“DON’T LET ME DIE”
Treating gunshot wounds, making a plea to stop the violence

by BENJAMIN THOMAS, MD

“Don’t let me die,” he told me. As I provided supplemental oxygen to him at the head of the bed, I told him, “You are in good hands. Everything will be OK.” But everything wasn’t OK. He had multiple gunshot wounds to his abdomen and died on the operating room table 30 minutes later. He was only 27 years old, not much younger than I at the time, and his last words were a plea to save his life.

To his family and friends, this would be a tragic loss that would change their lives.
EXERTIONAL HEAT STROKE

WHEN THEIR BODY TEMPERATURE RISES TO DANGEROUS LEVELS, IT CAN QUICKLY BECOME A LIFE-THREATENING SITUATION.

Exertional heat stroke (EHS) is a hyperthermic and hypermetabolic crisis that creates an immediate cascade of CNS and other serious complications. If core body temperatures remain elevated, EHS has been shown to cause long-term neurologic damage and death. 1-3

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References:
When their body temperature rises to dangerous levels, it can quickly become a life-threatening situation.  

Exertional heat stroke (EHS) is a hyperthermic and hypermetabolic crisis that creates an immediate cascade of CNS and other serious complications. If core body temperatures remain elevated, EHS has been shown to cause long-term neurologic damage and death.  

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“IAT Needs Further Scrutiny”

[Editors’ Note: In response to the Journal of Emergency Medicine article “IAT Needs Further Scrutiny” (May 3, 2017), Dr. Buettner wrote the following in response to Dr. Buettner’s article.]

I disagree with Dr. Buettner’s statement that the IAT is a test whose results don’t predict behavior of racial bias whatsoever. In my article, I never said that the IAT predicts behavior of racial bias whatsoever. Indeed, the IAT measures something deep and important in them. This bias here is “bandwagon bias.” Perhaps we should pause before jumping on board.

Over and over and over again, people are told that it is measuring something deep and important in them. This is exactly what the norms of psychology are supposed to protect test subjects against.

—Bernard L. Lopez, MD, MS, CPE, FACEP, FAAEM

Philadelphia, Pennsylvania

“Bandwagon Bias”

[Regarding “Is Bias Affecting You and Your Patients?” April 2017] The IAT does not predict behavior of racial bias whatsoever. Is credible science not important anymore? The bias here is “bandwagon bias.” Perhaps we should pause before jumping on board.

It’s hard to disagree with the conclusion of Fiedler and his colleagues that it is only “fair and appropriate to treat the IAT with the same scrutiny and scientific rigour as other diagnostic procedures.” If that’s true, then between Project Implicit and cutting-edge diversity trainings, the IAT has missed potentially millions of people. Over and over and over and over, the IAT, a test whose results don’t really mean anything for an individual test-taker, has induced strong emotional responses from people who are told that it is measuring something deep and important in them. This is exactly what the norms of psychology are supposed to protect test subjects against.

—Mark Buettner, DO, FACEP

“Recommended Reading”

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Dr. Lopez Responds

In my article, I never said that the IAT predicts behavior of racial bias. Much research has been done on the IAT since it was first described. Thus, the test has undergone significant scientific scrutiny and raises questions on just exactly what it measures. One school of thought is that the IAT may simply be measuring the association of positive evaluations with the “in” or majority group and negative evaluations with the “out” or minority group and that it may not be a specific attribute of thought (not measure prejudice) on potential biases but should not be used to measure one’s “prejudice.” Having a strong preference for a certain group does not mean that one is prejudiced against another. Knowledge of this preference is useful when dealing with someone from the “other” group as it allows you to consider how your bias may affect certain behaviors and decisions. The use of the IAT needs to be done in a controlled setting that stresses the fact that it does not measure prejudice and that it should simply stimulate thought about one’s unconscious biases.

I disagree with Dr. Buettner’s statement that the IAT is a test whose results don’t really mean anything for an individual test-taker. For the individual, the results suggest that in-group/out-group membership, and not nationality, was the important factor.

Too often, people are told to take the test on their own. Therein lies the potential harm— they read the results and may assume that they are prejudiced against a group. The test may also be used by diversity educators who may suggest the existence of prejudice. In this regard, I agree with Dr. Buettner that the IAT is misleading. In my article, I gave the opinion that the IAT is a tool that can be used to stimulate thought about one’s unconscious biases but should NOT be used to measure one’s “prejudices.” Having a strong preference for a certain group does not mean that one is prejudiced against another. Knowledge of this preference is useful when dealing with someone from the “other” group as it allows you to consider how your bias may affect certain behaviors and decisions. The use of the IAT needs to be done in a controlled setting that stresses the fact that it does not measure prejudice and that it should simply stimulate thought about one’s unconscious biases.

—Kevin Klauer, DO, EJD, FACEP

WHAT ARE YOU THINKING?

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DIARRHEA: A SYMPTOM, NOT A DIAGNOSIS

Hemolytic uremic syndrome is a rare but serious complication of E. coli infection

by PINGCHING N. KWAN, MD, FACEP; AND CHANGYOW C. KWAN, BS

THE CASE

A 3-year-old boy with watery diarrhea for the past three days as well as vomiting and fever that started the day prior is brought to the emergency department by his mother. No recent traveling or antibiotic usage is reported. He has otherwise been in good health. On physical exam, the patient appears well-developed, nourished, alert, and oriented. The vitals are stable, and the abdomen is non-tender and non-distended. At shift change, the patient’s condition seems to be improving. He can tolerate apple juice and no longer has fever. The patient is signed out to the incoming physician with pending diagnostic studies.

However, the patient starts to develop tarry black stools shortly after shift change, and on reassessment, the patient’s blood pressure is 80/45. He appears to be pale with a rapidly deteriorating clinical status. The initial diagnostic studies are significant for hematuria, metabolic acidosis with elevated creatinine, and C-reactive protein. Abdominal X-ray shows increased bowel gas (see Figure 1), and abdominal ultrasound does not suggest any radiographic evidence of intraperitoneal fluid. Two hours after shift change, the patient becomes more hypotensive, and his abdomen becomes more rigid. Emergent critical care transport is initiated while the patient becomes more hypotensive, and the patient is placed on vasopressors to maintain a systolic blood pressure above 90. The patient is transported to a tertiary pediatric medical center in Chicago.

The clinical course of HUS is shown in Figure 2. Diarrhea, abdominal pain, fever, and vomiting develop a few days after inoculation with the pathogen. Within a week, the patient’s condition can either resolve or develop to full-blown HUS. HUS is defined by the classic triad of microangiopathic hemolytic anemia, thrombocytopenia, and acute renal injury. Though the long-term prognosis for renal recovery is good, up to 50 percent of patients with HUS may require dialysis during the acute phase. Additionally, HUS can affect many other organ systems, including the central nervous system (CNS), gastrointestinal tract, liver, pancreas, and heart. CNS involvement, including seizures, coma, and stroke, is seen in up to 20 percent of cases and is associated with increased mortality.1 In this case, the patient was colonized with E. coli 0157 and had hematuria, rectal bleeding, and hypertension due to significant fluid loss, and early renal injury. Early recognition and treatment resulted in a complete recovery.

About 5 percent to 15 percent of people infected with STEC develop HUS. The incidence is about 2–3 per 100,000 children under 5 years of age in the United States.4 HUS can have severe complications, and early recognition and treatment are paramount to preventing morbidity and mortality.

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REFERENCES


FIGURE 1: Abdominal X-ray showing increased bowel gas.

FIGURE 2: Progression of E. coli 0157 infection in children.

HUS (~15%)
Spontaneous resolution (~85%)

Ingestion
Diarrhea
Abdominal pain
Fever
Vomiting

Positive culture
Diarrhea improves

(−50%)

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REFERENCES

No Merit Badges for Emergency Ultrasound

The case against APCA and ARDMS

by J. MATTHEW FIELDS, MD, FACEP

For those of you who haven’t been recently barraged by advertisements, a new organization called the Alliance for Physician Certification & Advancement (APCA) is offering a “special opportunity” to be certified in emergency ultrasound. It sounds awesome, except for a couple things: 1) It costs money, and 2) It’s completely unnecessary. The ACEP Emergency Ultrasound Guidelines already outline the pathways for emergency ultrasound training, which are either residency- or practice-based.

