Monday issue

Georgia Emergency Physician Dr. John Rogers Chosen as 2017–2018 President-Elect

WASHINGTON, D.C.—John Rogers, MD, FACEP, of Macon, Georgia, was elected 2017–2018 President-Elect of ACEP at the Council meeting on Saturday, Oct. 28, and will assume the presidency at next year’s meeting in San Diego, California.

Continued on page 6

Explore ACEP’s History in the Resource Center

Open Monday and Tuesday, 9:30 a.m. – 3:30 p.m., the 50th Anniversary Lounge is a place to see the journey so far before the big anniversary next year. Reflect on our amazing 50 years of history as a specialty and the role you’ve played in making ACEP great. The experience starts in Booth 327.

Opening Session

Democracy’s Final Exam: Will We Pass?

By Richard Quinn

WASHINGTON, D.C.—Journalism icon Bob Woodward sees the tumult of President Donald Trump’s first year in office and understands that people—on both sides of the political aisle—think they know how the “final exam of American democracy” will unfold. But Mr. Woodward, the ACEP17 keynote speaker on Sunday, cautioned against judging too quickly, as he once did.

The Washington Post associate editor, who helped report and investigate the Watergate scandal that pushed President Richard Nixon to resign in 1974, thought he knew the story of

Continued on page 8

How Do You Get Started in Advocacy for Your Specialty?

You already know that emergency physicians are the only health care providers who work 24-7-365 to care for patients, regardless of their ability to pay. Do your senators know this? They should.

The “Advocating for Change in Health Care Policy” course, led by Nathaniel R. Schlicher, MD, JD, FACEP, and Mary Jo Wagner, MD, FACEP, and moderated by Laura Wooster, MPH, will teach you all the key advocacy issues for emergency medicine at both the state and federal levels. You’ll leave with an action plan for developing relationships with your legislators and working with your colleagues to advance EM’s critical advocacy agenda.

Help Me, Senator! Advocating for Change in Health Care Policy

Monday, Oct. 30
4:30–5:30 p.m.
Room 145A

Use the ACEP17 Mobile App

Maximize your experience! The app is available in the iOS App Store and the Google Play store. Use your log-in credentials from your ACEP17 registration to get schedules, syllabi, surveys, and so much more.

Connect Yourself

- More Than 350 Courses and Labs
- World’s Largest EM Exhibit Hall
- Networking Events and Parties
Are you aware of the variety of support resources available for ELIQUIS patients?

Think ELIQUIS for the treatment of DVT/PE.

**INDICATIONS**
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.
DVT and pulmonary embolism (PE), and to reduce the risk of treatment of DVT/PE.

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Are you aware of the resources available to support ELIQUIS patients?

Consider the benefits and risks before neuraxial intervention

- concomitant use of other drugs that affect hemostasis,
- use of indwelling epidural catheters or undergoing spinal puncture. These hematomas may result treated with ELIQUIS who are receiving neuraxial anesthesia of therapy, consider coverage with another anticoagulant.

- other than pathological bleeding or completion of a course

If anticoagulation with ELIQUIS is discontinued for a reason including ELIQUIS, increases the risk of thrombotic events.

ELIQUIS INCREASES THE RISK OF THROMBOTIC EVENTS, WARNING: (A) PREMATURE DISCONTINUATION OF

- optimal timing between the administration of ELIQUIS
- a history of traumatic or repeated epidural or spinal punctures

Consider the benefits and risks before neuraxial intervention

- interrupted postoperative pain relief.
- there is no established way to reverse the anticoagulant

- Concomitant use of drugs affecting hemostasis increases

- There is no established way to reverse the anticoagulant

- Premature discontinuation of any oral

- SSRI, SNRI, and NSAIDs.

- The risk of these events may be increased by the postoperative

- Severe hypersensitivity reaction to ELIQUIS

CONTRAINDICATIONS

- 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 and 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.

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.

ELIQUIS and the ELIQUIS logo are registered trademarks of Bristol-Myers Squibb Company. © 2017 Bristol-Myers Squibb. All rights reserved. 432US1702142-02-01 07/17
**ELIQUIS® (apixaban) tablets, for oral use**

**WARNING:**

- **PREMATURE DISCONTINUATION OF ELIQUIS INCREASES THE RISK OF THROMBOTIC EVENTS—**
  - Patients treated with apixaban may experience a rebound increase in thrombotic risk after premature discontinuation, which may be greater than that following discontinuation of vitamin K antagonists.

- **SPINAL/PEDICULAR HERNIATION—**
  - Premature discontinuation of any oral anticoagulant, including ELIQUIS, increases the risk of spinal or pedicular herniation. If spinal or pedicular herniation is suspected, treatment with apixaban should be continued until surgical intervention has been performed.

**INDICATIONS AND USAGE**

**Reduction of Risk of Recurrence of DVT and PE—**

ELIQUIS is indicated to reduce the risk of symptomatic VTE (DVT or PE) in patients who have had an initial episode of symptomatic VTE.

**Treatment of Pulmonary Embolism—**

ELIQUIS is indicated to treat symptomatic PE in patients who have had an initial episode of PE.

**Prophylaxis of Deep Vein Thrombosis Following Hip or Knee Replacement Surgery—**

ELIQUIS is indicated to reduce the risk of VTE (DVT or PE) following total hip or knee replacement surgery.

