As a new medical director, I thought to myself, “What is the worst that could happen at our rural, 12-bed ED?” The scenarios we all know came to mind: pericardiocentesis, thoracotomy, lateral canthotomy, resuscitative endovascular balloon occlusion of the aorta, and skull trephination (burr hole). At our monthly departmental meetings, we reviewed all of these procedures so we would be ready. I ordered the necessary kits so we would have the tools on-site. Our hospital had never even had a skull trephination kit before.

The Case

A 2-year-old male was brought to the emergency department by his mother after falling out of a shopping cart seat and striking his head. He initially appeared well and was
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The Benzos and Chill Conversation Continues

Dr. Gadir,

Thank you for your response (August 2017) to our review article entitled “Benzos and Chill,” from December 2016.

We believe you may have missed the point of our article. You stated that we “failed to make crucial points regarding toxin-induced hyperthermic disorders,” but then go on to agree with us and discuss a completely different topic: the use of undifferentiated severe hyperthermia.

We want to make clear to the readers that our submission, “Benzos and Chill,” was a review on toxin-induced hyperthermic disorders. It is not an evidence-based approach to managing patients who present with undifferentiated hyperthermia.

The majority of patients (82 percent) presenting with toxin-induced hyperthermic disorders, in fact, have mild symptoms and may be treated with benzodiazepines, cooling, withdrawal of the offending agent and supportive care as we discussed in our article. It seems unreasonable and alarming to you to jump to an unmodified version of our article. You stated that we “failed to make crucial points regarding toxin-induced hyperthermic disorders,” but then go on to agree with us and discuss a completely different topic: the use of undifferentiated severe hyperthermia.

What you have failed to mention in your anecdotal approach, which we find critical in the management of undifferentiated severely hyperthermic patients, is the importance and effectiveness of using cooling techniques such as chemical, conductive, evaporative, radiation, and core cooling methods. In addition, buried at the end of your response, you also made an incorrect statement that neuromuscular blockade “immediately stops the source of the hyperthermia, and it does not matter what mechanism is in play.” For patients with undifferentiated severe hyperthermia, the source may actually be central, caused by failure of the brainstem, as seen in stroke patients. Therefore, even with neuromuscular blockade, the fire would likely continue to burn.

Finally, we would like to stress the importance of including a consultation with a local poison center or a board-certified medical toxicologist, such as Dr. Kashani, the co-author of the article, in the management of these patients.

- David Traffante, DO
- John Kashani, DO
- Paterson, New Jersey
We have effective treatments for opioid addiction—why don’t we use them?

by ALISTER MARTIN, MD, MPP; AND NATHAN MAX KUNZLER, MD

The Case
A 32-year-old female with anxiety and recent bimalleolar ankle fracture presents requesting help with her addiction to opioids. She started on a short prescription of oxycodone after undergoing a minor operation to repair her fractured ankle. She finished her prescription and continued to feel pain, so she went to her primary care physician, who felt uncomfortable writing her a prescription for addi- tional opioids. She initially resorted to using leftover Percocet from her husband’s previous injury. Once these were gone, she started seeking pain medications from friends and family and eventually began to buy prescription opio- ids from a drug dealer in the town where she grew up. As the cost of her addiction rose and she was unable to support her habit with pre- scription opioids alone, she resorted to snort- ing heroin for the first time one week prior to presentation. After she sobered, she realized that we’d only read about in medical

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schools—tuberculosis, pneumocystis, pan- cytopenias. Of course, we felt power- less because we didn’t have any idea what was going on—couldn’t even test for it in our department. And even af- ter we theoretically could, we didn’t because we didn’t have ready access to medications we could start them on. It could be very demoralizing.”—Massa- chusetts General Hospital emergency department attending

As the death toll rises year after year in the OUD epidemic, we are fortunate to have solu- tions to both these issues for the current crisis. In the emergency department, we can make a definitive diagnosis of OUD, and we can begin treatment that has been shown to be effective. Despite this opportunity, research shows that nearly 80 percent of people with OUD don’t receive any treatment, and those who present to our emergency departments for treatment often get referred to short-term de- toxification or abstinence-based “rehab,” both of which have extremely poor outcomes, with more than 80 percent of patients returning to opioid use.

A Different Course
Similar to the AIDS epidemic, advancements in medical therapies may play a role in chang- ing the tide in this current crisis. And emergen- cy departments, where many of these patients present, may be an optimal place to initiate this therapy. Consider that the most effective treatment for OUD is long-term management with medi- cation treatment. Decades of research show that these medications reduce overdose death, drug use, and health care costs while improv- ing health and the likelihood of remission.

After buprenorphine became an accepted treatment in France in the mid-1990s, other countries began to treat people addicted to heroin with the medication. In the time since buprenorphine was adopted as part of pub- lic policy, it has dramatically improved the chances that those addicted to opioids will stay clean and has lowered overdose death rates.

The use of buprenorphine in the emergency department in coordination with outpatient prescribers is promising. At Yale New Haven Hospital in Connecticut, a randomized con- trolled trial tested whether prescribing bu- prenorphine to ease withdrawal symptoms in combination with a counseling intervention and a referral for help improved the chance people would continue with addiction treat- ment. The study points to early success in buprenorphine’s role in the emergency de- partment.

Seventy-eight percent of patients in the bu- prenorphine group were in treatment 30 days later. By comparison, 37 percent of people who received only a referral were in treatment af- ter 30 days, and 45 percent of patients who re- ceived a brief counseling intervention and a referral were in treatment after 30 days. It should be noted that follow-up at six and 12 months showed fewer people still in treat- ment. While we may not yet know what is the best long-term strategy for these patients, we still should celebrate the evidence that an ED intervention can dramatically increase follow- up for these vulnerable patients.

Another study, performed at MedStar Un- ion Memorial Hospital in Baltimore, suggest- ed that buprenorphine started in the hospital prior to discharge could help those suffering from opioid addiction. It showed that patients who received buprenorphine therapy had an overall decrease in return hospital and ED vis- its and an improvement in patient perception of quality of life.

So why aren’t emergency physicians na- tionwide utilizing it to help patients?

In part, this is due to legislative hurdles. In 2000, Congress passed the Drug Addiction Treatment Act of 2000, a law that prohibits physicians from prescribing Suboxone unless they obtain a waiver. The waiver is grant- ed after successful completion of an eight-hour course whose cost is often left up to the pro- vider to cover. This additional barrier to entry makes access to medication treatment even

CONTINUED on page 6

The rising death toll from our nation’s opioid epidemic has been rivaled in modern medical history only by that at the peak of the AIDS epidemic in the early 1990s. Consider, in 1994, 15,000 Americans died from the disease. In 2015, 52,000 died from drug overdoses.

Emergency departments have stood at the front lines of both crises. Walk into any of our nation’s emergency departments and you’ll find no indications that we are reaching a pla- teau in rate at which lives are lost to opioid use disorder (OUD).

You’ll also find limited utilization of solu- tions that work. In the early days of the AIDS epidemic, emergency departments often served as the entry point of care for those patients who pre- sented with sequelae of the deadly disease. During that time, emergency physicians served as primary providers for vulnerable HIV patient populations, diagnosing critical AIDS-defining illnesses and treating patients suffering from the maladies of those condi- tions.

However, it wasn’t until the widespread utilization of medication-assisted therapies in the form of antiretroviral drug therapies that the crisis began to subside. Aimed by the Ryan White CARE Act, which provided fund- ing for these drug therapies for patients and resources for intensive physician education on the initiation of those therapies, the public health community orchestrated a multilat- eral response.