So why would a new organization suddenly offer a certificate for emergency ultrasound to emergency physicians? I have two thoughts: money and power. AP-CA’s FOCUS Academy is an online program that costs hundreds of dollars to take and must be maintained annually. Since it is virtual, it can be replicated at little cost to APCA. Who is APCA? APCA is under the umbrella of a larger organization called Inteleos. Inteleos also houses the American Registry for Diagnostic Medical Sonography (ARDMS). If ARDMS sounds familiar to you, it is because many emergency physicians have obtained Registered Diagnostic Medical Sonographer (RDMS) credentials. This past year, Inteleos restructured so that physician certification is done through APCA and technician certification is done through ARDMS. In the past, RDMS wasn’t so much a threat as an option for those of us who had done more scans and training. RDMS credentials may have helped emergency ultrasound directors achieve recognition of ultrasound expertise when emergency ultrasound was in its infancy. Clinical ultrasound is now a Residency Review Committee requirement and an emergency medicine milestone, so there is no need for any emergency physician to have RDMS credentials. Now that ARDMS has changed its robes to APCA and is attempting to profit from and exert control in our specialty, I feel it is time for emergency medicine and ARDMS to part ways.

External certification, in general, is bad for our specialty. In 1998, the American Medical Association created Resolution 802, which states that ultrasound is in the scope of practice of appropriately trained physicians and that training and education standards should be developed by each physician’s respective specialty. Since 2001, the emergency ultrasound guidelines have become one of the most utilized documents for clinical (point-of-care) ultrasound in the world. By leading the way in emergency ultrasound, we have not only saved lives but also discovered uses for ultrasound that would otherwise never have been realized (eg, extended focused assessment with sonography for trauma [FAST], critical care resuscitation, and procedural guidance). By never allowing external control, emergency medicine has been able to push the frontier of emergency ultrasound in modern medicine. It is incumbent on our specialty that we keep these tools under our supervision and never abdicate this responsibility to external entities.

Emergency medicine is probably just the beginning. APCA will likely expand to other specialties here and abroad. If we were crazy enough to buy into this unnecessary merit badge program, we would put APCA in a prime beginning. APCA will likely expand to other specialties here and abroad. If we were crazy enough to buy into this unnecessary merit badge program, we would put APCA in a prime position to manipulate the standards for ultrasound training and qualifications. We would essentially be letting a group not based in emergency medicine tell us how to train and practice with one of our most beloved bedside tools.

What can we do? The best thing we can do is … nothing! Don’t sign up for unnecessary merit badge courses in emergency medicine. You are only hurting your peers when credentialing committees see you with a merit badge certificate and then start demanding merit badge courses in emergency medicine. The case against APCA and ARDMS by J. MATTHEW FIELDS, MD, FACEP

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What can we do? The best thing we can do is … nothing! Don’t sign up for unnecessary merit badge courses in emergency medicine. You are only hurting your peers when credentialing committees see you with a merit badge certificate and then start demanding it of others.

“A New Spin” is the personal perspective of the author and does not represent an official position of ACEP Now or ACEP.
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A recent New Mexico Supreme Court decision has huge professional liability ramifications for physicians treating patients from another state. The March 13, 2017, ruling is of importance to emergency physicians who, under EMTALA, are unable to deny a patient care due to illness, injury, inability to pay, or lack of health history.

The issue at stake in Montaño v. Frezza was whether state’s laws claim legal jurisdiction when a patient who resides in one state (New Mexico, in this case) receives care in another (Texas, in this case).

Montaño-Frezza Case Background

More than a half million patients from eastern New Mexico rely on a range of medical care from physicians in Lubbock, Texas. Texas has significant medical liability reforms; New Mexico does not.

In 2003, Texas passed comprehensive reforms regarded nationally as the gold standard in medical liability legislation. These reforms included a $250,000 cap on pain-and-suffering-type damages and a heightened awareness of who qualifies under New Mexico’s Medical Liability Reform Act.

In 2004, Kimberly Montaño, a New Mexico resident, traveled to Lubbock to have gastric bypass surgery. The operation was performed in-network by bariatric surgeon Eldo Frezza, MD. At the time, Dr. Frezza was the chief of bariatric surgery at Texas Tech Hospital in Lubbock, a facility owned and operated by Texas Tech University Health Sciences Center. In the ensuing years, Dr. Frezza provided follow-up care for complications related to Ms. Montaño’s surgery. All of the care rendered by Dr. Frezza was in Texas. Dr. Frezza’s only connection to New Mexico was the fact that he was the only bariatric surgeon on the Lovelace New Mexico Health Plan.

Ms. Montaño sued Dr. Frezza in a New Mexico court. She argued her case should be tried under New Mexico law because her injuries “manifested” in New Mexico.

The Courts’ Decisions

The New Mexico appellate court agreed with the plaintiff, concluding the “place of wrong” is the place where the injury manifested and yet remained ineligible to buy into and purchase such coverage because he practiced in Lubbock. I like our local hospital, but Lubbock, he said. “These were doctors and nurses I wanted to work on me. They gave me the care I needed. Covenant Health, the dominant hospital system in the Texas Panhandle, accepts multiple critically ill patients from New Mexico daily.

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The New Mexico Court of Appeals ruled that New Mexico law is controlling, but ultimately, the state’s Supreme Court overturned that decision. The Texas College of Emergency Physicians and ACEP joined a “friend of the court” brief challenging the lower court’s ruling.

The New Mexico Supreme Court instructed the lower court to dismiss the complaint without prejudice. Writing for the majority, Justice Edward Chavez stated, “The public interest in maintaining access to cross-border medical services is promoted by applying the law where such services were rendered.”

The ruling, while not binding in all states, has persuasive authority, according to Alice Lorenz, New Mexico co-counsel for the Texas Alliance for Patient Access.

A Win for Emergency Physicians

Had the plaintiff prevailed, Texas doctors would have been twice bitten. They would have lost Texas medical liability protections and yet remained ineligible to buy into and receive the benefits of the New Mexico Patient Compensation Fund. The Patient Compensation Fund provides an excess layer of liability coverage for doctors and hospitals that qualify under New Mexico’s Medical Malpractice Act. Dr. Frezza did not qualify to purchase such coverage because he practiced in Texas only.

A loss in the Montaño case would likely have caused Texas doctors and hospitals to reconsider their willingness to accept trans-
series, EMpower, as an extension of the EMpower series in EM Resident magazine (www.emresident.org/empower). The goal is to highlight the value of the community EMRA embodies by sharing the incredible stories of former EMRA members and other pioneers in our field who used their early involvement in organized medicine as a launching pad for their careers. These conversations capture the unique perspectives and motivations that have guided emergency medicine trailblazers to enduring and fulfilling professional lives with the hopes of empowering current and future physicians to more effectively navigate the ever-changing landscape of our distinguished profession.

Together, EMRA and Radio Rounds have opened a fascinating window into the lives and careers of the best that emergency medicine has to offer. For example, ACEP President Rebecca Parker, MD, FACEP, talks about emergency medicine’s transformative efforts to tackle perceived diversity deficiencies with the hopes of empowering current and future physicians to more effectively navigate the ever-changing landscape of our distinguished profession.

DR. CORKER is an emergency medicine resident at Parkland Hospital, UT Southwestern Medical Center in Dallas. DR. DAS is an emergency medicine resident at Emory University School of Medicine in Atlanta. DR. JAROU is an emergency medicine resident at Denver Health Medical Center.