**Prophylaxis of Stroke in the Prevention of Deep Venous Thrombosis**

- **ELIQUIS is indicated to reduce the risk of symptomatic VTE (DVT or PE) in patients who have had an initial episode of symptomatic VTE.**

**Monitor patients frequently for signs and symptoms of neurological impairment (e.g., numbness or paresthesia).**

**Increased Risk of Thrombotic Events after Premature Discontinuation—**

Premature discontinuation of apixaban should not be considered as an alternative to unfractionated heparin for the initial treatment of patients with PE who present with hemodynamic instability or who may receive thrombolytic therapy or pulmonary embolectomy.

**ADVERSE REACTIONS**

The following adverse reactions are observed in greater detail in other sections of the prescribing information:

- **Increased risk of thrombotic events after premature discontinuation [see Warnings and Precautions and Clinical Studies].**

**Bleeding—**

- **[see Warnings and Precautions and Clinical Studies].**

**Clinical Trials Experience—**

Bleeding was assessed in each study beginning with the first dose of double-blind study drug.

- **Bleeding events within each subcategory were counted once per subject, but subjects may have had more than one adverse event.**

- **N=2780**

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<td>27/1202</td>
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- **Decrease in the Risk of Thrombotic Events**

In ARISTOTLE, the results for major bleeding were generally consistent across most major subgroups, including age, weight, CHADS2 score is from 0 to 6 used to estimate risk of stroke, with higher scores indicating greater risk, prior warfarin use, geographic region, and prior use at randomization (Figure 1). Subjects treated with apixaban had a lower risk of major bleeding than subjects treated with warfarin. The results for intracranial bleeding were generally consistent across all subgroups, including age, weight, CHADS2 score is from 0 to 6 used to estimate risk of stroke, with higher scores indicating greater risk, prior warfarin use, geographic region, and prior use at randomization (Figure 1). Subjects treated with apixaban had a lower risk of intracranial bleeding than subjects treated with warfarin. The results for fatal bleeding were generally consistent across most major subgroups, including age, weight, CHADS2 score is from 0 to 6 used to estimate risk of stroke, with higher scores indicating greater risk, prior warfarin use, geographic region, and prior use at randomization (Figure 1). Subjects treated with apixaban had a lower risk of fatal bleeding than subjects treated with warfarin. The results for death were generally consistent across most major subgroups, including age, weight, CHADS2 score is from 0 to 6 used to estimate risk of stroke, with higher scores indicating greater risk, prior warfarin use, geographic region, and prior use at randomization (Figure 1). Subjects treated with apixaban had a lower risk of death than subjects treated with warfarin.

- **Other Adverse Reactions**

Bleeding-related adverse reactions including drug hypersensitivity, such as skin rash, and anaphylactic reactions, such as allergic, angioedema and laryngeal edema were seen in ~1% of patients receiving ELIQUIS versus 1% of patients receiving placebo. (See Table 6 below).
Adverse reactions occurring in ≥1% of patients undergoing hip or knee replacement surgery in the 1 Phase I study and the 3 Phase II studies are listed in Table 4.

Table 4: Adverse Reactions Occurring in ≥1% of Patients in Either Group Undergoing Hip or Knee Replacement Surgery

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Table 5: Bleeding Results in the AMPLIFY-EXT Study

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Table 6: Adverse Reactions Occurring in ≥1% of Patients Undergoing Extending Treatment for DVT and PE in the AMPLIFY-EXT Study

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Nausea
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<td>75 (9.5)</td>
<td>134 (15.9)</td>
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Work Hard, Play Hard with EMRA

The Emergency Medicine Residents Association (EMRA) activities begin today with a hard-core simulation competition and will finish with an epic party. EMRA events come at no charge to residents and medical students.

**MONDAY**

**EMRA Resident SIMWars Competition**

9 a.m.–3 p.m.
Marriott Marquis, Liberty Ballroom, Salon L, Meeting Level 4

In this high-fidelity simulation competition, participants help decide the winning team.

**EMRA Party at Echostage**

10 p.m.–2 a.m.
Echostage
2355 Queens Chapel Rd. NE, Washington, D.C.

Come join EMRA members for a fantastic evening!

Sponsored by Envision Physician Services

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“Significant changes are occurring in our nation’s health care system, and emergency medicine will continue to play a vital role,” said Dr. Rogers. “Emergency physicians are the only ones available 24/7—no appointment necessary. Protecting people’s access to emergency care and making sure that people have fair insurance coverage for emergency care are two of my priorities.”

For the past year, Dr. Rogers has served as Chairman of ACEP’s Board of Directors. He is co-emergency department medical director at Coliseum Northside Hospital in Macon, Georgia. He has served as chairman of the Emergency Medicine Foundation, president of the Georgia College of Emergency Physicians, Delegate to the Medical Association of Georgia, and president of his hospital medical staff. Dr. Rogers was first elected to ACEP’s Board in 2011.

“Physicians lead differently,” said Dr. Rogers. “Physicians are motivated by patient-centric principles, not politics, profit, or personal gain. We are here on this earth for a purpose, our chosen purpose: to care for the acutely ill and injured. We are here...because we care about our patients, our craft, and those who practice it.”

Dr. Rogers completed his medical degree at the University of Iowa. He did his residency in the Department of Surgery at Medical Center of Central Georgia (now Mercer University) in Macon.