Physicians nationwide adapted their prac- tices to include initiation of antiviral thera- pies. Within two years of the introduction of antiretroviral drug therapy, the annual num- ber of lives lost to the AIDS epidemic had been halved. Again, we find our specialty at the forefront of another national epidemic. That’s because many patients with OUD utilize our emergency departments as an entry point into the treat- ment system. In 2011 alone, these were 5.1 mil- lion drug-related ED visits.

The AIDS crisis was difficult for emergency providers because making definitive diagnos- es in the emergency department was often impossible. Further, with rapidly evolving re- resistance patterns, it was often impossible to start appropriate treatment in the emergency department.

“I did my training in Brooklyn through the late ’80s, and what I remember most was how sick these HIV patients were. They were coming in with diseases that we’d only read about in medical

Historic Epidemic
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**New Policy on Reperfusion for STEMI**

**ACEP clinical policy on patients needing reperfusion therapy for acute ST-segment elevation myocardial infarction**

**by SUSAN B. PROMES, MD, MBA, FACEP**

On June 28, 2017, the ACEP Board of Directors approved a clinical policy developed by the ACEP Clinical Policies Committee on critical issues in the emergency department management of patients needing reperfusion therapy for acute ST-segment elevation myocardial infarction (STEMI). This policy is a revision to the 2006 ACEP clinical policy on the same topic. This revised policy, published in the November issue of *Annals of Emergency Medicine*, can be found on the ACEP website and has been submitted for inclusion in the National Guideline Clearinghouse.

Timely percutaneous coronary intervention (PCI) has become the standard treatment for acute STEMI Only a minority of hospitals in the United States are PCI capable, and even fewer can provide 24/7 availability of this intervention. Acute STEMI warrants emergent treatment. Rapid restoration of perfusion to the ischemic-related coronary artery by either PCI or fibrinolysis is paramount to achieve the best possible outcome for the patient. The benefit of timely fibrinolytic therapy, versus delayed PCI, must be considered in determining which mode of reperfusion therapy is best for the patient with acute STEMI. Patients with acute STEMI and contraindications to fibrinolytic therapy are not appropriate for fibrinolytic treatment.

The focus is on three critical questions regarding the evaluation and management of adult emergency department patients needing reperfusion therapy for acute STEMI. 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 where comments were received from emergency physicians, cardiologists, individual members of the American College of Cardiology Foundation/American Heart Association, a patient representative, and members of ACEP’s Medical-Legal Committee. These responses were used to refine and enhance this clinical policy.

**CRITICAL QUESTIONS AND RECOMMENDATIONS**

**QUESTION 1. In adult patients having a STEMI, are there patients for whom treatment with fibrinolytic therapy decreases the incidence of major adverse cardiac events (MACE) when PCI is delayed?**

**Patient Management Recommendations**

- **Level A:** None specified.
- **Level B:** Fibrinolitics may be administered to patients when door-to-balloon (D2B) time is anticipated to exceed 120 minutes.
- **Level C:** A dose reduction should be considered when administering fibrinolitics to patients age 75 years or older.

**QUESTION 2. In adult patients having a STEMI, does transfer to a PCI center decrease the incidence of MACE?**

**Patient Management Recommendations**

- **Level A:** None specified.

**NEW SPIN**

**ON MENT.**

9. **See “The Other Side of Addiction” in the October issue for an emergency physician’s perspective on running an addiction clinic.** It was via this mechanism that the team at Yale was able to demonstrate such a powerful effect without the necessity of all prescribers obtaining a license.

As we now face what may be the largest public health crisis of this century, we must ask ourselves, what is our responsibility moving forward? Is it acceptable for us to know that there is an effective treatment we can offer and still continue to advise outdated models of treatment or, worse still, offer no treatment at all?

We would never allow patients with acute coronary syndrome, stroke, or pulmonary embolism to leave our departments on outdated treatments or with a list of centers offering treatment for those conditions. Why then would we stand by as people suffer and die of OUD?

We know medication treatment for OUD is more effective, and we have the ability to be on the front lines offering effective treatment to people in dire need. Let us seize the moment and lead at this critical juncture. Let us, as a specialty, look forward to the day when we can remember this crisis and see it as we now see the AIDS crisis: a critical public health issue that, with aggressive and early advocacy, was conquered to allow our patients to live full and happy lives.

Let us do our part to make that future arrive sooner.

**References**


6. Dr. Martin is an emergency medicine resident at Massachusetts General Hospital/Brigham and Women’s Hospital in Boston. Dr. Kunzler is a clinical fellow in emergency medicine at Massachusetts General Hospital/Brigham and Women’s Hospital.

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

<table>
<thead>
<tr>
<th>Strength of recommendations regarding each critical question were made by subcommittee members using results from strength of evidence grading, expert opinion, and consensus among subcommittee members according to the following guidelines:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEVEL A RECOMMENDATIONS</strong> 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 RECOMMENDATIONS</strong> 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 RECOMMENDATIONS</strong> 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>

**Questions**

1. **In adult patients having a STEMI, are there patients for whom treatment with fibrinolytic therapy decreases the incidence of major adverse cardiac events (MACE) when PCI is delayed?**

2. **In adult patients having a STEMI, does transfer to a PCI center decrease the incidence of MACE?**

3. **In adult patients undergoing reperfusion therapy, should opioids be avoided to prevent adverse outcomes?**

**Patient Management Recommendations**

- **Level A:** None specified.
- **Level B:** To decrease the incidence of MACE, patients with STEMI should be transferred to a PCI-capable hospital as soon as possible.
- **Level C:** None specified.

**References**

Sickle cell disease (SCD) is an inherited hemoglobin disorder that affects approximately 100,000 individuals in the United States. Disease hallmarks include chronic hemolytic anemia, progressive organ damage, and, most notably to the emergency physician, pain. SCD causes pain in several ways. Acute episodes, caused by vaso-occlusion, last days to weeks at a time, whereas chronic pain commonly involves bony causes such as avascular necrosis and bone infarcts. Because disease-modifying therapies can reduce but not eliminate SCD pain, opioids have been a cornerstone of SCD pain management for decades. Amid today’s opioid epidemic where physicians are forced to be more cautious in their dispensation and administration of opioids, people with SCD experience new challenges in accessing opioids from emergency providers during acute pain episodes. We now know that opioids are more dangerous than previously recognized. This raises the question, should emergency physicians stop or reduce their use of opioids for SCD pain in the emergency department?

My clinical practice offers a unique perspective on this matter. While my formal training (and board certification) is in emergency medicine only, I designed, for myself, additional SCD-specific clinical training after residency and have pursued a research career focused on SCD. In 2012, I took over the adult SCD clinic at Mount Sinai in New York, which gave me the opportunity to study and work with patients with SCD in the setting of pain management. I have spent many hours discussing with patients and their families the benefits and risks of using opioids for pain management in the emergency department. Although my training and experience are in emergency medicine, I have also pursued advanced training in SCD-specific care, which allows me to offer a unique perspective on managing SCD pain in the emergency department.