EMPOWER PODCAST CONTINUED FROM PAGE 1

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1. Diversity & Inclusion and Leadership: Rebecca Parker, MD, FACEP
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5. Health Policy and Public Health: Aisha Liferidge, MD, FACEP
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DR. CORKER is an emergency medicine resident at Parkland Hospital, UT Southwestern Medical Center in Dallas. DR. DAS is an emergency medicine resident at Emory University School of Medicine in Atlanta. DR. JAROU is an emergency medicine resident at Denver Health Medical Center.
time in a seclusion room where she felt she was running out of oxygen. She reached by the bottom of the door, trying to suck in air, all the while the convinced the staff were trying to kill her. It was a traumatic experience for Eleanor; to this day, she finds it difficult to ride in a car with the windows up, and years after her hospitalization, she continued to visit my psychiatry blog as part of an effort to process an experience she wanted never to repeat, one she readily called traumatizing.

Doorway to Psychiatric Care
The emergency department is the doorway to involuntary psychiatric care, and most emergency departments don’t have psychiatrists on-site. The most crucial and controversial decision in psychiatry often falls on the shoulders of an emergency physician, with or without the help of a mental health professional. Patients are involuntarily committed because they are acutely suicidal, acutely psychotic, or both. Someone is worried they might be dangerous.

The forces in play here are considerable. We have patients, who may be too impaired to make decisions or even see that they are ill and who should ideally have the right to autonomy over their medical decisions. We have society, which may worry that people with mental illness pose a danger to others. We have the families, who watch a loved one suffer and miss the wonderful opportunities that life has to offer but who may have their own agendas for wanting a family member to be in the hospital. We have the doctor, who wants to do right by patients while simultaneously serving as the gatekeeper for resources (that rare psychiatric bed) and worrying about the malpractice implications of a bad outcome. We have the taxpayer, who pays for lost productivity, disability benefits, and institutionalization of these patients. Finally, we have the insurer, who wants to pay for as little as possible. All of these agencies are quietly in the background whenever a patient is at risk of dying.

If doctors in the emergency department begin with the idea that forced care is a good thing—that it helps people get well at times when they may be too sick to recognize that they are ill, and that treatment enables patients to stay housed, working, connected to their loved ones, and out of jail and institutions—they then do it a lot, sometimes with a “better safe than sorry” approach. However, if doctors start off with the assumption that forced care is potentially traumatizing in a way that leaves some patients with years of distress, then the threshold for committing patients to involuntary treatment is significantly altered, and involuntary hospitalization gets viewed as a last resort.

Sometimes, there is simply no choice but to hospitalize people against their will and to use physical force to keep everyone safe, especially when patients are delusional, disorganized, and agitated. This is not something that should be done lightly. Involuntary treatment initiates a process whereby the treatment team becomes the adversary to the patients they are trying to serve. It makes for long and difficult days for everyone. Furthermore, when it comes to suicidal patients, we don’t know if involuntary care prevents suicide. Still, it can be very difficult to let a suicidal patient leave an emergency department if the doctor believes the patient is at risk of dying.

We know very little about involuntary psychiatric treatment. There are no national statistics on how many people are involuntarily hospitalized each year, and there are no statistics on how common it is for people to be traumatized. What we do know is that in the battle over involuntary psychiatric care, there are no organized patient groups lobbying for legislation to make forced care easier. There are, however, organized groups of people who call themselves “psychiatric survivors,” who feel they have been injured by what psychiatrists have to offer. There is no doubt that our treatment of those with psychiatric disorders needs to be more thoughtful and respectful. Ultimately, forced care puts us in the very awkward position of being the adversaries to the people we are trying to serve.

Smoothing the Way for Psychiatric Treatment
So what’s a doctor in the emergency department to do? I would contend that if, after careful assessment and consideration of less restrictive alternatives, there is no choice but to involuntarily hospitalize a patient, the first action should be to try to convince the patient to sign in voluntarily. This seems obvious, but it doesn’t always work out that way. Why would busy doctors expend the effort to convince patients to sign in if they could more easily force care?

Remember that Eleanor came to the emergency department seeking help; she would have signed in to the hospital, but that option was never offered.

Obviously, the use of physical force should be avoided unless absolutely necessary to maintain a safe environment. While restraints, seclusion, and the forcible injection of medication may be necessary to keep everyone safe, the ED setting is one where patients easily escalate. They may have been brought from their homes by the police in handcuffs, and they may be required to wait hours or even days for evaluation and admission. From the point of view of anguished patients, this is embarrassing and difficult. Force should not be used for strict adherence to policy—for example, to force a person in no obvious physical distress to have admission lab work. It didn’t serve United Airlines well, and it doesn’t serve psychiatry well!

Finally, I would say be nice to involuntary patients. They are some of our sickest and most dangerous patients and will likely benefit from remaining in our care. They may make us angry, and they may be a lot of work, but these patients need us. Like all human beings, those in need of emergency care may well appreciate small acts of kindness.

The most crucial and controversial decision in psychiatry often falls on the shoulders of an emergency physician, with or without the help of a mental health professional.
New Policy on Psychiatric Boarding

ACEP clinical policy on adult mental health patients in the emergency department

by DEVORAH NAZARIAN, MD

In January 2017, the ACEP Board of Directors approved a clinical policy developed by the ACEP Clinical Policies Committee on critical issues in the diagnosis and management of adult psychiatric patients presenting to the emergency department. This policy was published in the April issue of the *Annals of Emergency Medicine,* can be found on the ACEP website, and has been accepted for inclusion in the National Guideline Clearinghouse.

While the number of mental health-related visits to emergency departments has increased steadily, the number of inpatient psychiatric beds has decreased. Substantial declines in mental health resources have additionally burdened emergency departments with increasing numbers of patients with mental health issues. The “boarding” process for mental health patients in emergency departments nationwide averages seven to 11 hours and often takes more than 24 hours when patients require transfer to an outside facility. New systems and resources need to be made available to better serve mental health patients.

Based on input from the ACEP membership, the committee focused on the critical questions regarding the evaluation and management of adult psychiatric patients in the emergency department. A systematic review of the evidence was conducted, and the committee made recommendations (A, B, or C) based on the strength of evidence (see Table 1). This clinical policy underwent internal and external review during a 60-day open-comment period, and responses were used to refine and enhance this clinical policy.

**CRITICAL QUESTIONS AND RECOMMENDATIONS**

**QUESTION 1.** In the alert adult patient presenting to the emergency department with acute psychiatric symptoms, should routine laboratory tests be used to identify contributory medical conditions (nonpsychiatric disorders)?

**Patient Management Recommendations**

- **Level A:** None specified.
- **Level B:** None specified.
- **Level C:** Do not routinely order laboratory testing on patients with acute psychiatric symptoms. Use medical history, previous psychiatric diagnosis, and physician examination to guide testing.

It is important to note that this is a level C recommendation because of the limited amount of data with sufficient quality to support a higher-level recommendation. However, this should not be interpreted to imply that there is strong evidence supporting the use of laboratory diagnostics in most emergency department mental health patients.

In addition, it is likely that subsets of patients with higher rates of disease (eg, elderly, immunosuppressed, new-onset psychosis, substance abuse) may benefit from routine laboratory testing. Routine urine toxicology testing has not been shown to provide benefit in terms of influencing the management or disposition of ED patients, but it may be helpful for an objective understanding of the patient’s potential substance abuse on transfer to a psychiatric facility.

**QUESTION 2.** In the patient with new-onset psychosis without focal neurologic deficit, should brain imaging be obtained acutely?

**Patient Management Recommendations**

- **Level A:** None specified.
- **Level B:** None specified.
- **Level C:** Use individual assessment of risk factors to guide brain imaging in the emergency department for patients with new-onset psychosis without focal neurologic deficit (consensus recommendation).

There were no Class I, II, or III studies to answer this question. In the Class X studies that did categorize imaging abnormalities, the percentage of imaging findings described as being clinically relevant, influencing clinical management, or altering diagnosis ranged from 0 percent to approximately 5 percent.

**QUESTION 3.** In adult patients presenting to the emergency department with suicidal ideation, can risk-assessment tools in the emergency department identify those who are safe for discharge?