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**ELECT**

**CONTINUED FROM PAGE 1**

Congratulations to the new and re-elected Board members: (left to right) Alison Haddock, MD, FACEP; Stephen H. Anderson, MD, FACEP (re-elected); Jon Mark Hirshon, MD, PhD, MPH, FACEP (re-elected); Aisha T. Liferidge, MD, FACEP.

Congratulations to new Council Officers: (left to right) Vice Speaker Gary R. Katz, MD, MBA, FACEP; Speaker John G. McManus, Jr., MD, MBA, FACEP; Speaker John G. McManus, Jr., MD, MBA, FACEP.
YOUR NEXT PATIENT EXPOSED TO SMOKE MAY HAVE CYANIDE POISONING

Visit CYANIDEINSIGHT.COM to learn the causes, signs, and symptoms of cyanide poisoning.
OPENING SESSION | CONTINUED FROM PAGE 1

President Gerald Ford pardoning Nixon shortly thereafter.

“It’s the final corruption of Watergate,” Mr. Woodward told a crowded ballroom of emergency physicians. “There was an aroma of a deal between Nixon and Ford. Ford gets the presidency. Nixon resigns, but is pardoned.”

But some 25 years later, Mr. Woodward spoke to Ford for the first time about why he pardoned Nixon. “Ford said, in this plaintive voice I will never forget, ‘You know, I needed my own presidency,’” Mr. Woodward said. “The country had to move on. I had to move on. The only way to get Nixon off the front page and into history was to pardon him. That was the national interest.’”

The pardon helped cost Ford the 1976 presidential election, but the lesson to Mr. Woodward was that “the lens of history” frames a different picture. It’s a valuable perspective as President Trump’s “energized” pace prompts the media to forecast the future and question his motives.

“I was so sure I knew in ’74, not just what had happened, but what it meant,” Mr. Woodward said, adding, “It is a lesson that will never leave me and it is a lesson that we sit in this moment in history, which is a really, really important moment, and I think the stakes could not be higher about what Trump’s going to do, but we don’t know.”

Mr. Woodward said the media must be careful in its tone and coverage of President Trump, lest its credibility be further eroded. And it has to “entertain the possibility . . . that Trump is operating in good faith” to do the job of the president.

So how does Mr. Woodward, who has written books on eight presidents and is working on his ninth, define the job description for the world’s most powerful man?

“To figure out what the next stage of good leadership is for a majority of people in the country,” he said, “A real majority. Not one party, not interest groups, not a series of interest groups. But really step back and say, ‘What do we need?’”

And the answer to that question will truly determine how the “final exam of American democracy” goes. O

RICHARD QUINN is a freelance writer in New Jersey.

ACEP's Opening General Session Sunday drew a full house at the Washington Convention Center.

Q: WHY DID YOU COME TO ACEP17?

“I’m still looking for a niche. I have a lot of interest and I like a lot of things. And I can’t decide what I really want to hone in on as a provider now that I’m done with all my training. [This meeting] kind of helps ... recapture my focus and my motivation.”

- Danielle Mercurio, DO, FAAP, pediatric emergency physician, Johns Hopkins All Children’s Hospital, St. Petersburg, Florida

ACEP Council Reviews Opioid Policies and More at Annual Meeting

WASHINGTON, D.C.—The 2017 ACEP Council considered several resolutions during its annual meeting this week, including issues related to public policies, clinical matters, and emergency medicine practice trends.

This year’s 410-member Council represents all 53 chapters, 37 ACEP sections of membership, the Emergency Medicine Residents’ Association (EMRA), the Association of Academic Chairs in Emergency Medicine, the Council of Emergency Medicine Residency Directors, and the Society of Academic Emergency Medicine.

The resolutions adopted by the Council do not become College policy until they are reviewed and approved by the ACEP Board of Directors on Wednesday.

The Council considered a resolution on endorsing paid parental leave for emergency physicians, and after debate on both sides, an amended version was ultimately adopted. Those opposed stated that paid leave is not feasible for small democratic group practices or for certain other types of employment pay structures, while those in favor argued that being able to take time off to care for children was a wellness issue as well as a burnout issue.

The Council also considered a resolution on the usage of freestanding emergency centers during federally declared disasters. After debate on both sides, the Council voted to refer this resolution to the Board of Directors.

The Council also adopted resolutions related to:

• 9-1-1 number access and pre-arrival instructions
• Coverage for patient home medication while on observation status
• CPR training
• Demonstrating the value of emergency medicine to policymakers and the public
• Development and study of supervised injection facilities
• Maternity and paternity leave
• ACEP Wellness Center services
• Resolution co-sponsorship memo
• Studying the impact and potential membership benefits of a new chapter or section representing locums physicians
• Chapter bylaws conformance standards
• Seating of past Chairs of the Board in the ACEP Council
• Funding of emergency medicine training
• Information sharing, regular ACEP/Chapter contact, and regional state/chapter relationships
• Essential medicines
• Generic injectable drug shortages
• Expanding ACEP policy on workforce diversity in health care settings
• Guidelines for opioid prescribing
• Participation in ED information exchange and prescription drug monitoring systems

• Retirement or interruption of clinical emergency practice
• Workplace violence
• Support for harm reduction and syringe services programs

The Council referred these resolutions to the Board of Directors for further discussion:

• Legislation requiring hyperbaric medicine facility accreditation for federal payment
• Prescription drug pricing
• Freestanding emergency centers as a care model for maintaining access to emergency care in underserved, rural, and federally declared disaster areas
• Immigrant and non-citizen access to care
• Reimbursement for hepatitis C virus testing performed in the emergency department
• Maintenance of competence for practicing emergency physicians
• Group contract negotiation to end-of-term timelines
• Impact of climate change on patient health and implications for emergency medicine
• Improving patient safety through transparency in malpractice settlements
• Non-fatal strangulation
• Promoting clinical effectiveness
Improve Quality with CEDR and E-QUAL

CEDR
As part of its ongoing commitment to providing the highest quality of emergency care, ACEP has developed the CEDR. This is the first emergency medicine specialty-wide registry to support emergency physicians’ efforts to improve quality and practice in all types of emergency departments, even as practice and payment policies change over the coming years. The ACEP CEDR has been approved by Centers for Medicare and Medicaid Services (CMS) as a qualified clinical data registry. The CEDR will provide a unified method for ACEP members to collect and submit Physician Quality Reporting System data, maintenance of certification, ongoing professional practice evaluation and other local and national quality initiatives. Visit us to get more information, watch demonstrations, and sign up.

Monday, 7 a.m.–6 p.m.;
Tuesday, 7:30 a.m.–5:30 p.m.
Walter E. Washington Convention Center, Level 1, West Salon Foyer

E-QUAL
The ACEP Emergency Quality Network (E-QUAL) is a CMS supported Support and Alignment Network of the Transforming Clinical Practice Initiative. E-QUAL has been designed to engage emergency clinicians and leverage emergency departments to improve clinical outcomes and coordination of care and to reduce costs within three focus areas:
- Improve outcomes for sepsis.
- Reduce avoidable imaging in low-risk patients through implementation of with ACEP’s Choosing Wisely program.
- Improve value of ED chest pain evaluation by reducing avoidable admissions in low-risk patients with chest pain.

Participation in E-QUAL will demonstrate the value and importance of EM care in addition to clinicians earning improvement activity credit for the new merit-based incentive payment system program, MOC Part IV credit, access to free eCME, and more resources and guidelines in the E-QUAL toolkits.

Monday, 7 a.m.–6 p.m.;
Tuesday, 7:30 a.m.–5:30 p.m.
Walter E. Washington Convention Center, Level 1, West Salon Foyer
Partying at the NEW PRESIDENT’S AWARDS GALA

This sold-out red-carpet event featured dinner, dancing, a presentation of the ACEP Leadership Awards, and an elegant welcome for our newest class of FACEP members. Don’t miss it next year—and be sure to buy your tickets early!
Don’t Miss These innovatED Events

innovatED offers an unprecedented look at new technology, products, and services available to emergency practitioners. Don’t miss these exciting events.

**MONDAY**

**Interactive Discussion: Improving Patient-Centric Outcomes with Psychiatric Advance Directives**
11 a.m.–11:30 a.m.
Location: Behavioral and Psychiatric Emergencies Area
Presented by Phyllis Foxworth, advocacy vice president, Depression and Bipolar Support Alliance
Sponsored by Foundation for Advancing Alcohol Responsibility and Advanced Recovery Systems

**Medical Device Pitch Event**
Noon–12:30 p.m.
Location: Innovation Spotlight Theater
Featuring four incubatED participants: Adroit Surgical, LLC; Forest Devices; InnOvital Systems; and Multisensor Diagnostics, LLC

**In VITAS Healthcare, The John A. Hartford Foundation, and West Health Institute**

**The Hospital Visit**
11:15–11:25 a.m.
Location: Innovation Spotlight Theater
A short film by Allergan models the treatment of acute bacterial skin and skin structure infection (ABSSSI).
Sponsored by Allergan

**Creating, Implementing, and Sustaining an Atrial Fibrillation Protocol in the Emergency Department**
11:30–11:36 a.m.
Location: Innovation Spotlight Theater
Presented by Christopher Baugh, MD, MBA, FACEP, medical director of emergency department, operations and observation medicine, Brigham and Women’s Hospital; assistant professor, Harvard Medical School

**Simulation: Pharmacologic Management of Agitation**
11:30–11:45 a.m.
Location: Behavioral and Psychiatric Emergencies Area
Presented by Michael Guttenberg, DO, medical director, Center for Emergency Medical Services, Northwell Health; Kate B. O’Neill, RN, MSN, director of clinical operations, emergency medicine service line, Northwell Health; and Maria Margaglione, actress, Coalition on Psychiatric Emergencies, web and visual communications director, Depression and Bipolar Support Alliance
Sponsored by Foundation for Advancing Alcohol Responsibility and Advanced Recovery Systems

**Are You Ready? Transitions of Care in the Emergency Department and Future Measurement Reporting**
11:30–12:30 p.m.
Location: Steelcase Health Idea Lounge
Presented by Susan Pasley, MS, BSN, RN, clinical product executive
Sponsored by Bravado Health

**Low-Acuity Patient Pod**
11:45–11:51 a.m.
Location: Innovation Spotlight Theater
 Presented by Dave Vincent, AIA, ACHA, LEED AP, principal and senior vice president, HKS, Inc.
Sponsored by HKS, Inc.