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opioid crisis. Based on a 2011 study of emergency department (ED) utilization, admission rates, and hospital length of stay, I attribute much of our success in reducing acute-care utilization to our relentless outpatient efforts to minimize long-term opioid use and rapidly identify aberrant behaviors and opioid misuse before they get out of control. Complying with new government regulations regarding opioid monitoring and prescriptions has not been a problem for my practice because our protocols generally exceed these requirements. That being said, my clinic still prescribes a tremendous number of opioids (both long- and short-acting) because, until our disease-modifying SCD therapies improve, opioids are still indicated as first-line therapy for SCD pain. To the question of whether emergency physicians should reduce or restrict their use of opioids for acute sickle cell pain, my answer is that while dispensation of prescriptions should be limited, use of IV opioids in the emergency department should continue or (at some point) be eliminated. There is a practice I support. To be clear, I firmly believe that people living with SCD should have ready access to prescription opioids at home. However, prescription opioids are an extremely dangerous class of medication, and people can and should take steps to reduce their risk of addiction. While IV opioids given during an ED visit cannot be diverted or sold, prescriptions can. Having SCD means patients have a legitimate indication for accessing large quantities of opioids over long periods. In today’s climate, it is appropriate to recommend that such an individual receive medication from one provider who has an individual’s reasons for overutilization of opioids is not appropriate. Josh Field’s publication in the American Journal of Hematology describes how intensive management (which involves a careful assessment of an individual’s reasons for overutilization of the emergency department before opioids are withheld) can safely reduce excess ED visits. Prescription opioids are also a cornerstone of SCD pain management, and people with SCD must still have access to this class of medications. However, limiting opioid prescriptions written from the emergency department is a practice I support. To be clear, I firmly believe that people living with SCD should have ready access to prescription opioids at home. However, prescription opioids are an extremely dangerous class of medication, and people can and should take steps to reduce their risk of addiction. While IV opioids given during an ED visit cannot be diverted or sold, prescriptions can. Having SCD means patients have a legitimate indication for accessing large quantities of opioids over long periods. In today’s climate, it is appropriate to recommend that such an individual receive medication from one provider who has the capability and knowledge to appropriately monitor the patient. It is our responsibility to provide knowledgeable SCD providers so that patients can acquire these medications without the need for an ED visit. The prescription opioid crisis presents an opportunity for our specialty to learn and ultimately do better for our patients. Highly impactful research has shown that a single opioid prescription for more than ten days’ duration is associated with long-term opioid use. Indeed, for minor pain we must be more parsimonious in our dispensation of opioids. However, for some conditions, SCD included, opioids are still indicated as first-line therapy. IV opioids given in the emergency department during acute SCD pain episodes play almost no role in facilitating the larger prescription opioid crisis, and we should continue to use them aggressively until disease-modifying SCD therapies render opioids obsolete.

References

DR. GLASSBERG is assistant professor of emergency medicine, hematology, and medical oncology and associate director of the Mount Sinai Comprehensive Sickle Cell Program at the Icahn School of Medicine at Mount Sinai in New York.
KK: What an ominous responsibility to be representing 37,000 of your closest friends. What were some of your key achievements this year so far?

RP: I wanted to look at and watch health care reform and the changes going on in the Affordable Care Act (ACA), which is heavy on the reimbursement piece. The second piece was heavily focusing on diversity and inclusion.

The topic came up when I was running for President. I spoke from the position of a woman emergency physician when I talked about diversity and inclusion. I saw this as an opportunity in terms of leadership development within the organization.

The response was quite amazing and surprising, regarding the amount of people who really embraced this. After I won the election at ACEP16, I had people stop after the Council meeting to talk about how important this was, thanking me for doing this. So this clearly has been important to the membership, but how could we move forward? We hired a consultant to help us work through how we could approach this. We put together a summit, and two directives came from it: why are we doing this, and we needed a task force to come up with some strategies and tactics. Using the information from that terrific group, I sat down with Dr. Steve Stack and Dr. Sandy Schneider and put together an editorial that was published in the Annals of Emergency Medicine. There are a couple of key points regarding why ACEP should do this. Our population is diversifying, and in some cities, those considered a minority are actually a majority in the population. Medical students are also diversifying. In fact, the Association of American Medical Colleges is focused on regulations for medical schools that they must recruit medical students that reflect the communities around them.

The percentage of women in emergency medicine is below the average that is in our medical schools. We’re not capturing women and other minorities in the same way that other specialties are. Our leadership doesn’t always reflect membership, even with women not making up 50 percent of our specialty. Where’s the disconnect? We’re not capturing all of our talent or all the types of people that we have. What about the care we deliver? We know that genders experience pain or different diseases differently. We know that people in different cultures describe their symptoms differently and have cultural differences, which impact health care choices.

Our task force has identified three priorities: 1) engaging the emergency medicine community, 2) identifying and tackling barriers to professional development, and 3) the health disparities piece. In the end, we’re stronger as a College and specialty if we’re accepting all of our unique differences.

KK: Can you speak about your successes with diversity and inclusion? Why is this important to the membership?

RP: The topic came up when I was running for President. I spoke from the position of a woman emergency physician when I talked about diversity and inclusion. I saw this as an opportunity in terms of leadership development within the organization.

The problem with the second one is that it was very vague. What’s “usual and customary”? For 25 years, we had used a percentage amount that would be paid under Medicare. Therefore, what would be paid under Medicare?

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KK: What’s going on that people should expect to see in the future?

RP: A partnership with the CDC to combat the opioid crisis.

• A collaboration with The Joint Commission to improve safety of boarded mental health patients.

• Wellness resources derived from a wellness summit including many emergency medicine organizations.

• Collaborative work with ABEM regarding the maintenance of certification process.

KK: Let’s end with your elevator speech. Convince me to renew my membership next year.

RP: The value of membership. ACEP represents all emergency medicine. ACEP is an organization that is advocating on the Hill, doing public relations, working with other specialty societies on behalf of emergency physicians, and is very effective at that. We have the high impact at the highest levels.

It’s your home away from home. ACEP is the place where, for me and for many others, I’ve got friends and where I’ve got my family. It’s where I found my professional mission and my professional and personal home, as well. It’s that next step of organization for you, no matter what stage of your career. It’s a place for you to find your home. You’re welcome anytime, particularly when you need it most.

References
Can You Spot a Lisfranc Injury?

Excuse my French! These fractures are easy to miss, but critical to detect

by YENISLEIDY PAEZ PEREZ, DO

The Case
A 24-year-old male presents to the emergency department after sustaining an injury to his right foot during football practice the previous day. He states he was viciously tackled while sprinting across the field. After falling on a plantar-flexed, fixed foot, he felt a snap in the center of his foot and developed immediate pain and swelling over the dorsum of his foot. On physical exam, there is maximal swelling over the first and second tarsometatarsal joints, and he is unable to bear weight.

Introduction
The midfoot is composed of the cuboid, navicular, and three cuneiform bones, which form the arch of the foot. The Lisfranc joint complex is composed of the bones and ligaments that connect the midfoot to the five metatarsals of the forefoot. The Lisfranc ligament connects the base of the second metatarsal to the lateral aspect of the medial cuneiform (see Figures 1 and 2). This oblique ligament is what provides stability to the joint, despite the absence of a ligamentous connection between the first and second metatarsal. The annual incidence of Lisfranc injuries is 1 in 55,000 persons per year. These injuries can be difficult to recognize and are most commonly misdiagnosed as an ankle sprain on initial visit to the emergency department. Undiagnosed cases can result in long-term misalignment and functional weight-bearing difficulties. Therefore, it is important to keep a high index of suspicion and perform a detailed physical exam. Also, keep in mind that 20 percent of Lisfranc joint injuries are missed on initial radiographs.

What Is the Mechanism of Injury?
These injuries can result from a direct crush mechanism or high-velocity blunt trauma, such as from a motor vehicle accident. However, the injury most commonly occurs indirectly from extreme plantar flexion with rotation of the ankle, during which the second metatarsal is prone to dislocate dorsally if an axial load is applied at the same time. Examples include falling from a horse with the foot caught in the stirrup, stepping off a curb, or planting your foot when you are unable to bear weight.

Physical Exam Suggestive of Lisfranc Fracture
- Inability to bear weight or stand on toes.
- Ecchymosis on medial plantar aspect of foot is pathognomonic but may be absent in minor fractures (see Figure 3).
- Dorsal midfoot pain and swelling.
- Pain elicited with passive supination and pronation of the forefoot with the hindfoot held fixed.