**Patient Management Recommendations**

- **Level A:** None specified.
- **Level B:** None specified.
- **Level C:** In patients presenting to the emergency department with suicidal ideation, physicians should not use currently available risk-assessment tools in isolation to identify low-risk patients who are safe for discharge. The best approach to determine risk is an appropriate psychiatric assessment and good clinical judgment, taking patient, family, and community factors into account.

**QUESTION 4.** In the adult patient presenting to the emergency department with acute agitation, can ketamine be used safely and effectively? Class III studies were identified that investigated whether risk assessment can identify patients who are at risk for future self-harm. The designs of these studies were problematic, and no tool has been demonstrated to accurately predict the risk of suicide among patients in the emergency department.

**Patient Management Recommendations**

- **Level A:** None specified.
- **Level B:** None specified.
- **Level C:** Ketamine is an option for immediate sedation of the severely agitated patient who may be violent or aggressive (consensus recommendation).

Management of acutely agitated patients in the emergency department remains a critical issue. Most of these patients can be sedated safely with antipsychotics and/or benzodi- azepines. However, there remains a subset of extremely agitated patients for whom this approach will not be effective. These patients have a significant effect on the emergency department staff in terms of time and dedicated resources required to maintain a safe environment for patients and others in the emergency department. Although there is a lack of Class I, II, or III studies establishing the safety and efficacy of ketamine to control acute agitation in the emergency department, the skills set of emergency physicians and their familiarity with the use of ketamine make it a reasonable choice when immediate control of the acutely agitated patient is required for patient and/or staff safety.

**Table 1. Translation of Classes of Evidence to Recommendation Levels**

<table>
<thead>
<tr>
<th>Class of Evidence</th>
<th>Recommendation Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level A</strong></td>
<td>Recommendations generally accepted principles for patient care that reflect a high degree of clinical certainty (eg, based on evidence from one or more Class of Evidence I or multiple Class of Evidence II studies).</td>
</tr>
<tr>
<td><strong>Level B</strong></td>
<td>Recommendations for patient care that may identify a particular strategy or range of strategies that reflect moderate clinical certainty (eg, based on evidence from one or more Class of Evidence II studies or strong consensus of Class of Evidence III studies).</td>
</tr>
<tr>
<td><strong>Level C</strong></td>
<td>Recommendations for patient care that are based on evidence from Class of Evidence III studies or, in the absence of any adequate published literature, based on expert consensus. In instances where consensus recommendations were made, “consensus” is placed in parentheses at the end of the recommendation.</td>
</tr>
</tbody>
</table>

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Clinical Trial Results Matter

Explore the efficacy and safety data at hcp.eliquis.com

NVAF
Indicated to reduce the risk of stroke and systemic embolism in patients with NVAF

INDICATIONS
ELIQUIS is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (NVAF). ELIQUIS is indicated for the treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and to reduce the risk of recurrent DVT and PE following initial therapy.

IMPORTANT SAFETY INFORMATION

WARNING: (A) PREMATURE DISCONTINUATION OF ELIQUIS INCREASES THE RISK OF THROMBOTIC EVENTS, (B) SPINAL/EPIDURAL HEMATOMA

(A) Premature discontinuation of any oral anticoagulant, including ELIQUIS, increases the risk of thrombotic events. If anticoagulation with ELIQUIS is discontinued for a reason other than pathological bleeding or completion of a course of therapy, consider coverage with another anticoagulant.

(B) Epidural or spinal hematomas may occur in patients treated with ELIQUIS who are receiving neuraxial anesthesia or undergoing spinal puncture. These hematomas may result in long-term or permanent paralysis. Consider these risks when scheduling patients for spinal procedures. Factors that can increase the risk of developing epidural or spinal hematomas in these patients include:
- use of indwelling epidural catheters
- concomitant use of other drugs that affect hemostasis, such as nonsteroidal anti-inflammatory drugs (NSAIDs), platelet inhibitors, other anticoagulants
- a history of traumatic or repeated epidural or spinal punctures
- a history of spinal deformity or spinal surgery
- optimal timing between the administration of ELIQUIS and neuraxial procedures is not known

Monitor patients frequently for signs and symptoms of neurological impairment. If neurological compromise is noted, urgent treatment is necessary. Consider the benefits and risks before neuraxial intervention in patients anticoagulated or to be anticoagulated.

CONTRAINDICATIONS
- Active pathological bleeding
- Severe hypersensitivity reaction to ELIQUIS (e.g., anaphylactic reactions)

WARNINGS AND PRECAUTIONS
- Increased Risk of Thrombotic Events after Premature Discontinuation: Premature discontinuation of any oral anticoagulant, including ELIQUIS, in the absence of adequate alternative anticoagulation increases the risk of thrombotic events. An increased rate of stroke was observed during the transition from ELIQUIS to warfarin in clinical trials in atrial fibrillation patients. If ELIQUIS is discontinued for a reason other than pathological bleeding or completion of a course of therapy, consider coverage with another anticoagulant.
- Bleeding Risk: ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding.
  - Concomitant use of drugs affecting hemostasis increases the risk of bleeding, including aspirin and other antiplatelet agents, other anticoagulants, heparin, thrombolytic agents, SSRIs, SNRIs, and NSAIDs.
  - Advise patients of signs and symptoms of blood loss and to report them immediately or go to an emergency room. Discontinue ELIQUIS in patients with active pathological hemorrhage.
  - There is no established way to reverse the anticoagulant effect of apixaban, which can be expected to persist for at least 24 hours after the last dose (i.e., about two half-lives). A specific antidote for ELIQUIS is not available.
- Spinal/Epidural Anesthesia or Puncture: Patients treated with ELIQUIS undergoing spinal epidural anesthesia or puncture may develop an epidural or spinal hematoma which can result in long-term or permanent paralysis. The risk of these events may be increased by the postoperative use of indwelling epidural catheters or the concomitant use of medicinal products affecting hemostasis. Indwelling epidural or intrathecal catheters should not be removed earlier than 24 hours after the last administration of ELIQUIS.
ELIQUIS® (apixaban) tablets 5mg
and 2.5mg

DVT/PE
Indicated for the treatment of DVT and PE, and to reduce the risk of recurrent DVT and PE following initial therapy.

WARNINGS AND PRECAUTIONS (cont’d)

The next dose of ELIQUIS should not be administered earlier than 5 hours after the removal of the catheter. The risk may also be increased by traumatic or repeated epidural or spinal puncture. If traumatic puncture occurs, delay the administration of ELIQUIS for 48 hours.

Monitor patients frequently and if neurological compromise is noted, urgent diagnosis and treatment is necessary. Physicians should consider the potential benefit versus the risk of neuraxial intervention in ELIQUIS patients.

• Prosthetic Heart Valves: The safety and efficacy of ELIQUIS have not been studied in patients with prosthetic heart valves and is not recommended in these patients.

• Acute PE in Hemodynamically Unstable Patients or Patients who Require Thrombolysis or Pulmonary Embolectomy: Initiation of ELIQUIS is not recommended as an alternative to unfractionated heparin for the initial treatment of patients with PE who present with hemodynamic instability or who may receive thrombolysis or pulmonary embolectomy.

ADVERSE REACTIONS

• The most common and most serious adverse reactions reported with ELIQUIS were related to bleeding.

TEMPORARY INTERRUPTION FOR SURGERY AND OTHER INTERVENTIONS

• ELIQUIS should be discontinued at least 48 hours prior to elective surgery or invasive procedures with a moderate or high risk of unacceptable or clinically significant bleeding. ELIQUIS should be discontinued at least 24 hours prior to elective surgery or invasive procedures with a low risk of bleeding or where the bleeding would be noncritical in location and easily controlled. Bridging anticoagulation during the 24 to 48 hours after stopping ELIQUIS prior to the intervention is not generally required. ELIQUIS should be restarted after the surgical or other procedures as soon as adequate hemostasis has been established.