**In With the Old: Innovations in Palliative and Geriatric ED Care**
2:30–2:36 p.m.
Location: Palliative and Geriatric Care Area
Sponsored by VITAS Healthcare, The John A. Hartford Foundation, and West Health Institute

**Help When You Least Expect It: Peer Support in the ED**
2:45–2:51 p.m.
Location: Innovation Spotlight Theater
Presented by Thomas Lane, CRPS, senior director, community and recovery services, Magellan Health care

**Low-Acuity Patient Pod**
3–3:05 p.m.
Location: Innovation Spotlight Theater
Presented by Dave Vincent
Sponsored by HKS, Inc.

MONDAY, 11:30 A.M.
NEMPAC Give-A-Shift Lounge
WCC, Concourse B
NEMPAC is hosting a fundraiser for Rep. Ruiz, the only board-certified emergency physician in Congress. A donation is suggested to attend.

**NEMPAC “Give-A-Shift” Donor Lounge**
MONDAY–TUESDAY
8 a.m.–4 p.m.
Washington Convention Center
(by invitation only)
A Modern Approach to Concussion Diagnosis and Management
by VANESSA CACERES

As the literature on concussions grows exponentially, the annual “Concussion Update” session at the ACEP annual meeting becomes more and more relevant to emergency physicians. Led by Andrew D. Perron, MD, FACEP, professor and residency program director in the department of emergency medicine at Maine Medical Center in Portland, the session will cover a range of concussion-related topics, including chronic traumatic encephalopathy, brain remodeling, return-to-play guidelines and the connection of concussion to other diseases.

“There is more unknown about concussion than known. This frustrates some people.”
—Dr. Perron

Many of these areas are only beginning to be understood, Dr. Perron said. He wants to caution attendees who may be looking for definitive answers for concussion diagnosis and treatment. “There is more unknown about concussion than known,” he said. “This frustrates some people.”

The evolving definition of concussion also will be part of Dr. Perron’s session. “Concussion is now defined as a complex pathophysiological process affecting the brain and induced by traumatic biomechanical forces. The process can last from hours to weeks,” he said. This changes how concussion is potentially managed.

As players in various sports and coaches become more aware of concussions, there also appears to be an increase in the number of diagnoses, Dr. Perron said. That will also be discussed during the session.

“Concussion Update 2017” also will cover modern concussion treatment, as well as concussion and the law.

Dr. Perron

Catching Those Life-Threatening ENT Cases
by VANESSA CACERES

Sometimes a sore throat seen in the emergency department is just part of the latest virus going around. Other times, it could be the sign of something life-threatening. If you’re seeing multiple patients for run-of-the-mill illnesses, you could miss diagnosing something important in the ears, nose, or throat.

During “Sore Throats That Kill and Other Nightmare ENT Emergencies,” Tracy G. Sanson, MD, FACEP, associate professor of emergency medicine at the University of Central Florida College of Medicine in Orlando, will discuss ENT “monsters” that you don’t want to miss diagnosing. “We want to increase the potential for getting the diagnosis right,” Dr. Sanson said.

One common error Dr. Sanson will urge attendees to avoid is treating all sore throats (or other ENT maladies) the same way. For example, if it’s flu season and everyone is presenting with the same symptoms, you could miss that “snake in the grass” of a more severe problem, she said.

“We want to increase the potential for getting the diagnosis right.”
—Dr. Sanson

Dr. Sanson will address how keeping an open mind about an ENT-related diagnosis makes it less likely that you’ll miss something important. For example, if you’re seeing a patient with a seemingly routine sore throat but their pain seems out of proportion and they have mental status changes, you’ll also want to consider other diagnoses, including Lemierre syndrome, which is a significant infection.

Dr. Sanson also will discuss the importance of using proper personal protection during ENT exams and implementing great lighting to help identify subtler findings.

S sewn:

Dr. Sanson

Reach for Success with These Five Tips
by RICHARD QUINN

The first rule of being successful is simple to Kerry Broderick, MD, FACEP, of Denver Health.

“You have to show up,” said Dr. Broderick, who will present “Top 5 Habits of Highly Successful Emergency Physicians” today. “You have to be present. You can’t just say, ‘I want to be successful.’”

“If you don’t reach and say, ‘I want to be on that committee,’ or work to do that, then you’re never going to get there. People aren’t just going to hand it to you. You have to reach out … to get success.”
—Dr. Broderick

Success, of course, is different for different physicians. Some might want to just work 12-hour shifts and go home. Others may want to rise to a C-suite position. Still others might want to be actively involved in ACEP.

Regardless of your goal, the habits of success remain the same, Dr. Broderick said. Be present. Engage with people actively. Plan for accomplishing your goals.

“This is more about things that you can put into place in your life and you can be successful,” she said. “They are the same principles about being present, engaging in the moment of what you’re trying to do, making a difference, and reaching, making sure that you reach for what you want, and then reflection.”

Reaching for goals is an important note, Dr. Broderick said. People often undersell themselves when a more positive attitude could be the key to success.

“If you don’t reach for things, you’re never going to get things,” she said. “If you don’t reach and say, ‘I want to be on that committee,’ or work to do that, then you’re never going to get there. People aren’t just going to hand it to you. You have to reach out … to get success.”

