The perceived need for intravenous antibiotics drives many hospital admissions. In a sense, the decision to administer IV antibiotics instead of oral formulations represents a line in the sand between infections we are worried might kill a patient and ones that won’t.

But for the vast majority of common infections we treat in the emergency department, oral antibiotics should actually be preferred over IV when efficacy, safety, efficiency, and cost are taken into account together. My goal is to convince you to correctly choose oral antibiotics more often. I believe this will lead to fewer admissions, fewer hassles, and less suffering for our patients.

Over the past year, ACEP has been developing a new journal to join the Annals of Emergency Medicine and ACEP Now as flagship publications of the College. The new journal, entitled JACEP Open (The Journal of the American College of Emergency Physicians Open), published its first articles in December 2019 and will debut its first issue in February 2020. Its inaugural Editor in Chief is Henry Wang, MD, MS, professor and executive vice-chair of research in the department of emergency medicine at the University of Texas Health McGovern Medical School in Houston. He is a prolific researcher and editor who has served as deputy editor for the Annals of Emergency Medicine.

Dr. Wang recently sat down with ACEP

CONTINUED on page 16

IV vs. PO

Are IV antibiotics better than oral antibiotics for common ED infections?

by ANTON HELMAN, MD, CCFP(EM), FCFP

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Of course, there are various physiological arguments that support oral antibiotics being theoretically as effective as IV antibiotics. But I know that, in order for us to

CONTINUED on page 24

SKEPTICS’ GUIDE TO EM “CAN WE PAY YOU $100 TO NOT GET A CT?”

SEE PAGE 23

CAREER TRANSITION

CHANGING PATHS FROM ACADEMIA TO BUSINESS

SEE PAGE 10

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EM CASES

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CONTINUED on page 24
EDs Can’t Fix Overcrowding Alone

In response to “ED Overcrowding” by Anton Helman, MD, CCMP(E), FCCP (Nov. 2019), the case of Brian Sinclair would indeed be dramatic were it not for the fact that this has happened in other emergency departments all over the world. Let me be clear: There are indeed known solutions to the problem of ED overcrowding. Implementing all the CQI and Lean efforts within the ED do not solve this problem; they are diversions from the real problem. We are, in effect, “polishing shiny toys” to show we’re doing our part. These efforts, however, create an impediment to real solutions by creating an expectation that yet one more internal solution can solve this problem. Thus, we put providers at triage, implement guidelines, and blame ourselves. You have delays in radiology reads? Well, order fewer tests. You have too many admissions? Admit fewer. In short, only when the ED is “perfect” and has polished all the shiny toys will there be pressure outside the ED. So, go at it.

There are three known solutions that increase capacity and reduce boarding: smoothing of electives, early discharges, and increasing the number of weekend discharges. The full capacity protocol is a “failure” protocol to be used in times when beds can’t be found. Not only do these solutions work, but they ultimately benefit patients, staff, physicians, and the financial health of the institution. In one institution, smoothing resulted in a $10 million improvement in the bottom line with elimination of boarding. In another institution, enhancing weekend discharges not only reduced boarding from an average of 30 patients to zero, but was so effective that a 30-bed inpatient unit was closed; this effort represented a $70 million positive improvement for the hospital.

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**INDICATION**
ELIQUIS is indicated for the treatment of deep vein thrombosis and pulmonary embolism.

**IMPORTANT SAFETY INFORMATION**

**WARNING:**
(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.

Please see additional Important Safety Information and Brief Summary of Full Prescribing Information, including **Boxed WARNINGS**, on adjacent pages.
AMPLIFY 1,2 Study Design
A randomized, double-blind, phase III trial to determine whether ELIQUI S was noninferior to enoxaparin/warfarin for the incidence of recurrent venous thromboembolism (VTE)* or VTE-related death in 5400 patients with objectively confirmed, symptomatic proximal DVT/PE. 2693 patients were randomized to ELIQUIS 10 mg orally twice daily for 7 days followed by 5 mg orally twice daily for 6 months, and 2707 patients were randomized to standard of care, which was initial enoxaparin 1 mg/kg twice daily subcutaneously for at least 5 days (until INR ≥2), followed by warfarin (target INR range: 2.0-3.0) orally for 6 months. The primary efficacy endpoint was recurrent VTE* or VTE-related death, and the primary safety endpoint was major bleeding.