DRUG INTERACTIONS

• Strong Dual Inhibitors of CYP3A4 and P-gp: Inhibitors of cytochrome P450 3A4 (CYP3A4) and P-glycoprotein (P-gp) increase exposure to apixaban and increase the risk of bleeding. For patients receiving ELIQUIS doses of 5 mg or 10 mg twice daily, reduce the dose of ELIQUIS by 50% when ELIQUIS is coadministered with drugs that are strong dual inhibitors of CYP3A4 and P-gp (e.g., ketoconazole, itraconazole, ritonavir, or clarithromycin). In patients already taking 2.5 mg twice daily, avoid coadministration of ELIQUIS with strong dual inhibitors of CYP3A4 and P-gp.

• Strong Dual Inducers of CYP3A4 and P-gp: Avoid concomitant use of ELIQUIS with strong dual inducers of CYP3A4 and P-gp (e.g., rifampin, carbamazepine, phenytoin, St. John’s wort) because such drugs will decrease exposure to apixaban and increase the risk of stroke and other thromboembolic events.

• Anticoagulants and Antiplatelet Agents: Coadministration of antiplatelet agents, fibrinolytics, heparin, aspirin, and chronic NSAID use increases the risk of bleeding. APPRAISE-2, a placebo-controlled clinical trial of apixaban in high-risk post-acute coronary syndrome patients treated with aspirin or the combination of aspirin and clopidogrel, was terminated early due to a higher rate of bleeding with apixaban compared to placebo.

PREGNANCY CATEGORY B

• There are no adequate and well-controlled studies of ELIQUIS in pregnant women. Treatment is likely to increase the risk of hemorrhage during pregnancy and delivery. ELIQUIS should be used during pregnancy only if the potential benefit outweighs the potential risk to the mother and fetus.


Please see Brief Summary of Full Prescribing Information, including Boxed WARNINGS, on adjacent pages.

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INDICATIONS AND USAGE
Reduction of Risk of Stroke and Systemic Embolism in Nonvalvular Atrial Fibrillation—ELIQUIS® is indicated for the prevention of stroke and systemic embolism in patients with nonvalvular atrial fibrillation.

Prophylaxis of Venous Thromboembolism Following Hip or Knee Replacement Surgery—ELIQUIS is indicated for the prophylaxis of deep-vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in patients who are undergoing hip or knee replacement surgery.

Thrombolytic Therapy—ELIQUIS is indicated for thrombolytic therapy in selected patients with pulmonary embolism (PE) who present with hemodynamic instability or who may receive thrombolytic therapy or pulmonary embolectomy.

Thrombolysis in Myocardial Infarction (TIMI) 25—ELIQUIS is indicated for the treatment of PE when administered within 12 hours after the onset of ischemic symptoms.

Management of Non-Valvular Atrial Fibrillation—ELIQUIS is indicated for the management of non-valvular atrial fibrillation (Table 1).

It is not known if ELIQUIS is effective or safe for the prevention of stroke and systemic embolism in patients with valvular atrial fibrillation.

DOSE AND ADMINISTRATION

For patients with PE, ELIQUIS should be administered within 12 hours after the onset of ischemic symptoms.

Dosage in Nonvalvular Atrial Fibrillation—ELIQUIS is indicated for the prevention of stroke and systemic embolism in patients with nonvalvular atrial fibrillation.

ELIQUIS is indicated for the treatment of PE.

When neuraxial anesthesia (spinal/epidural anesthesia) or spinal/epidural puncture is employed, consider the risk in neuraxial catheters or the concomitant use of medicinal products affecting hemostasis. Indwelling epidural catheters or the concomitant use of medicinal products affecting hemostasis may result in long-term or permanent paralysis. Therefore, neuraxial anesthesia or neuraxial catheters should not be used in patients who are at risk of developing an epidural or spinal hematoma which can result in long-term or permanent paralysis.

Hemodialysis does not appear to have a substantial impact on apixaban exposure. When PCCs are used, monitoring for the anticoagulation effect of apixaban [see Clinical Pharmacology (12.2) in full Prescribing Information] is recommended.

Rate of Major Thrombotic Events—The safety of ELIQUIS was evaluated in the ARISTOTLE and AVERROES studies.

Bleeding

Bleeding at a critical site: intracranial, intraspinal, intraocular, pericardial, intra-articular, intramuscular or subcutaneous hemorrhage is a common adverse reaction associated with anticoagulant therapy.

Table 2 shows the number of patients experiencing major bleeding during the treatment period and the bleeding rate per patient-year in ARISTOTLE and AVERROES.

Intracranial hemorrhage occurs commonly in patients treated with ELIQUIS who are at risk of developing an epidural or spinal hematoma.

In contrast, the use of neuraxial anesthesia or neuraxial catheters should not be used in patients who are at risk of developing an epidural or spinal hematoma which can result in long-term or permanent paralysis.
Adverse reactions occurring in ≥1% of patients undergoing hip or knee replacement surgery in the 1 Phase trial and the Phase 3 trials are listed in Table 4.

Table 4: Adverse Reactions Occurring in ≥1% of Patients in Either Group

<table>
<thead>
<tr>
<th>Reaction</th>
<th>ELIQUIS (apixaban)</th>
<th>Placebo</th>
<th>Placebo-Proprietary</th>
<th>Placebo-Proprietary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>N=2689</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>91 (3.4)</td>
<td>60 (2.2)</td>
<td>13 (1.4)</td>
<td>11 (1.2)</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>89 (3.3)</td>
<td>130 (4.8)</td>
<td>39 (4.2)</td>
<td>40 (4.5)</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>93 (3.5)</td>
<td>100 (3.8)</td>
<td>42 (4.5)</td>
<td>47 (5.3)</td>
</tr>
<tr>
<td>Thrombosis</td>
<td>97 (3.6)</td>
<td>104 (3.9)</td>
<td>38 (4.1)</td>
<td>37 (4.2)</td>
</tr>
<tr>
<td>Venous thrombosis</td>
<td>106 (4.0)</td>
<td>117 (4.4)</td>
<td>45 (4.9)</td>
<td>45 (5.1)</td>
</tr>
</tbody>
</table>

Adverse reactions occurring in ≥1% of patients in the AMPLIFY study are listed in Table 6.

Table 6: Adverse Reactions Occurring in ≥1% of Patients Treated for DVT and PE in the AMPLIFY Study

<table>
<thead>
<tr>
<th>Reaction</th>
<th>ELIQUIS (apixaban)</th>
<th>Placebo</th>
<th>Placebo-Proprietary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>N=2689</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Anemia</td>
<td>91 (3.4)</td>
<td>60 (2.2)</td>
<td></td>
</tr>
<tr>
<td>Leukopenia</td>
<td>89 (3.3)</td>
<td>130 (4.8)</td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>93 (3.5)</td>
<td>100 (3.8)</td>
<td></td>
</tr>
<tr>
<td>Thrombosis</td>
<td>97 (3.6)</td>
<td>104 (3.9)</td>
<td></td>
</tr>
<tr>
<td>Venous thrombosis</td>
<td>106 (4.0)</td>
<td>117 (4.4)</td>
<td></td>
</tr>
</tbody>
</table>

Table 7: Bleeding Risks in the AMPLIFY-EXT Study

<table>
<thead>
<tr>
<th>Bleeding Risk</th>
<th>Placebo</th>
<th>Placebo-Proprietary</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major</td>
<td>12 (0.4)</td>
<td></td>
</tr>
<tr>
<td>CRNM*</td>
<td>25 (0.9)</td>
<td></td>
</tr>
<tr>
<td>Minor</td>
<td>32 (1.2)</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>47 (1.7)</td>
<td></td>
</tr>
</tbody>
</table>

The safety and effectiveness of ELIQUIS have been established in the AMPLIFY and AMPLIFY-EXT studies, including 2689 patients exposed to ELIQUIS 10 mg twice daily, 3305 patients exposed to ELIQUIS 5 mg twice daily, and 3508 patients exposed to ELIQUIS 2.5 mg twice daily. Common adverse reactions (>1%) were gingival bleeding, epistaxis, contusions, hematoma, rectal hemorrhage, hemoptysis, menometrorrhagia, genital hemorrhage.

