACEP website when it launches later this month. In the meantime, for a copy of any of the above, please contact [Julie Wassom](#), ACEP's Policy and Practice Coordinator.

Graduating Residents: Renew your Membership Today!

Take advantage of huge discounts and freebies!

ACEP is offering \$20 off national dues, PEER for \$50 and a free 2018 Graduating Resident Education Collection of 25 courses specifically for emergency physicians in their first year out. Just go to www.acep.org/renew to take advantage. Those who renew also get a cool ER/DR T-Shirt and Critical Decisions in Emergency Medicine online free for one year. [Renew now](#) using Promo Code FOCUS2018. Check it off the list!



Don't Miss the Premiere Event for Emergency Medicine Advocates and Leaders!

Attendees at the annual [Leadership & Advocacy Conference](#) will advocate for improvements in the practice environment for our specialty and access for our patients. First-timers will receive special training on how to meet and educate your Members of Congress while seasoned participants will build upon valuable Congressional connections. A new "[Solutions Summit](#)" has been added on May 23 where attendees will discover innovative solutions on key topics such as opioids and end-of-life issues that demonstrate emergency medicine's value and leadership. CME credit will be given for the Summit.

Confirmed Speakers Include:

- U.S. Surgeon General Vice Admiral (VADM) Jerome M. Adams, M.D., M.P.H.
- HHS Assistant Secretary for Preparedness and Response Bill Kadlec, MD will be presenting during the Public Policy Town Hall on Emergency Preparedness.
- Amy Walter, National Editor for The Cook Political Report, will offer her predictions for the mid-term elections.
- Senator Bill Cassidy, MD (R-LA)
- Representative Kyrsten Sinema (D-AZ)

[REGISTER TODAY!](#)

Not able to attend the LAC18? Now is not the time to sit on the sidelines.

Join the [ACEP 911 Grassroots Legislative Network](#) today to help emergency medicine convey our principles and priorities to legislators in Washington DC and their home districts. With the mid-term elections coming up in November and party control of the House and Senate hanging in the balance, now is the perfect time to reach out on the local level to educate your legislators about the specialty and offer to serve as a local resource on issues relating to the delivery of health care.

Already a member of the Network? Take your advocacy to the next level. Host an emergency department visit for your legislator or invite them to meet with a group of local

emergency physicians from your chapter. Visit the [ACEP Grassroots Advocacy Center](#) for detailed information on how to join the program and start engaging with legislators today!

Free Training on Medication-Assisted Treatment

Eight hours of training on medication-assisted treatment (MAT) is required to obtain a waiver from the Drug Enforcement Agency to prescribe buprenorphine, one of three medications approved by the FDA for the treatment of opioid use disorder. [Providers Clinical Support System \(PCSS\)](#) offers free waiver training for physicians to prescribe medication for the treatment of opioid use disorder.

PCSS uses three formats in training on MAT:

- Live eight-hour training
- “Half and Half” format, which involves 3.75 hours of online training and 4.25 hours of face-to-face training.
- Live training (provided in a webinar format) and an online portion that must be completed after participating in the full live training webinar (Provided twice a month by PCSS partner organization American Osteopathic Academy of Addiction Medicine)

Trainings are open to all practicing physicians. Residents may take the course and apply for their waiver when they receive their DEA license. For upcoming trainings consult the [MAT Waiver Training Calendar](#). For more information on PCSS, [click here](#).

Become an Accredited Geriatric Emergency Department Today

Recognizing that one size ED care does not fit all, [The Geriatric Emergency Department Accreditation Program](#) (GEDA), was developed by leaders in emergency medicine to ensure that our older patients receive well-coordinated, quality care at the appropriate level at every ED encounter. Become accredited and show the public that

your institution is focused on the highest standards of care for your community's older citizens.

Make Change Happen in ACEP

The Council meeting is YOUR opportunity to influence the ACEP agenda. If you have a hot topic that you believe ACEP should address, write that resolution! It only takes two members to submit a resolution. [Click here](#) to learn the ins-and-outs of Council Resolutions, and [click here](#) to see submission guidelines. **Deadline is July 1, 2018.** Be the change - submit your resolution today.

Learn to Improve Patient Safety, Reduce Costs at One-Day Hospital Flow Conference

ACEP is pleased to announce this collaboration between ACEP and the American Hospital Association. Join leaders in hospital flow at the [Innovation Leadership Challenge: Collaborating to Improve Hospital Flow, Save Lives & Reduce Costs Conference](#) to learn about proven innovative processes, tools & insights prior to the AHA Leadership Summit July 25. [Register today.](#)



Welcome New Members

Jeremy J Corbett, MD
Wesley Field
Alexander T Krivchenia, MD

**Kentucky Chapter ACEP, P.O. Box 2831,
Louisville, KY 40201**

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