≈90% of patients in the AMPLIFY trial had an unprovoked DVT/PE at baseline.1

- The 10% of patients with a provoked DVT/PE were required to have an additional ongoing risk factor in order to be randomized1

*Recurrent symptomatic VTE (nonfatal DVT or nonfatal PE).

WARNINGS AND PRECAUTIONS
- Increased Risk of Thrombotic Events after Premature Discontinuation: Premature discontinuation of any oral anticoagulant, including ELIQUI S, 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.
  - The anticoagulant effect of apixaban can be expected to persist for at least 24 hours after the last dose (i.e., about two half-lives). An agent to reverse the anti-factor Xa activity of apixaban is available. Please visit www.andexxa.com for more information on availability of a reversal agent.

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

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

DISCONTINUATION
- Premature discontinuation of any oral anticoagulant, including ELIQUIS, in the absence of adequate alternative anticoagulation increases the risk of thrombotic events. 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.

- Patients with Antiphospholipid Syndrome (APS): Direct-acting oral anticoagulants (DOACs) including ELIQUIS are not recommended for patients with a history of thrombosis who are diagnosed with APS. The efficacy and safety of ELIQUIS in patients with APS have not been established.

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.

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

Clarithromycin
Although clarithromycin is a combined P-gp and strong CYP3A4 inhibitor, pharmacokinetic data suggest that no dose adjustment is necessary with concomitant administration with ELIQUIS.
ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding.1

- Discontinuation rate due to bleeding events: 0.7% in ELIQUIS-treated patients vs 1.7% with enoxaparin/warfarin1
- In AMPLIFY, the most commonly observed adverse reactions in ELIQUIS-treated patients (incidence ≥1%) were epistaxis, contusion, hematuria, menorrhagia, hemoptysis, rectal hemorrhage, and gingival bleeding.

**Important Safety Information (Cont’d)**

**Drug Interactions (Cont’d)**

- **Combined P-gp and Strong CYP3A4 Inducers:** Avoid concomitant use of ELIQUIS with combined P-gp and strong CYP3A4 inducers (e.g., rifampin, carbamazepine, phenytoin, St. John’s wort) because such drugs will decrease exposure to apixaban.
- **Anticoagulants and Antiplatelet Agents:** Coadministration of antiplatelet agents, fibrinolytics, heparin, aspirin, and chronic NSAID use increases the risk of bleeding. APPRAISE-2, a placebo-controlled clinical trial of apixaban in high-risk post-acute coronary syndrome patients treated with aspirin or the combination of aspirin and clopidogrel, was terminated early due to a higher rate of bleeding with apixaban compared to placebo.

**Pregnancy**

- The limited available data on ELIQUIS use in pregnant women are insufficient to inform drug-associated risks of major birth defects, miscarriage, or adverse developmental outcomes.

**Lactation**

- Breastfeeding is not recommended during treatment with ELIQUIS.

**References:**

INDICATIONS AND USAGE

ELIQUIS® (apixaban) is indicated to reduce the risk of pulmonary embolism (PE), in patients who have undergone hip or knee replacement surgery. (see Warnings and Precautions)

ADVERSE REACTIONS

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

- Increased Risk of Thrombotic Events
- Bleeding
- Major Thrombotic Events after Premature Discontinuation
- Major Thrombotic Events
- Hemorrhagic Events
- Other Adverse Reactions
- Rare Events
- Other Events

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 risk of stroke was observed during the transition from ELIQUIS to warfarin in clinical trials of hip and knee replacement surgery patients. ELIQUIS is discontinuation for a reason other than planned discontinuation or completion of a course of therapy. (see Warfarin, Reversal of Anticoagulant Effect, and Clinical Studies [14.1] in full Prescribing Information).