The mean duration of exposure to ELIQUIS was 154 days and to enoxaparin/warfarin 150 days. In the 1 Phase study, adverse reactions related to bleeding occurred in 47.5% (1079/2262) ELIQUIS-treated patients compared to 25.6% (319/1252) enoxaparin/warfarin-treated patients. The discontinuation rate due to bleeding events was 0.7% in the ELIQUIS-treated patients compared to 1.1% in enoxaparin/warfarin-treated patients in the AMPLIFY study.

In the AMPLIFY study, safety was statistically superior to enoxaparin/warfarin in the primary safety endpoint of major bleeding risk (0.93, 95% CI [0.77, 1.11], P<0.005).

Bleeding events from the AMPLIFY study are summarized in Table 5.

Table 5: Bleeding Events in the AMPLIFY Study

<table>
<thead>
<tr>
<th>Bleeding Event</th>
<th>Placebo</th>
<th>Placebo-Proprietary</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major bleeding</td>
<td>24 (0.9)</td>
<td></td>
</tr>
<tr>
<td>CRNM*</td>
<td>36 (1.3)</td>
<td></td>
</tr>
<tr>
<td>Minor bleeding</td>
<td>60 (2.3)</td>
<td></td>
</tr>
</tbody>
</table>

Adverse reactions occurring in ≥1% of patients in the AMPLIFY study and listed in Table 6.

Table 8: Adverse Reactions Occurring in ≥1% of Patients Undergoing Extension Treatment for DVT or PE in the AMPLIFY Study

<table>
<thead>
<tr>
<th>Reaction</th>
<th>ELIQUIS (apixaban)</th>
<th>Placebo</th>
<th>Placebo-Proprietary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>CRNM*</td>
<td>25 (0.9)</td>
<td>13 (0.5)</td>
<td></td>
</tr>
</tbody>
</table>

Adverse reactions occurring in ≥1% of patients in the AMPLIFY study are listed in Table 8.
**The Case**
You get a call that a 50-year-old woman collapsed while running a marathon. Bystanders started CPR immediately. Nearby paramedics found her to be in ventricular fibrillation (VF). She was shocked three times and given 3 amps of epinephrine. She is still in VF when she arrives at your emergency department.

Advanced cardiac life support (ACLS) was originally designed to give us a common language and help us avoid paralysis in a crisis situation. However, with each year that passes, it seems like ACLS has become more and more simplified to appeal to a broader scope of rescuers, including those who rarely run codes. Yet cardiac arrest physiology just isn’t that simple. Managing these patients requires a lot more finesse. Practitioners working in settings where they manage codes regularly (e.g., the emergency department) should be expected to have a more sophisticated approach when standard ACLS algorithms aren’t effective. In this month’s column, I’ll suggest four strategies to improve the chances of return of spontaneous circulation (ROSC) in shock-resistant VF and, perhaps, survival to hospital discharge. Shock-resistant VF, or electrical storm, is defined as three or more sustained episodes of VF in a 24-hour period.

1. **Prepare Your Team**
Team-based preparation prior to patient arrival is essential to optimizing cardiac arrest care and takes fewer than five minutes. It can be broken down into three points to be discussed in a team huddle:

- What do we know? What do we expect to see based on the call that we? It helps us to think about probable first-line management, chest compressions, medication administration, and defibrillation. It also helps us to deal with the most likely immediate life-threatening issues.

- What do we do? What actions will we take, and what contingency plans will we have in place if those actions fail? Teams respond more efficiently and decidedly if they have anticipated failure rather than having failure of a plan surprise them.

- Role assignment: Assign logistical tasks to team members, including definitive airway management, chest compressions, medication administration, and defibrillation. In this case, consider premixing amiodarone 300 mg and esmolol 500 mcg/kg and settling up for dual-shock therapy.

2. **Consider Stopping Epinephrine**
Epinephrine is associated with increased myocardial oxygen consumption and ventricular dysrythmias and has never been shown to improve survival to hospital discharge in cardiac arrest. Epinephrine, in the doses used in cardiac arrest, causes cerebral vasconstriction that may impair tissue oxygenation and brain perfusion and compromise neurological recovery. There is an argument to be made that epinephrine should be decreased or eliminated in patients with shock-refractory VF because of its catecholamine effects. It makes little physiologic sense to add catecholamine fuel, like epinephrine, to the catecholamine firestorm of refractory VF. In fact, we want to achieve the opposite: Block the catecholamine surge so that the VF breaks.

3. **Block Sympathetic Tone**
Shock-resistant VF increases sympathetic tone, which leads to a vicious cycle of fibrillation and ischemic event as the primary cause, cardiac arrest experts recommend consulting an interventional cardiologist for consideration of immediate transfer to the cath lab for all VF patients who have achieved ROSC.

4. **Consider Dual-Shock Defibrillation**
If standard defibrillation isn’t working, consider double defibrillation. Animal studies show that most failed shocks are actually successful shocks but that the patient goes back into VF in less than one second. Eighty percent of patients who are resistant to a single shock will respond to dual shock. The idea is that you need to depolarize 90 percent of the myocardium to achieve effective defibrillation. If the patient has defibrillator pads in the traditional positions on the chest, attach a second set of pads from a second defibrillator in the anterior-posterior “sandwich” position (see image). At the time of defibrillation, both shock buttons are depressed simultaneously.

To perform dual-shock defibrillation, place one set of defibrillator pads in the traditional positions on the chest (blue pads) and attach a second set of pads from a second defibrillator in the anterior-posterior “sandwich” position (red pads).
forever. To the greater world around him, he is sadly another unfortunate statistic of inner-city gun violence. The photos shown this month are not of this particular patient but of those who shared the same fear, pain, and stress of being a victim of violence.

This topic of inner-city violence strikes a chord with me. Being an African-American physician, I cannot help but lament over the loss of life in the community I serve. Normally, I try to place some mental and emotional distance between myself and the tragic events that I frequently encounter in the emergency department to preserve my humanity. However, that distance becomes hard to place when you are continually treating peers who look like you and come from a similar background as you. I cannot help but feel something. Despair? Anger? Guilt? Maybe all of the above? Whatever the feeling is, it drives the question of how we, as a society, can stop the violence.

Injuries from gun violence account for nearly 37,000 emergency department visits annually. Firearms are the second leading cause of death among youths (14–24 years of age) in the United States and disproportionately affect youth and adult populations in minority communities stricken by poverty and neglect. Individuals victimized by firearms are at higher risk to be reinjured and rehospitalized, especially within the first year after their injury. They experience higher rates of functional disability, PTSD, and depression. Furthermore, the societal costs associated with firearm violence, injury, and death are not trivial. Every year, an estimated $660 million is spent on lost wages and productivity.

A handful of interventions such as blight remediation and therapist-delivered interventions have been shown to decrease firearm and non-firearm violence. However, there is still a paucity of medical literature and validated interventions on how we as a medical community can ameliorate the effects of gun violence. As emergency physicians, we are on the front lines of this epidemic and have a unique but powerful capacity to make change. I am by no means advocating for the infringement of people’s Second Amendment rights. My plea is that we do more in curtailing this epidemic by supporting more research around this issue, investing in community-based interventions, and advocating for future victims who may become nameless statistics.

References
Stab Wound Taxonomy

Listen carefully, wounds have a story to tell

by RALPH J. RIVIELLO, MD, MS, FACEP, AND HEATHER V. ROZZI, MD, FACEP

THE CASE: A 58-year-old male presents to the emergency department in cardiac arrest after sustaining a stab wound to the left neck (zone 1). The patient was apneic with a faint pulse at the scene but arrested on route to the emergency department. Medics have the patient intubated, and two large-bore IVs have been initiated with crystalloids infusing. He is still pulseless in the emergency department. A focused assessment with sonography for trauma (FAST) exam is negative. After brief resuscitative efforts in the trauma bay, the patient is pronounced dead.