Dr. Broderick

Discover Opioid Alternatives and How to Get Paid for Using Them
by KAREN APPOLD

With the country’s opioid epidemic continuing to worsen, Alexis M. LaPietra, DO, an emergency physician at St. Joseph’s Regional Medical Center in Paterson, New Jersey, will show practitioners how to effectively manage acute and chronic muscular pain without using these highly addictive drugs—and get compensated for it—in “Alternatives to Opioids for Pain Management: Meds, Needles, and Your Hands.”

“I will review evidence-based alternative medications and modalities that physicians can easily use in the emergency room,” Dr. LaPietra said. In particular, she will discuss multimodal analgesia for musculoskeletal pain, as well as how to perform trigger-point injections and osteopathic manipulative medicine. By also providing billing and coding information, her session will fully equip attendees to start employing the modalities immediately.

“An emergency physician’s toolbox contains many alternatives; most opioids can be reserved…”
—Dr. LaPietra

“An emergency physician’s toolbox contains many alternatives; most opioids can be reserved as a second-line or rescue medication only,” said Dr. LaPietra, who has formal training in pain management. “Opioids are no longer the only option we have to battle pain.”

Dr. LaPietra is the founder and chair of the ACEP Pain Management Section, as well as one of the founders of the nationally recognized Alternatives to Opioids (ALTO) Program, which endorses many of the techniques she’ll discuss. By implementing this program, her institution decreased opioid use in its emergency department by more than 40 percent in the first three months post-implementation.

KAREN APPOLD is a journalist based in Lehigh Valley, Pennsylvania.
New Wellness Center Focuses on the Whole Physician

VARYING FROM PREVIOUS ANNUAL MEETINGS, the ACEP Wellness Center has taken on a new approach this year. Stretching, meditation, and inspirational and thought-provoking talks are just a few of the enhancements found from 9:30 a.m.–3:30 p.m. Monday and Tuesday in the ACEP Resource Center.

This re-imagined Wellness Center is the result of a renewed commitment from ACEP to physician wellness that shifts the investment of the previous flu shots and blood pressure checks to promote wellness for all members. The ACEP Board voted last Spring to eliminate the lab testing, as participation had declined significantly and the costs continued to increase. In the past 10 years, lab tests went from 752 participants to just 299 in 2016, despite promotion through multiple communication channels. However, costs for these services continued to increase and the nominal fee charged for the tests did not cover the expense of the service.

Sponsorship opportunities to supplement these costs have had mixed results, and only twice have companies been willing to sponsor the booth in conjunction with a new product that aligns with wellness. Neither renewed.

The Council voted on Saturday to reexamine options for the ACEP Wellness Center services, and the offerings at the annual meeting may continue to evolve.

Additionally, the ACEP Well Being Committee is working on a plan for 2018 that will move to a variety of wellness activities and initiatives outside of the Exhibit Hall and promote wellness throughout the meeting.

Make Every Second Count with Critically Ill Infants

by ART HSIEH

WASHINGTON, D.C.—The first 30 minutes of managing a sick infant in the emergency department consists of identifying and managing airway, breathing, and circulation problems early and aggressively, according to Jennifer D. H. Walthall, MD, FACEP, deputy health commission-er at the Indiana State Department of Health and associate professor of clinical emergency medicine at Indiana University School of Medicine in Indianapolis.

Early identification of critically sick children is essential to effective resuscitation. While emergency physicians are trained to distinguish “sick” from “not sick” in adult patients, pediatric patients present a third category of “could be sick.” A fuzzy but consolable child is a reassuring sight; an infant that is inconsolable, irritated, and not interacting with the environment is a potentially critical situation. Activating a team response early will help set the stage for a successful resuscitation.

Performing noninvasive steps to correct hypoxia, using humidified oxygen and CPAP/IPPV can help avoid intubation and subsequent chances of ventilator-acquired pneumonia, according to Dr. Walthall. For those who are lethargic or obtunded secondary to respiratory failure, have signs of a lung injury, or can be anticipated to have high metabolic demands (think of severe meningitis, complex congenital heart disease), intubation is indicated.

Cool extremities, capillary refill greater than three seconds, tachycardia, and tachypnea are indications that circulatory support is necessary. Interventions must begin before the child becomes altered or obtunded. Establish two large bore peripheral IVs, using ultrasound-guided insertion techniques if available. Alternatively, inserting a feeding catheter into a neonatal umbilical vein allows fluid resuscitation to begin while establishing peripheral access. Intravenous placement is also a viable access route. If central venous catheter placement through the femoral route is performed, the leg may turn blue or become swollen despite correct catheter placement.

Fluid rates remain at 20 mL/kg for pediatric patients. For the neonate or for cardiac conditions, 10 mL/kg is appropriate. Fluid therapy is goal directed toward decreasing capillary refill times and improving mental status. Continuing down the treatment tree, Dr. Walthall suggested using peripheral or inhaled routes of administration for vasopressor management. Extracorporeal membrane oxygenation is indicated for shock situations of all types refractory to treatment.

For patients suspected of sepsis, antibiotic treatment should begin by the end of the first 30 minutes of treatment. Corticosteroids should be considered for refractory shock situations. Biomarkers including lactate, C-reactive protein, procalcitonin, IL-18, and CD-64 should be added to standard lab draws.

Recombinant activated protein C administration has not been identified as a useful tool in managing pediatric patients in refractory shock, and it’s unclear what the effects are of nitric oxide. Glycemic control in pediatric patients may not be as critical as in adult patients.