Diagnosis
Obtain three view radiographs of the foot (anteroposterior [AP], lateral, and standard 45-degree oblique views). Ideally, weight-bearing stress views should be obtained since initial plain X-rays may fail to show subtle widening of the articulation spaces (see Figure 4). Consider a CT scan of the foot if X-rays do not show an injury but you remain highly suspicious.

Normal Three-Column Anatomy of Lisfranc Complex on X-Ray (see Figures 1 and 5)
- On the AP view, the medial edge of the base of the second metatarsal (M2) should line up with the medial edge of the middle cuneiform (C2).
- The gap between the second metatarsal and medial cuneiform is <2 mm.
- On the oblique view, the medial edge of the third and fourth metatarsal should line up with the medial edges of the middle cuneiform and cuboid, respectively.
- On the lateral view, the superior border of the first metatarsal (M1) should align with the superior border of the medial cuneiform (C1).

X-Ray Findings Suspicious for Lisfranc Injuries
- On the AP view, widening of >2 mm between the base of the first and second metatarsal indicates instability (See Figure 4).

Figure 1(TOP LEFT): Normal AP weight-bearing radiograph of the left midfoot showing first metatarsal base (M1), second metatarsal (M2), third metatarsal (M3), medial cuneiform (C1), middle cuneiform (C2), lateral cuneiform (C3), and navicular bone (Nav). Note that there is less than 2 mm between C1 and M2 and between M1 and M2.

Figure 2(TOP RIGHT): The Lisfranc ligament connects the base of the second metatarsal to the lateral aspect of the medial cuneiform.

Figure 3(LEFT): Plantar ecchymosis. Right: Medial, intermediate and lateral column associated with midfoot biomechanics.

French surgeon Jacques Lisfranc de St. Martin, for whom the Lisfranc joint and Lisfranc fracture are named.
• “Fleck sign” is pathognomonic for a Lisfranc injury. This is a small bony fragment avulsed from the second metatarsal base or medial cuneiform (see Figure 6).

Management

Stable dislocation/fracture injuries are defined as having less than 2 mm of displacement between the first metatarsal and medial cuneiform. These can be managed non-operatively with reduction and casting. The patient should be placed in a non-weight-bearing below-the-knee cast for six weeks and have outpatient orthopedic follow-up in two weeks.

For unstable fractures and dislocations, immediate orthopedic consultation is needed for surgical intervention with internal fixation. After surgery, immobilization and non-weight-bearing status is recommend for eight to 12 weeks. Full weight-bearing is typically not permitted until all hardware is removed.

References


DR. PAEZ PEREZ is an emergency medicine resident at St. Joseph’s Regional Medical Center in Paterson, New Jersey.
I sat at the ACEP headquarters attending an EMS board review course as the Texas Emergency Medical Taskforce (EMTF) was springing into action to respond to what would become one of the worst natural disasters in U.S. history. I am the medical director of EMTF 1, which encompasses the Texas Panhandle, including Amarillo and Lubbock, where I am the EMS medical director, and I call Amarillo home. It wasn’t much of a surprise when the text and email requesting my deployment to the Texas coast came through. By then, Hurricane Harvey had hit, and the damage was done. I knew only what I could gather from the news as I made arrangements for shift coverage, canceled a Las Vegas trip for me and my wife, and gathered a backpack full of stuff to live for five days in who knows where (see Figure 1).

My air travel to San Antonio was uneventful and I pointed a rental car towards Corpus Christi, Texas. We were around 60 hours after landfall. Houston was now being battered with rain, and reports of flooding were coming over the radio and Facebook. Our mobile medical unit (MMU), a fancy term for a rather large expandable tent with dozens of ED beds (see Figure 2), was being setup up at a commandeered (I didn’t know you could really do that) private airport in Ingleside, which was right outside of Aransas Pass and along the primary road in and out of the areas worst hit by the eye of Harvey.

I finally arrived at our site, where it was overcast, with steady 30-plus-mile-per-hour winds and a rather ominous appearing sky. Toppled and smashed primary road in and out of the areas worst hit by the eyewall. Like most, I’ve seen thousands of pictures of natural destruction, but nothing equates to seeing this in real life. I love to see the humor people can express when they have lost so much (see Figures 7 and 8). The number of broken telephone poles was astounding (see Figures 9 and 10), but even more amazing were the hundreds of line-worker crews with buckets, drills, and rigs working on restoring power to this area. They came from all over the country. I have a new appreciation for the way their trade pulls together in a disaster.

Some have asked about our living conditions. It wasn’t the Marriott, but it’s closer than you would think. We were in large tents with thousands of square footage and air-conditioning to the point of being too cold. We had MREs, but as the community around us stabilized and more people lent a hand, our unit became a popular place for food donation and for responders to come and eat (see Figure 11). We had no fewer than three to five dinner offerings each night and plenty of lunch and breakfast. I felt bad, having so much food at our

One grandfather in a hat (see Figure 4): “I wear it everywhere. My daughter gave it to me 11 years ago when she had her daughter. We got lucky. We left, came back, nothing out of place. The neighbor’s house is gone. Strange how that happens. I really just need a tetanus shot. I have cuts everywhere.”

Meet Shirley (see Figure 5) and her owner: “I’ve had her four months, and she was two months old when I got her. She is full of piss and vinegar. She took the storm better than I did. We didn’t have much, but we still have each other. I ran out of my medications. Can you do a refill? I have the empty bottles....”

And a man who evacuated and returned to destruction (see Figure 6): “They said it was going to be a cat 1, so we just left. I wanted to get my girls to safety, and my mom... she’s dying. She wanted to die at home. When they said it was going to be a cat 3, I wanted to go back and board the windows, but my wife wouldn’t let me. Her room is destroyed, the rest of the house is a wreck. She’s stuck in Austin now. This shirt is about all I have. My friends called me Stewie.”

I took a brief break and ventured into some of the areas hit hardest by the eyewall. Like most, I’ve seen thousands of pictures of natural destruction, but nothing equates to seeing this in real life. I love to see the humor people can express when they have lost so much (see Figures 7 and 8).
disposal, and hoped nobody within 100 miles of us was hungry. I started feeding most of my patients, and they appreciated it. Most of them hadn’t had much of a hot meal for days. The sleeping cots, with a foam topper, were surprisingly comfortable. We received access to a community center not far away with hot showers and clean bathrooms. We lived better than most within 20 miles of us.

We sent most of the patients we treated home (or what was left of it). Some were sent to the nearest open hospital, which was more than 45 miles away. The industry that really came together during the storm was the area’s independent freestanding emergency centers (FECs). One such facility was just five miles from us, and it had CT, X-ray, and lab up and running with its backup power. We sent them patients needing resources but not admission. Back in Rockport, another FEC was up and running and taking care of dozens of patients in the middle of the disaster zone.

As I reflect, we had it too good. We had one another and our families, with life as usual back at home. For the people of the coastal bend of Texas, their stuff was gone, their homes destroyed, and their lives turned upside down. But Texas is strong, and the Astros just won the World Series. The future is bright for Texas!