Forensic Pearls

A stab wound is a form of sharp-force trauma caused by a thrusting action whose injury length on the body surface is less than its depth of penetration into the body. The force is delivered along the long axis of a narrow, sharply pointed object. The impact force is concentrated at the tip of the object—and the sharper the tip, the more easily it can penetrate the skin. Stab wounds can be homicidal, self-inflicted, or accidental. Internal and external hemorrhage are of concern when treating stabbing victims. Knives tend to make up the majority of weapons used in stabbings. However, any pointed object can be a weapon (eg, pencil, screwdriver, barbecue fork, scissors, awl, etc.).

The skin edges of a stab wound are called the wound’s margins, and the ends or tips are the wound’s angles. The length of the wound is measured from one angle to the other. A line drawn between the two angles is the long/longitudinal axis. The longitudinal axis can be described as vertical, horizontal, or angled. The width is the widest measurement between the two margins.

Several factors should be considered when determining the characteristics of a stab wound. These include motion used, force applied, sharpness/dullness of the tip, type/nature of the weapon, and type/nature of tissue encountered.

There are several things that can be learned about the weapon from looking at the wound itself. However, determining the dimensions of the weapon and depth of penetration are not among them. This is due to the effect of elasticity of skin shrinking slightly on withdrawal of the object (by up to 2 mm). Also, when the blade has entered the skin at an oblique angle, the length of the entry slit may be longer than expected. Skin elasticity and Langer’s lines (orientation of collagen fibers in the dermis) can cause wounds to gap, contributing to miscalculations. If the weapon has not fully entered the skin, the wound depth will correspond to the part that has penetrated the skin and will not represent the maximum length of the weapon. In addition, objects are rarely pushed into the body and withdrawn at exactly the same angle, and rocking of the knife distorts a wound’s appearance. Finally, compressible body parts, like the abdomen or chest wall, often indent during the stabbing, and thus the area penetrated can be at a depth greater than the weapon.

Characteristics of Stab Wounds

- Stab wounds have clean-cut edges.
- Single-edge knives (like kitchen knives) cause wounds that have a clearly pointed edge.
- Serrated knives may leave serrations on wounds caused by other single-edge knives.
- Knives or weapons with two sharp edges (double-edge blades), such as military knives, bayonets, and ceremonial daggers, show pointed edges on both sides of the wound or a spindle-shaped entry slit tapered at both ends.
- Knives with blade guards (at the handle end closest to the blade) can produce distinctive bruising/abrasions to the side of one of the wound angles.
- Bruising may also be present where the assailant’s fist impacts against the skin during the stabbing, depending on the amount of force used and depth of weapon penetration.
- Wounds caused by other implements may cause patterned wounds characteristic of the sharp end of the weapon, such as an X-shaped wound from a Phillips head screwdriver.
- Traditional screwdrivers and chisels usually produce rectangular wounds with abraded margins.
- Ice picks and awls produce wounds that can be mistaken for small caliber gunshot wounds (rounded defect surrounded by thin rimmed abrasion).
- Scissors may produce different wounds depending upon their design and position (open or closed) at the time of the injury. Closed scissor wounds are single and Z-shaped. Open scissors wounds are paired, with varying distances between the pair.

A 58-year-old male with a stab wound to the left neck (zone 1).
1. Sepsis & 2. Near Drowning

Serum lactate screening for sepsis and prophylactic antibiotics in near drowning called into question. You decide!

by Landon Jones, MD, and Richard M. Cantor, MD, FAAP, FACEP

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

Question 1: Are serum lactate levels good screening tools for sepsis in pediatric patients?

In adults, a screening serum lactate ≥ 24 mmol/L identifies patients at significantly higher risk of death from sepsis, serving as a valuable risk stratification tool.1 For this reason, it is common practice to obtain this test in adult patients suspected of having sepsis. However, in children, there are considerably less data on this topic.2

The literature on this topic has typically been limited to pediatric ICU patients. One early study was a very small (n=11) prospective pediatric ICU study.3 The authors evaluated children ages 1 to 18 years in septic shock who required mechanical ventilation. In these 11 children, they drew 53 serum lactate samples—an initial sample in each, plus six-hour trending follow-up samples. In these patients, only 15 of 53 (29 percent) samples were >1.8 mmol/L. Of the initial lactates drawn, only 2 of 11 (18 percent) were >4 mmol/L, suggesting that serum lactates are not good screening tests for severe sepsis/septic shock in pediatric patients. Another retrospective study of 183 children younger than 18 years evaluated screening serum lactate measurements as an outcome predictor in a pediatric emergency department.4 Death was not predicted by the serum lactate in that study.

A later prospective observational cohort study (n=239) evaluated screening serum lactate levels in children younger than 19 years if they met systemic inflammatory response syndrome (SIRS) criteria.5 Predefined levels of serum lactates were normal (<2 mmol/L), intermediate (2-4 mmol/L), and hyperlactemia (>4 mmol/L). The primary endpoint was end-organ dysfunction within 24 hours. For patients with hyperlactatemia (>4 mmol/L), the sensitivity for end-organ dysfunction was only 31 percent (4 of 13); the majority of patients with end-organ damage within 24 hours of ED presentation presented in the <4 mmol/L group. While the relative risk of end-organ damage within 24 hours was higher (5.5; 95% CI, 1.9-16) in the hyperlactatemia group, having a serum lactate ≥4 mmol/L did not rule out a seriously septic child, suggesting that practitioners should not use screening serum lactates alone to risk-stratify pediatric patients suspected of having sepsis.

A recent pediatric prospective, observational, cohort study (n=1,299), similar to previous adult studies, evaluated whether an elevated screening serum lactate ≥36 mg/dL (3.6 mmol/L) was associated with increased mortality in pediatric patients.6 The primary outcome was in-hospital, all-cause mortality within 30 days. The overall mortality was 1.9 percent (25 of 1,299). In patients with lactates ≥36 mg/dL, the mortality was 4.8 percent (5 of 103) versus 1.7 percent (20 of 1,196) in the group <36 mg/dL. While the mortality in the hyperlactatemia group (≥36 mg/dL) was higher, the difference in mortality was not nearly as robust as in the adult literature.

For this reason, screening serum lactates in children should not be routine. More important, a serum lactate in the 18–36 mg/dL group (2–4 mmol/L) should not falsely reassure the practitioner that a child is not sick, as there were a number of deaths in this group.

While screening pediatric patients for sepsis with serum lactate is not routine, there are data to suggest that trending lactates for clearance is associated with less persistent organ dysfunction at 48 hours.7

Conclusions: Serum lactate measurements in children do not provide the robust sepsis risk stratification demonstrated in the adult literature. While hyperlactatemia (>4 mmol/L) may suggest a sicker patient, it is very important to recognize that a normal or intermediate lactate level should not falsely reassure you that a child is not sick.

Question 2: Do prophylactic antibiotics decrease the likelihood of drowning-associated pneumonias in children?

In general, the data are scarce and based on a mixture of adult and pediatric patients. One of the earliest studies on this topic was a retrospective study of 95 consecutive children and adults (ages 1 to 79).8 Of these patients, 81 of 95 (89 percent) survived, and they appeared to have a variety of presentations, with 33 patients requiring intubation. The data are very limited, and the authors noted, “More patients died who received prophylactic antibiotic therapy [7 (of 54 (13.0 percent)) than did those from whom such therapy was withheld until gram staining, culture, and the clinical course suggested the presence of active infection [12 of 36 (33.3 percent)].” There was one patient unaccounted for and no mention of statistical significance. They did not mention the patients’ ages or the severity of illness for patients who received prophylactic antibiotics.

An older retrospective study of 40 patients, with 33 of the patients younger than 17 years, found that prophylactic antibiotics given to 31 of 40 patients “had no apparent benefit” in the patient population.9 An additional retrospective study of 125 submersion victims included an unspecified breakdown of children versus adults and found no significant benefit from prophylactic antibiotics.10

Conclusions: While there has been no reported benefit from prophylactic antibiotics in cases of near drowning, there have been no prospective trials assessing this topic. Current expert consensus on this very limited topic by the Wilderness Medical Society recommends that “there is no evidence to support empiric antibiotic therapy in the treatment of drowning patients.”11 Thus, the use of prophylactic antibiotics remains at the discretion of the treating physician.