Family-centered care of the sick child is essential to a good management approach, Dr. Walthall stressed. Parents should be able to observe the care being performed by the resuscitation team. A trained nurse, social worker, or chaplain helps to translate what the parents see so they gain a rapid understanding of what’s happening to their child. This level of interaction facilitates the communication between the physician and care team with the family, and does not impact outcomes or errors in treatment.

“When a child passes away at the end of the resuscitation process, putting my arm around a mom that I have known for that period of time is much better for her, and for me, than walking into a quiet room and introducing myself to a stranger,” Dr. Walthall concluded.

ART HSIEH is a paramedic, educator, and writer based in Northern California.

Annals of Emergency Medicine

Find answers from the leading emergency medicine peer-reviewed journal in the ACEP Resource Center during Exhibit Hall hours.

DON’T MISS THESE EXCITING EXHIBIT HALL EVENTS!

Annals of Emergency Medicine

You are interested in new visual abstracts? See a presentation by Annals’ social media editor, Seth Trueger, MD, MPH, and one of Annals’ associate editors, Megan Ranney, MD, MPH, at 11 a.m. on Monday.

Win Prizes Today in the Resource Center

Stop by the ACEP Resource Center daily for your chance to win fabulous prizes! ACEP is giving away the best emergency medicine education, provided by ACEP eOME, Critical Decisions, and PEER. You could win one of nine ACEP educational product subscriptions.

ACEP Resource Center

Exhibit Hall

Monday–Tuesday 9:30 a.m.–3:30 p.m.

Adventures Outside the ED: A Wilderness Experience

Exhibit Hall, Booth #931

How well could you treat a patient outside of your emergency department? Wilderness medicine is an exciting, rapidly evolving field that focuses on the prevention, triage, and initial treatment of acute injuries and illnesses under resource-limited conditions, from recreational outings to expeditions to humanitarian missions. Learn new practical skills, participate in scenarios, meet a legendary figure and author in the field, see new products, and actively challenge yourself on a novel addition to the ACEP experience—a 26-foot climbing wall!

Feated scenarios:

• Snakebite 911
• Cholera, Diarrhea at Altitude, and Exertional Heat Illness
• Chest Pain, Multisystem Trauma

Book Signing with Paul Auerbach, MD, MS, FACEP

Monday, 11:30 a.m.–12:30 p.m.

Climbing Wall Operating Hours

Monday–Tuesday, 11:30 a.m.–3:30 p.m.

Sponsored by BTG International Inc., Hydralyte, swyMed, and SAM Medical
ACEP HONORS GROUPS IN THE 100% CLUB

ACEP’s Group Recognition Program is a great way to show your employees that you care about their continued success. This year, there are 140 groups in ACEP’s 100% Club. If your group is interested in participating in ACEP’s Group Recognition Program, please visit the ACEP17 registration area or the Resource Center inside the Exhibit Hall.

ACEP PROUDLY RECOGNIZES THESE GROUPS THAT HAVE ALL ELIGIBLE EMERGENCY PHYSICIANS ENROLLED AS MEMBERS:

NEW GROUPS THIS YEAR

Alvarado Emergency Medical Associates Inc.
Continental Freeman Emergency Medical Associates
CEP EM Advocacy Physicians
China Emergency Medical Associates
College Medical Center Emergency Associates
Emergency Care Specialists WMI
Encino Medical Center Emergency Physician Associates
Flagstaff Emergency Physicians
Florida Emergency Physicians
Kang & Associates
Florida Regional Emergency Associates
FrontLine Emergency Care Specialist
Georgia Emergency Medical Specialist
Georgia Emergency Physician Specialists LLC
Glen Falls Hospital ED Physicians
Grand River Emergency Medical PLC
Green Country Emergency Physicians
Hawaii Emergency Physicians Associates Incorporated
Idaho Emergency Physicians PA
Indiana University Health Physicians
Johns Hopkins Medical Institute Faculty
Lehigh Valley Physicians Group
LJI Forest Hills Northwell Emergency Physicians
Long Island Emergency Medical Care PC
Long Island Jewish Emergency Physicians
Long Island Jewish Valley Stream
Maine Medical Center Emergency Physicians
Medical Center Emergency Services
Medical Services of Prescott
Mercy Hospital Emergency Physicians
Mercy Medical Center Emergency Medicine Physicians
Memorial Valley Emergency Associates
Mid Atlantic Emergency Medical Associates
Midland Emergency Room Corporation PC
Napa Valley Emergency Medical Group
New York Methodist Hospital Emergency Physicians
Newport Emergency Medical Group Incorporated
Newport Emergency Physicians Incorporated
North Memorial Emergency Physicians
North Shore Plainview Hospital
North Shore University Hospital Glen Cove
North Sound Emergency Medicine
North West Iowa Emergency Physicians
Northeast Emergency Medicine Specialists
Northside Emergency Associates
Northwell Huntington Hospital
Northwell LI Lenox Hill HealthPlex
Northwell Southside Hospital
Northwell University Hospital at Syosset

HealthFront Emergency Physicians
Henry Ford Hospital Emergency Department
Hollywood Presbyterian Emergency Medical Associates
Reno Emergency Physicians
University of North Carolina Emergency Physicians
West Hills Emergency Medical Associates Inc.
White Plains Hospital Emergency Physicians

DON’T MISS THESE EMF EVENTS

The Emergency Medicine Foundation (EMF) is the charity of and for emergency physicians. Founded in 1972 by visionary leaders of ACEP, EMF promotes education and research that develops career emergency medicine researchers, improves patient care, and provides the basis for effective health policy. Throughout its 45-year history, EMF has provided more than $16 million in funding to help enhance the specialty of emergency medicine. Learn more at emfoundation.org.