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DR. TROUTMAN is the President-Elect of the Texas College of Emergency Physicians. He is the CEO and co-founder of a FEC called ER Now in Amarillo and Wichita Falls, Texas. He is the EMS medical director for UMC EMS, Lubbock Fire Rescue, Amarillo Medical Service, Amarillo Fire Department, and Vernon Fire Department.
January, we published “Diversity in Recent Leadership Positions,” which highlighted the recent accomplishments and honors of Leon L. Haley Jr., MD, MHSA, FACEP, CPE, Marcus L. Martin, MD, FACEP; and Lynne D. Richardson, MD, FACEP. Dr. Haley, Dr. Martin, and Dr. Richardson have landed roles that reach way beyond emergency medicine alone. Announcements are one thing, but how great leaders achieve success is quite another. The road to leadership is shaped by many experiences and many people, both positive and not so positive. In an interview with ACEP Now’s Medical Editor in Chief Kevin Klauser, DO, EID, FACEP, these three emergency medicine icons talk about their career paths, influences, and experiences. Here is Part 2 of that conversation; Part 1 appeared in the November issue.

KK: It seems like being first sometimes has additional challenges because you are breaking down barriers while also trying to do your job. Would that be a fair statement?

MM: I agree 100 percent. It’s isolation; often we’re singled out, easily seen, placed under the microscope. Higher expectations are demanded of us. But we don’t have time to cry or to falter or to appear weak. We have to rely on our inner strengths. In my case, I’ve always relied on having conversations with my wife when I go home, and I try to make sure that I’ve built consensus with as many of the faculty, students, and staff.

LM: I think all of us, in many respects, embrace being first because somebody had to be first to help get us where we are, but at the same time, there are those unique challenges. There’s the “under the gun,” the high expectations. There’s the feeling that you’re carrying the weight of people on your back. I think those are unique challenges that the average, quite frankly, white male doesn’t have to carry those extra burdens they may have to deal with because there are, when you become an administrative leader or clinical leader, a lot of tasks that come with those roles. I think the art of mentorship has gone away for many folks. There aren’t as many mentors out there that are available to spend the time necessary. I think trying to find enough people who want to be mentors, particularly to women, African-Americans, and underrepresented minorities, is harder.

KK: I read an article that was very intriguing to me in JAMA. The concept was the minority tax. Your thoughts?

LR: For some people, it is a wonderful opportunity, but does that then marginalize you in ways that pursuing other avenues might not? Every individual has to struggle with lots of choices, and there are lots of things to weigh as you make these professional decisions.

KK: Do you have any advice for emergency physicians who experience diversity and inclusion challenges?

MM: Considering the minority tax, if you have a minority in a position of leadership and there was a white person, particularly a white male, in that position prior, and everything else is constant, the black person is expected to raise the bar or increase the diversity of the medical school class or do something totally different just because he’s black—and that’s the minority tax. Regarding getting into a position like chief diversity officer, I feel that should be something that someone truly wants to do. Some people get pigeonholed into it because there’s nobody else to do it; in my case, there was a desire to do it.

KK: Do you think we’ve lost good leaders because of this?

LR: Absolutely. I think one of the most heinous consequences of the disparities in opportunities that still exist in this country is the loss of talent and all of the leaders, scientists, and researchers who never get the chance to make the kind of contributions we’ve been able to make because they aren’t strong enough or don’t get the support they need to overcome the barriers that all of us have faced. I know I can speak certainly for Marcus and Leon in saying all of us are very focused on spending a lot of time and energy in making it easier for the ones coming behind us than it was for us.

KK: Leon, what are your thoughts on leadership and limitations that you’ve overcome but maybe others haven’t?

LR: I think there’s a challenge for people because there are people who cause the extra burden they may have to deal with because there are, when you become an administrative leader or clinical leader, a lot of tasks that come with those roles. I think the art of mentorship has gone away for many folks. There aren’t as many mentors out there that are available to spend the time necessary. I think trying to find enough people who want to be mentors, particularly to women, African-Americans, and underrepresented minorities, is harder.

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KK: Do you have any advice for emergency physicians who experience diversity and inclusion challenges?

LR: I do want to add one thing since I was the only one that, in fact, had a whole additional set of challenges because I built my career while being an essentially single parent to my two daughters. I often reflect on the sacrifices not only that I had to make but that my children made or I arranged for them to have to make in order for me to do some of the things that I’ve done in my career. I say that not seeking praise but so that women who are facing the same set of challenges know that it can be done and that I don’t think you have to make a choice between having a successful career and being a dedicated parent.

My message to colleagues who are from the majority group is that I think it’s really important that they understand the damage that is done by discrimination and racism, not just to those who are victimized by it but by the perpetrators of it. And being pro diversity and inclusion should be motivated not just for social justice reasons and ethical reasons and humanitarian reasons but for very practical reasons. Diverse teams are actually higher-performing than homogeneous teams. My message is that diversity and inclusion is good for everyone, and it should be embraced by everyone.

KK: Leon, your final thoughts on guidance to others?

LM: I think I would agree with Lynne. I think, obviously, identifying mentors early in your career is always important. I think having a good career plan—what it is you want to do in your life—is critical. Making sure you know your pathway and who are the people who can help you, regardless of whether they’re black, white, male, or female, is critically important.

MM: Emergency physicians must practice the art of medicine not permitting interference of duty to the patient regardless of human variations inclusive of religion, nationality, race/ethnicity, social standing, sexual orientation, veteran status, ability/disability, or any other diverse factor. I encourage experienced emergency physicians to take under their wings and mentor one or more budding healthcare providers, especially from underserved or disadvantaged backgrounds. Our communities and our nation will be better served in the long run, and hopefully health care disparities will further narrow.

Reference
running around the triage room. After a period of observation, he became increasingly somnolent, and on repeat exam, his pupils were slightly unequal. A head CT revealed a large epidural hematoma with midline shift. His pupils quickly became significantly worse at 6 mm and 2 mm, and he became unresponsive. I intubated him and called the nearest pediatric trauma center (one hour away) to begin arranging for helicopter transport. During the conversation with the trauma surgeon at the major academic center, I told him I was planning on doing an emergent burr hole. He said, “I’ve never done one of those—it’s up to you.”

I had seen one of these in residency and went to the supply room to find the newly arrived burr hole kit, took deep breath, then started to prepare for the procedure by reviewing the CT. I performed the burr hole with the technique described below and evacuated 150 mL of blood. The pupils improved. We placed a sterile dressing on the wound, and the helicopter team transported the patient to the pediatric trauma center.

One month later, the mother brought the boy back to the emergency department. The patient was running around the emergency department with no deficits and gave me a hug.

**Location to Drill**

Emergency department skull trephinations are done in the temporal location 2 cm anterior and 2 cm superior to the tragus.

**Technique**

1. Measure the skull thickness on CT to set stopper depth (see Figure 1).
2. Shave the hair with clippers; sterile prep and drape.
3. Inject local anesthetic and then make a 4-cm vertical skin incision down to the periosteum at a point 2 cm superior and 2 cm anterior to the tragus.
4. Use a periosteal elevator to expose the skull.
5. Have an assistant hold the patient’s head firmly prior to drilling.
6. Apply the trephine with gentle, steady pressure until the skull is penetrated. The two nonautomated choices for trephine are the Integra hand crank model with stopper (see Figure 1) and the Galt trephine (see Figure 2). The bone fragment may come out in the device or may need to be removed with forceps. Place the bone fragment in a sterile cup with saline.
7. Once the bone fragment is removed, the clot may not immediately extrude. Use a small sterile pediatric suction catheter to facilitate hematoma drainage.
8. If identified, the bleeding artery (usually the middle meningeal) may be ligated/clamped.

**Complications**

- Emergency department skull trephinations should only be performed in the temporal region to avoid venous sinus injury and complications of air embolism or hemorrhage.
- Avoid plunging by using the stopper on the hand crank or by measuring skull thickness on the CT image.
- Infection is a possibility.