References
Appendicitis? NOT a Problem!

Nonoperative treatment of pediatric appendicitis

by KEN MILNE, MD, MSC, CCFP-EM, FCFP, FRMMS

The Case

Johnny is a 10-year-old boy who presents to the emergency department after a 24-hour history of abdominal pain. It started in the periumbilical region and is located in the right lower quadrant. The pain is increasing in severity. His mother knew something was wrong when he did not want to eat dinner or play soccer with friends after school. He was nauseated and developed a low-grade fever. On examination, he is maximally tender over McBurney’s point. An ultrasound confirms acute, uncomplicated appendicitis.

Background

One of the most common pediatric surgical emergencies is appendicitis. The peak incidence is in the second decade of life, with a lifetime risk of 7 percent to 8 percent.1

The standard treatment for acute appendicitis, ever since Dr. Charles McBurney described it in 1889, has been appendectomy.2 This surgical approach has been highly successful for more than a century.

There have been a number of recent publications suggesting a nonoperative treatment (NOT) of appendicitis in adults.3,4 They propose using antibiotics rather than surgery to manage this common condition.

Clinical Question

Is NOT safe and effective in pediatric patients with acute, uncomplicated appendicitis?

Reference


Key Results

Ten studies were included that had a total of 413 pediatric patients selected or randomized to NOT.

- **Primary Outcome:** NOT was successful in 97 percent of cases (95% CI, 95–99%).
- **Secondary Outcome:**
  - **Serious Adverse Events:** None reported.
  - **Long-Term Efficacy of NOT:** 82 percent (95% CI, 77–87%).
  - **Recurrence Appendicitis:** 14 percent (95% CI, 7–21%).
  - **Hospital Length of Stay:** Mean difference, 0.5 days fewer with appendectomy (95% CI, 0.2–0.8; P=0.002).

Authors’ Conclusion

“Current data suggest that NOT is safe. It appears effective as initial treatment in 97 percent of children with acute, uncomplicated appendicitis, and the rate of recurrent appendicitis is 14 percent. Longer-term clinical outcomes and cost-effectiveness of NOT compared with appendectomy require further evaluation, preferably in large randomized trials, to reliably inform decision-making.”

Evidence-Based Medicine Commentary

**Quality of Studies:** Nine of the 10 studies were observational studies. This is a low level of evidence. Only associations can be concluded, not cause and effect. Four of these studies had no comparison group. Only one small randomized pilot study of 50 patients was included.

**Lack of Blinding:** There was no blinding in any of the studies. It would be difficult to conduct a study with a sham surgery group to address this bias.

**Antibiotic Regimes:** There was no standard antibiotic protocol. While this may be pragmatic, it makes it difficult to know what would be the best antibiotic regimen for acute,
Tips for Negotiating Employment Contracts

Focus on the end of the relationship, not the beginning

by KEVIN M. KLAUER, DO, EJD, FACEP

QUESTION: I’m getting ready to look for my first job as an emergency physician. What should I know about negotiating my first employment contract?

ANSWER: This is a great question. My response is fairly brief and not intended to give adequate treatment to employment or independent contractor agreements but merely to provide some practical tips that every emergency physician should be aware of regarding employment or independent contractor agreements.

1. Contracts should be written in plain English. The concept of writing contracts with the overly laborious use of the Queen’s English has long since passed. Although you shouldn’t be expected to fully understand the legal effect of every legal term, you should be able to read the contract and come away with a general understanding of the intent. If you don’t understand it, don’t sign it. It’s not a sign of weakness to ask for clarification. There’s a pretty good chance that the person who obtained it from an attorney—or, worse, from the Internet—can’t explain it either.

2. Professional liability coverage should be expected but not assumed. You should either have occurrence-based medical malpractice coverage or claims-made coverage with a tail. Basically, occurrence-based coverage provides you coverage for any occurrence during the policy duration regardless of when the claim is filed. So if you work for a group in 2017, leave in 2018, and are sued in 2020, you will be covered by an occurrence-based policy that was in force the entire agreement. However, if you had a claims-made policy and didn’t have a tail, the claim would not be covered. Claims-made is a face-value term. When a claim is made, the claim is covered if your policy is in force. However, when the policy ends, no prior acts are covered. So if you work for a group in 2017 and leave in 2018, any claims filed after the coverage year 2017 would not be covered unless you have tail coverage, which covers those prior acts. These terms must be clear in your agreement.

3. Integration is a very important concept in contract law. An integrated agreement is the entire agreement. When you sign your employment or independent contractor agreement, integration ensures that both parties understand they are bound by the terms in the contract and of that agreement only. In other words, if someone promised you something but it’s not in the integrated agreement, they have no legal obligation to perform to that promise.

4. Outside activities can be limited by a future employer. This is seen more often in academic contracts. A clause may exist limiting time spent on outside pursuits or discouraging conduct by requiring that earnings for such activities be re-Imputed to the employer. At some places, this may be required. However, if you are uncomfortable, ask to have that clause removed or amended. For instance, if you are already engaged in writing a book or teaching advanced cardiac life support, the compromise could be to have those activities excluded.

5. Sign-on (signing) bonuses can be tricky. Don’t focus on the cash; focus on the terms. Spending money is generally pretty easy, but paying money back that you don’t have isn’t. Pay close attention to the repayment terms. How do you fulfill your obligations, and what happens if you leave prior to the fulfillment date? Chances are, if you bail early, they are going to want their money back. My advice is to save that money until you have fulfilled that portion of your agreement. You don’t want to finance the repayment of your sign-on bonus if you decide you want to leave prematurely. If you do spend it, make certain you save enough to cover your tax liability the following year.

6. Noncompete clauses and restrictive covenants are very common. They are not unique to health care and certainly not to emergency medicine. The intended goal is to protect a business interest. I think most would agree that if a group, big or small, spends time, money, and other

CONTINUED on page 22
resources to obtain an ED contract, staff and manage that department, and develop a long-standing relationship with the hospital, they are entitled to protect their investment from one of their employees. However, the extent of that business interest and that of the restrictions placed on the physician are the greatest points of contention. Many would agree that the business interest, in most cases, begins and ends at the front door of that hospital. In other words, a noncompete that disallows a physician to work anywhere in the state would be far beyond a reasonable business interest. The enforceability of such clauses varies from state to state and with the specific circumstances of a given case. It isn’t right or wrong to have noncompete clauses, to sign them, or to not sign them. Just make certain that you can live with whatever restrictions are listed when and if you choose to separate.

Contract reviews are worth the relatively minimal amount you’ll pay for them. Although you are likely to spend $500 to $1,000 for a contract review, this will ensure that the rights and obligations of both parties are thoroughly understood by you and that your interests are met. I have heard from many residents that their attendings have offered to perform such reviews. That certainly may be of value but shouldn’t be your only source of input. If attendings have no formal education in contract law, what would qualify them to opine on such matters? Just because someone has been around the block a few times and has read many contracts does not qualify them to interpret a legal document and its full impact on the parties. When you have a leaky faucet, who do you call? Chances are, you call a plumber. When you need legal advice, call a lawyer.

Philosophers have said that funerals are for the living, not the dead. Contracts are similar in that they are most important when you’re leaving, not when you’re staying. Early in your employment, the relationship is often at its best, so it’s easy not to become overly worried about the details of an agreement. However, you should read your agreement from the perspective you’ll have if and when you leave. If you can’t live with the terms, don’t sign the agreement.

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While NOT of acute, uncomplicated pediatric appendicitis is interesting, there is not enough high-quality evidence to recommend it at this time.

**Case Resolution**

The surgeon is called, obtains informed consent from Johnny’s parents, and successfully performs an appendectomy.

**Bottom Line**

While NOT of acute, uncomplicated pediatric appendicitis is interesting, there is not enough high-quality evidence to recommend it at this time.

**References**


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