EMF Major Donor Lounge
Monday–Tuesday, 7 a.m.–4 p.m.
Capitol, Meeting Level 4, Marriott Marquis (by invitation only)

EMF donors who have given $600 or more since Jan. 1, 2017, and Wiegenstein Legacy Society members can relax in this private setting with comfortable seating, meals, beverages, and business center amenities.

EMF Silent Auction
Monday–Tuesday, 8 a.m.–5 p.m.
WCC, Level C, Concourse B

One-of-a-kind experiences; sports, music, and celebrity memorabilia; art; jewelry; hotel packages; and more. Bid, buy, and support EMF to make a lasting impact on emergency medicine.
Integrate the Science with the Education at ACEP’s Research Forum

THIS YEAR’S THREE-DAY ELECTRONIC SHOWCASE is larger than ever and has been integrated throughout ACEP17:
- Research Forum abstracts will be available to view near the course rooms and arranged by subject to enhance your learning experience.
- View and discuss original research that will impact your daily practice on the topics and issues that matter most to you and your patients.
- Learn from a panel of experts during “Prime-Time Practice Changers: Highlights of the Research Forum” on Tuesday and interact with researchers during the Wine and Cheese Networking Social on Monday.

Sponsored by GE Healthcare

MONDAY SCHEDULE
For a full listing of presentations, see the ACEP17 mobile app or pages 33–50 in the onsite program. All events take place at the Walter E. Washington Convention Center.

Electronic Presentations
9–9:50 a.m.
- Health Care Policy/Health Services Research
  Room 154A
- Research Methodology
  Room 154A
- Education
  Room 154B
- Toxicology & Pharmacology
  Room 154B
- Palliative and End-of-Life Care
  Room 154B
- Infectious Diseases
  Room 155
- Pediatrics
  Room 159A
- International/Global
  Room 159B

10–10:50 a.m.
- Health Care Policy/Health Services Research
  Room 154A
- Pain Management
  Room 154B
- Palliative and End-of-Life Care
  Room 155
- Pediatrics
  Room 159A
- Psychiatry
  Room 159B

11–11:50 a.m.
- Health Care Policy/Health Services Research
  Room 154A
- Basic Science
  Room 154B
- Geriatrics
  Room 155
- Pain Management
  Room 154B
- Geriatrics
  Room 155

Electronic Presentations
2–2:50 p.m.
- Health Care Policy/Health Services Research
  Room 154A
- Diagnostics
  Room 154B
- Neurology
  Room 154B
- Quality and Patient Safety
  Room 155
- Pediatrics
  Room 159A
- Trauma
  Room 159B

3–3:50 p.m.
- Health Care Policy/Health Services Research
  Room 154A
- Basic Science
  Room 154B
- Geriatrics
  Room 155
- Pain Management
  Room 154B
- Geriatrics
  Room 155

A RARE EMERGENCY, OR JUST A PAIN IN THE BACK?

By RICHARD QUINN

WASHINGTON, D.C.—Most emergency physicians aren’t overly worried about that 62-year-old patient presenting with back pain once they find out the person just started Pilates last week and has no other underlying medical issues. But what about the same patient who presents back pain and a fever in their dialysis treatment on the same day?

Rahul Bhat, MD, FACEP, of MedStar Health in Washington, D.C., said there is no easy answer to non-traumatic back pain, but being in the mindset to at least ask questions about it—even though 95 percent of cases are routine—will help you catch relatively rare diagnoses. “If you play not to lose, then you have to really make sure you pick up that last 5 percent,” Dr. Bhat said after his session, “Non-traumatic Back Pain: Reasons Why It Should Tighten Your Sphincter.” “If you don’t, at some point once every year or two, you’re going to have a dangerous diagnosis that you miss.”

Dr. Bhat said emergency physicians should pay attention to five main causes of spinal cord compression: infections, hematomas, fractures, tumors, and disc issues. Asking targeted questions about “red flag” risk factors and symptoms can dramatically increase the chances of catching a diagnosis that might otherwise be missed.

But, Dr. Bhat emphasizes, those questions should not be left to rote memorization. Instead, emergency physicians should commit the questions to a checklist or a templated note that ensures all of the necessary questions are asked.

“If you have to memorize them, I don’t think anyone is actually going to stick with it,” Dr. Bhat said. “But if you have it templated, it probably takes three to five minutes to ask all these questions. And it’s worth doing it because if you miss it, you’re going to be paying a lot more time down the road.”

While presentations of nontraumatic back pain rarely lead to paralysis or death, Dr. Bhat said cases that could have more significant outcomes will become a larger part of emergency physicians’ duties over time.

“The rate of cord compression that we’re going to see is just going to go up,” he said. “Because of IV drug abuse, additional medical problems, [and] older population.”

RICHARD QUINN is a freelance writer in New Jersey.

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