**Historical Perspective**

Trephinations of the skull have been found in human skulls older than 10,000 years of age. Skulls from virtually every major civilization show evidence of successful trephinations. There are three common methods for performing trephinations:

1. Scaping bone (see Figure 3)
2. Drilling a series of small holes and connecting them
3. Making crosshatch cuts in the bone and connecting them to remove a rectangular piece of bone

**Discussion**

The medical literature supports skull trephination by emergency physicians in emergency departments without immediate neurosurgery capability for the talk-and-deteriorate patient with anisocoria, Glasgow Coma Scale (GCS) score <9, and CT-proven epidural hematoma (EDH). The available studies are retrospective and small. 1,2 A small (n=5) retrospective chart review by Smith et al examined all known cases of skull trephination done by emergency physicians at non-neurosurgical institutions before transfer to a neurosurgical institution.3 These common methods for performing trephinations:

**References**


**DR. BEFFA** is an emergency physician with VEP Healthcare and medical director of the emergency department at Sutter Amador Hospital in Jackson, California.
Houston, Wee Have a Problem
Cath? Suprapubic? Or…

by KEN MILNE, MD, MSC, CCFP-EM, FCP, FRMRS

The Case
The emergency department is getting busier with the after-work and after-school crowds. The next patient is a 5-month-old boy brought in by his parents because of a fever. The fever started that morning, and they kept him home from day care. The infant is immunized, looks well, and is drinking fluids in the department. Your examination does not indicate a source of infection. A urinary tract infection (UTI) is a possibility, but you know it could take a long time to get a noninvasive urine sample. In addition, bagged samples can often be falsely positive, and then you would need to get a urine sample using an invasive method such as a catheter. Could there be a way to increase the chance of getting a clean catch urine in fewer than five minutes?

Background
Urine samples are frequently required to rule in or rule out UTIs in children presenting to the emergency department with vomiting, fever, abdominal pain, and/or nonspecific illnesses.

The American Academy of Pediatrics (AAP) states that the diagnosis of a UTI requires a urinalysis and a urine culture. This comes from its 2016 clinical practice guidelines for the diagnosis and management of UTIs that reaffirmed earlier recommendations.

There are many reasons to rule in or rule out UTIs in children. These include the fact that missed UTIs can result in renal scarring and other pathology, appropriate antibiotic stewardship, and the avoidance of expensive and unnecessary imaging studies.

The AAP strongly recommends an invasive urine sample if the child looks unwell and requires antimicrobial therapy. The urine sample can be obtained with a suprapubic aspiration or urethral catheterization. Obtaining an invasive sample is a clinical decision.

The AAP also makes a strong recommendation that if the clinician determines that the febrile infant has a low likelihood of a UTI, then no urine testing is necessary as long as there is close clinical follow-up.

If the infant does not have a low likelihood of having a UTI but looks well, the AAP recommends two options: obtain the urine sample using one of the invasive method mentioned previously, or use a two-step approach to identify a UTI. The first step is to obtain a urine sample using a noninvasive method such as a bagged urine specimen. If the sample shows no evidence of a UTI, then cultures may be omitted. If the bagged sample shows evidence of a UTI, then the second step is to use an invasive method and perform a urine culture.

Clinical Question
In infants suspected of having a UTI, does the

Evidence-Based Medicine Commentary
Selection Bias: There may have been some selection bias. It appears that the patients were identified and recruited by the same emergency department that did the intervention.

External Validity: This was a single center, tertiary pediatric hospital in Australia and may not represent the same pediatric population presenting to pediatric, community, or rural emergency departments in the United States. Also, note that they also excluded neonates and those older than 12 months of age.

Statistical Significance: The sample size was calculated with 80 percent power to detect a difference of 15 percent between groups in the primary outcome. They did find a 19 percent difference, but the lower end of the 95 percent confidence interval was 11 percent.

Clinical Significance: The 15 percent difference was decided by consensus of 20 pediatricians and pediatric emergency medicine experts. However, others might consider a larger or smaller difference clinically significant.

Satisfaction Scores: The 5-point Likert scale they used was counterintuitive. They used 1 to mean “very satisfied” and 5 to mean “very unsatisfied,” which is opposite of the usual application of the tool.

Bottom Line: The Quick-Wee method can increase the success rate of getting a clean catch urine in infants suspected of having a UTI.

Case Resolution
You suggest to the parents using the Quick-Wee method to get a clean catch urine sample. After explaining how it is done, they agree. A few minutes later, you are sending off the sample to the lab for step one, urinalysis.

Thank you to Dr. Natalie May, an emergency physician with a subspecialty in pediatric emergency medicine and editor for the St. Emlyn’s blog and podcast. Remember to be skeptical of anything you learn, even if you heard it on the Skeptics’ Guide to Emergency Medicine.

Table 1: Secondary Outcomes of Quick-Wee Versus Usual Care for Urine Collection in Infants

<table>
<thead>
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<th>Quick-Wee</th>
<th>Usual Care</th>
<th>P Value</th>
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<tr>
<td>Successful Catch of Urine</td>
<td>30%</td>
<td>9%</td>
<td>&lt;0.001</td>
</tr>
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<td>Rate of Contamination</td>
<td>27%</td>
<td>45%</td>
<td>0.29</td>
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<tr>
<td>Median Parental Satisfaction</td>
<td>2</td>
<td>3</td>
<td>&lt;0.001</td>
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Authors’ Conclusion
"Quick-Wee is a simple cutaneous stimulation method that significantly increases the five-minute voiding rate and success rate of clean catch urine collection.”

Key Results
There were 170 in the control group and 174 in the intervention group, totaling 344 subjects. It was evenly split between male and female infants, with the mean age being 5.4 months. The most common clinical indication for urine collection was fever (42 percent), followed by unsettled baby (96 percent). Only 17 percent of infants had urine collected because a UTI was specifically suspected.

Primary Outcome: Voiding within five minutes (31 percent Quick-Wee versus 12 percent usual care); an absolute difference of 19 percent (95% CI, 11%–28%). Number needed to treat was five.

Secondary Outcomes: See Table 1.

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Quick-Wee® voiding stimulation method of gentle cutaneous suprapubic stimulation using gauze soaked in cold fluid.

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Reference
Don’t Skate to Where the Puck Was

Chasing markets that are currently performing can be a poor long-term investment strategy

by JAMES M. DAHLE, MD, FACEP

Q. International stocks are doing really well, so I’m thinking about investing more money into them. What do you think?

A. I grew up playing ice hockey and continued to play in high school, college, and even now. Coaches often gave us the same advice that hockey legend Wayne Gretzky’s dad gave to him: “Skate to where the puck is going to be, not where it has been.”

Ice hockey is a fast-paced game where the participants are constantly moving, often at full speed, and the ability to read the play and get ahead of it is critical to success. In recent years, this quote has been pulled into the business world and is often used to encourage innovation, attempting to figure out what products consumers are going to want to buy in coming years. However, it can also be applied to individual investors and their portfolios.

Investors’ brains are wired such that the natural tendency is to invest money into asset classes that have done well in the recent past. Recency bias, as it is termed, is the human tendency to assume that recent trends will continue. When investors see that an investment asset class, such as international stocks or real estate, has done well recently, they assume that it will continue to do so. They not only keep their money invested in those classes, they also double down on the bet by investing more. They may even sell other assets that haven’t done as well to pile more money into that asset. Investors are truly skating to where the puck has already been.

The problem with this approach is that the various asset classes tend to go through cycles, and when an asset class has performed well, it may be more likely to do poorly than well in the near future. This comes down to valuations. This may be most easily understood by looking at a bond (ie, a loan...
to a company or government). As the value of the bond goes up, its yield—or how much you get paid per dollar of value—goes down and vice versa. Stocks and real estate properties work the same way; The less you pay for the asset, the higher your profits per dollar invested.

Performance Chasing Can Leave You Behind

The tendency to skate to where the puck has been in investing is called performance chasing, and it can be hazardous to your wealth. It is difficult to avoid because it is so natural to do. In addition, the financial media encourages this behavior by highlighting investments (and their purchasers) that have recently done well. This can be seen in newspapers like The Wall Street Journal, magazines such as Forbes and Money, and television stations such as CNBC. Even radio show gurus get in on the act, encouraging you to pick mutual funds primarily based on their past performance. Well, there’s a reason that mutual funds are legally required to tell you that past performance doesn’t indicate future performance—because it’s true!

Performance chasing causes investors to buy high and then sell low as they move their money into the new “hot” investment, repeating this flawed process. You don’t have to buy high and sell low very many times in your career to completely sabotage your retirement plans. As Warren Buffett has said, “When hamburgers go up in price, we weep. For most people, it’s the same with everything in life they will be buying—except stocks. When stocks go down and you can get more for your money, people don’t like them anymore.”

This tendency is easily displayed by looking at mutual fund cash flows. When stocks do poorly, people take money out of them, and when they do well, people invest more. Stock mutual fund cash flows were negative from late 2008 to 2012 before turning positive in 2013 to 2014, well after stocks had recovered from the bear market associated with the global financial crisis. Meanwhile, those investors who bought (or simply didn’t sell) at market lows were handsomely rewarded. Bond cash flows showed the opposite, with money coming in from 2008 to 2012, then out in 2013 to 2014. Herd mentality might help groups of animals in the wild avoid predators, but it doesn’t help investors achieve the returns they deserve.

Most of the time, investors are rewarded most for their willingness to sit on their hands and
follow a simple, boring written investment plan over decades.

Performance chasing between mutual funds within a given asset class can be just as dangerous as performance chasing between various asset classes. Investing giant Vanguard performed a study looking at performance chasing and discovered that, between 2004 and 2013, this dangerous practice cost investors a 2 percent to 3 percent per year performance drop in every asset class they looked at.

Unfortunately, when it comes to investing, figuring out where the puck is going is just as hard to do as not skating to where it has been. Lots of self-styled “contrarians” think that just avoiding the crowds will lead to investing success, and they wander off into areas of the market that never have, and never will, perform well. To make matters even more confusing, markets do exhibit “momentum” to a certain extent. That is, something that performed well recently continues to perform well not because of any underlying economic fundamentals but simply because it has done well recently and investors are still piling into it, chasing performance.

**What to Do Instead**

It turns out that the winning strategy, returning to our analogy at the ice rink, is to get the players on your team to play their positions. By doing that, no matter where on the ice the puck goes, you have a player nearby to pick up the puck. The way you get your investing “players” to play their positions is by developing a written investment plan where a certain percentage of the portfolio is dedicated to a given type of investment. Perhaps your plan is 40 percent of the portfolio in US stocks, 20 percent in international stocks, 20 percent in bonds, and 20 percent in real estate. After a year, the portfolio will deviate from these percentages because one of these asset classes performed better than the others during that year, even though nobody had any idea which asset class it was going to be at the beginning of the year. So wise investors rebalance the portfolio, returning it to the original percentages. This encourages investors to invest rationally, rather than emotionally, and forces them to sell high (the asset class that did best) and buy low (the asset class that did the worst).

In any given year, the best asset class may be stocks, bonds, or real estate. No matter what happens, your portfolio, if adequately funded, will perform well enough over your career to reach your investing goals, allowing you to sleep well at night. If you find yourself wanting to skate to where the puck has already been, go back to your written investment plan to help you stay the course. If you don’t yet have a written investment plan, you need to write one, either on your own or with the assistance of a competent, fairly priced adviser.
Expecting to be excited and challenged?
Come join our team today!

SEEKING EMERGENCY DEPARTMENT PHYSICIANS

The busiest ED in North Carolina, and one of the top 15 busiest in the nation, treats 95k adult and 35k pediatric cases annually in its 92 beds. We are currently seeking residency trained BC/BE emergency physicians to work in the 75 bed adult ED. This ED serves a high acuity patient population with 28% annual admission rate. There are over 90 hours of adult physician coverage daily and over 110 hours mid-level coverage daily. It is a Level III Trauma Center with robust hospitalist service, interventional cardiology 24/7, cardiac surgery, neurosurgery, etc. The facility is Chest Pain and Stroke accredited. The EMS system is hospital owned and managed with an award winning paramedic program. Of note, the Pediatric ED is separate and has 17 dedicated beds with an additional 24 hours of physician coverage and 20 hours of mid-level coverage. We welcomed our inaugural class of Emergency Medicine Residents in July 2017. Opportunities exist for both clinical and academic emergency physicians.

MEDICAL DIRECTOR OF ULTRASOUND

The Department of Emergency Medicine at Cape Fear Valley Health is seeking a highly-motivated Director of Emergency Ultrasound to join our staff and faculty. The ideal candidate will be fellowship trained in Emergency Ultrasound and have experience with advanced ultrasound applications; resident, faculty, and staff education; research; ultrasound workflow; image management; equipment maintenance; and a working knowledge of credentialing, billing, documentation, and reimbursement.

Affiliated with Campbell University School of Osteopathic Medicine, the candidate will enjoy a Core Faculty appointment commensurate with experience, in our Emergency Residency Program with associated dedicated protected time.

TOP TIER COMPENSATION

The cash compensation package is valued at over $250/hour, including evening, night, and holiday differentials, as well as a quarterly incentive bonus. We offer a generous sign-on bonus plus moving stipend. The comprehensive benefits package includes Malpractice Insurance Paid; CME Time and Allowance; 403(b) match and 457(b); and health, dental, and other desirable benefits.

THE AREA

Cape Fear Valley Health is located in the thriving and diverse community of Fayetteville, NC which consists of more than 319,000 residents. Fayetteville has received the prestigious All-America City Award three times from the National Civic League.

Known for its many golf courses (Pinehurst is located only 30 minutes away), our central location provides easy access to beautiful beaches to our east and to the majestic Blue Ridge Mountains to our west. Our mild climate, low cost of living, and patriotic spirit makes our location ideal for rising healthcare professionals and families.

CAPE FEAR VALLEY HEALTH

Please contact Ashley Dowless, Interim Director, Physician Recruitment at 910-615-1888 or adowll@capefearvalley.com for additional information.
Emergency Physicians of Tidewater (EPT) is a physician-owned, physician-run, democratic group of ABEM/AOBEM eligible/certified EM physicians serving the Norfolk/Virginia Beach area for the past 40+ years. We provide coverage to 5 hospital-based EDs and 2 free-standing EDs in the area. Facilities include a Level 1 trauma center, Level 3 trauma center, academic medicine and community medicine sites. All EPT physicians serve as community faculty to the EVMS Emergency Medicine residents. EMR via EPIC.

Great opportunities for involvement in administration, EMS, ultrasound, hyperbarics and teaching of medical students and residents. Very competitive financial package and schedule. Beautiful, affordable coastal living.

Please send CV to eptrecruiter@gmail.com or call (757) 467-4200 for more information.

ECU is an EEO/AA employer and accommodates individuals with disabilities. Applicants must comply with the Immigration Reform and Control Act. Proper documentation of identity and employability required at the time of employment. Current references must be provided upon request.
**THE DEPARTMENT OF EMERGENCY MEDICINE**

**Service. Education. Leadership.**

**Exciting Emergency Medicine Opportunities**

**Academic Faculty & Clinical Faculty Opening**

The Department of Emergency Medicine at Baylor College of Medicine is looking for Faculty who are interested in a career in Academic Emergency Medicine. We are currently hiring faculty of all ranks commensurate with prior experience and seeking applicants who have demonstrated a strong interest and background in medical education, simulation, ultrasound, or research. Clinical opportunities are also available at our affiliated hospitals.

The Department of Emergency Medicine at Baylor College of Medicine, a top medical school, is located in the world’s largest medical center, in Houston, Texas. The Baylor Emergency Medicine Residency was established in 2010, and we recently received department status in Jan 2017. Our residency program has grown to 14 residents per year in a 3-year format. We offer a highly competitive academic salary and benefits commensurate to academic level and experience.

Our academic program is based out of Ben Taub General Hospital and Baylor St. Luke’s Medical Center. Ben Taub General Hospital is the largest Level 1 trauma center in southeast Texas with certified stroke and STEMI programs that sees nearly 100,000 emergency visits per year. Baylor St. Luke’s Medical Center is home to the Texas Heart Institute and with freestanding Baylor St. Luke’s Emergency Centers offers multiple additional practice sites for Baylor faculty. BCM has a collaborative affiliation with eight world-class hospitals and clinics in the Texas Medical Center.

These affiliations, along with the medical school’s preeminence in education and research, help to create one of the strongest emergency medicine experiences in the country.

Those interested in a position or further information may contact Dr. Dick Kuo via email dckuo@bcm.edu or by phone at 713-873-7044. Please send a CV and cover letter with your past experience and interests.

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**Los Angeles**

**Downtown Los Angeles:**

Quality STEM Stroke Center, good Metrics, paramedic receiving (no peds inpatients). Physician coverage 38-40 hrs/day with NP & PA 12-20 hrs/day, 1.9 pts/hr, stable 26 yr contract. Core group physicians average 23 years tenure. Require Board certified or Board eligible (residency trained) with experience. Day & night shifts (max 5 nights/mo.). Salary competitive.

**Tustin – Orange County:**

New ER opening December, paramedic Receiving, 110-bed hospital, 9 bed ER, Anticipate 600-900 visits/mo. Base + Incentive (patient volume + RVU) $24 hr. Shifts

**Los Angeles:**

Low volume 700/mo. urgent care non-Paramedic receiving, less stress, 20 yr. contract w/stable history. Patients 1/hr. Base + Incentive

**Norwalk:**

Low volume 600/mo. Paramedic receiving. Patients 8/hr. 10-year history stable. $110/hr. 24hr shifts available

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**Washington, Olympia:**


Send CV to Kathleen Martin, 413 Lilly Rd. N.E., Olympia, WA 98506 or kathleen.martin@providence.org

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**Miami- Coral Gables, Florida**

Rare opening at Doctors Hospital, close to shopping, beaches and the University of Miami.

Established, independent private group Doctors Hospital is part of the larger Baptist Health South Florida System

20 Bed ED with 22,000 annual ED visits with generous staffing.

Please send CV to Sofia Forteza at erstatinc@bellsouth.net or call (786)308-9092.

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**Academic Emergency Medicine Physicians**

The University of Chicago’s Department of Medicine, Section of Emergency Medicine, is seeking full-time faculty members to serve as Emergency Physicians as we prepare to open a new adult emergency department and establish an adult Level 1 Trauma Center. Academic rank is dependent on qualifications. Applicants are required to be board certified or board eligible in emergency medicine and to be eligible for Illinois licensure by the start of appointment. Responsibilities will include teaching in the educational programs sponsored by the Section and participation in scholarly activity. We seek candidates looking to develop an academic niche that builds upon our academic program and speaking engagements, along with the medical school’s preeminence in education and research, help to create one of the strongest emergency medicine experiences in the country.

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**Envision Physician Services**

We're offering competitive pay, medical benefits package. Those interested must apply by uploading a cover letter and resume. For more details, please call or text Lori Higbee at 727.253.0707 or lori.higbee@emcare.com. For a complete list of openings, visit www.EnvisionPhysicianServices.com.

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**Tampa, Florida**

Medical Director opportunity at our prestigious practice at Tampa Community Hospital in Tampa, FL. Candidates must be Board Certified in Emergency Medicine with previous leadership and administrative experience.

Tampa Community Hospital is a 201-bed hospital with an annual ED volume of 22,000 visits.

21-bed ED. This is an ideal ED volume of 22,000 visits.

We seek candidates looking to develop an academic niche that builds upon our missions of promoting academic excellence, diversity, and teamwork in service to our patients.

Interested applicants should submit a CV, letter of intent, and 1 letter of recommendation for the position to the Program Director, Dr. Tyson Pillow (pillow@bcm.edu). Sign-on bonus and relocation assistance. Full-time, part-time and per diem opportunities. Ask about our travel opportunities.

For more details, please call or text Lori Higbee at 727.253.0707 or lori.higbee@emcare.com. For a complete list of openings, visit www.EnvisionPhysicianServices.com.

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**Georgia**

Envision Physician Services has ED Physician and Leadership opportunities located in Augusta, Dublin and Waycross, Georgia. We’re offering competitive pay, sign-on bonus and relocation assistance. Full-time, part-time and per diem opportunities. Ask about our travel opportunities.

For more details, please call or text Lori Higbee at 727.253.0707 or lori.higbee@emcare.com. For a complete list of openings, visit www.EnvisionPhysicianServices.com.

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**FAX CV to 213-482-0577 or call 213-482-0588, or email neubauerjanice@gmail.com**
The Emergency Medicine Department at Penn State Health Milton S. Hershey Medical Center seeks energetic, highly motivated and talented physicians to join our Penn State Hershey family. Opportunities exist in both teaching and community hospital sites. This is an excellent opportunity from both an academic and a clinical perspective. As one of Pennsylvania’s busiest Emergency Departments treating over 75,000 patients annually, Hershey Medical Center is a Magnet® healthcare organization and the only Level 1 Adult and Level 1 Pediatric Trauma Center in PA with state-of-the-art resuscitation/truma bays, incorporated Pediatric Emergency Department and Observation Unit, along with our Life Lion Flight Critical Care and Ground EMS Division. We offer salaries commensurate with qualifications, sign-on bonus, relocation assistance, physician incentive program and a CME allowance. Our comprehensive benefit package includes health insurance, education assistance, retirement options, on-campus fitness center, day care, credit union and so much more! For your health, Hershey Medical Center is a smoke-free campus. Applicants must have graduated from an accredited Emergency Medicine Residency Program and be board eligible or board certified by ABEM or AOBEM. We seek candidates with strong interpersonal skills and the ability to work collaboratively within diverse academic and clinical environments. Observation experience is a plus.

FOR ADDITIONAL INFORMATION, PLEASE CONTACT:

Susan B. Promes, Professor and Chair, Department of Emergency Medicine, c/o Heather Peffley, Physician Recruiter, Penn State Health Milton S. Hershey Medical Center, 500 University Drive, PO Box 855 Mail Code A595, Hershey PA 17033, Email: hppeffley@pennstatehealth.psu.edu
OR apply online at: http://hmc.pennstatehealth.org/careers/physicians

Penn State Health Milton S. Hershey Medical Center is committed to affirmative action, equal opportunity, and the diversity of its workforce. Equal Opportunity Employer – Women/Men/Protected Veterans/Disabled.
RUNNING ON EMPTY?

80% of physicians today are professionally overextended or at capacity, leaving them with no time to see additional patients.

Physician burnout rates top 50% in latest Mayo study and work life balance continues to worsen.

8.7 HOURS

The average time a doctor spends per week on administrative work brought about by healthcare reform efforts and EHRs, with certain specialties closing in on 50% of their day.

We’re a national, physician-led organization that gives clinicians the opportunity and the flexibility to grow.

Join us to get fulfilled, plug in to
EnvisionPhysicianServices.com/RechargeYourCareer