DOSAGE AND ADMINISTRATION

Dosage and Administration

To treat DVT, the recommended dosage is 2 mg twice daily for 7 days and then 2 mg once daily for 3 months, followed by a bridging anticoagulant for at least 24 to 48 hours. (see Warnings and Precautions)

Bridging anticoagulation is not generally required. ELIQUIS should be restarted location and easily controlled. Bridging anticoagulation during the 24 to 48 hours after stopping

Clinical Trials Experience

Because clinical trials are conducted under strictly controlled conditions, adverse reactions observed in the clinical trials may not reflect the occurrence of reactions seen in everyday medical practice, where patients may have limitations in medical or other resources. Adverse reactions observed during clinical trials were generally consistent with those seen during clinical development. (see Warnings and Precautions and Clinical Studies [14.1] in full Prescribing Information).

WARNINGS AND PRECAUTIONS

Severe hypersensitivity reaction to ELIQUIS (e.g., anaphylactic reactions) — ELIQUIS should be avoided in patients with a history of severe hypersensitivity reactions to ELIQUIS or to any of its excipients.

Increased Risk of Thrombotic Events after Premature Discontinuation — ELIQUIS should not be used if the patient is not expected to complete a course of therapy, as anticoagulant therapy is continued until completion of a course of therapy. (see Warnings and Precautions, Major Thrombotic Events after Premature Discontinuation).

WARNING: Premature Discontinuation of ELIQUIS Increases the Risk of Thrombotic Events

ELIQUIS should not be stopped for a critical site: intracranial, intraspinal, intraocular, pericardial, intra-articular, intramuscular with compartment syndrome, or retroperitoneal. Bleeding into a critical site may be life-threatening, and may be associated with long-term neurologic sequelae or death. (see Warnings and Precautions, Major Thrombotic Events after Premature Discontinuation)

Mitral Valve Prolapse

Reduced efficacy of apixaban in patients with mitral valve prolapse increases the risk of thrombotic events. (see Warnings and Precautions, Reduced Efficacy in Patients with Mitral Valve Prolapse)

Patients with Mitral Valve Prolapse

The safety and efficacy of ELIQUIS have not been studied in patients with mitral valve prolapse, heart with valvular heart defects. Therefore, use of ELIQUIS is not recommended in those patients.

Acute PE in Hemodynamically Unstable Patients or Patients who Require Thrombolysis or Mechanical Device Placement

Initiation of ELIQUIS (apixaban) is not recommended as an alternative to unfractionated heparin for the initial treatment of patients who are hemodynamically unstable or who present with hemorrhagic instability or who may need pulmonary thromboendarterectomy. (see Warnings and Precautions)

Patients with Antiphospholipid Syndrome

Direct-acting and anticoagulants, including ELIQUIS, are not recommended for patients with antiphospholipid syndrome (APS). Anticoagulation with warfarin or low molecular weight heparin is preferred in patients with APS. However, anticoagulation with warfarin is not always feasible or recommended. (see Warnings and Precautions, Antiphospholipid Syndrome, and Clinical Studies [14.1] in full Prescribing Information)

ADVERSE REACTIONS

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

- Increased risk of thrombotic events after premature discontinuation (see Warnings and Precautions)
- Bleeding (see Warnings and Precautions)
- Spinal/epidural anesthesia or puncture (see Warnings and Precautions)

Clinical Trials Experience

Because clinical trials are conducted under strictly controlled conditions, adverse reactions observed in the clinical trials may not reflect the occurrence of reactions seen in everyday medical practice, where patients may have limitations in medical or other resources. Adverse reactions observed during clinical trials were generally consistent with those seen during clinical development. (see Warnings and Precautions, Clinical Studies [14.1] in full Prescribing Information)
Adverse reactions occurring in <1% of patients undergoing hip or knee replacement surgery in the Phase IV study and the 2 Phase III studies are listed in Table 4.

Table 4: Adverse Reactions Occurring in <1% of Patients in Either Glioblastoma Multiforme or Carcinoid Tumor Phase III Studies

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>7 (1.4)</td>
</tr>
<tr>
<td>Nausea</td>
<td>6 (1.2)</td>
</tr>
</tbody>
</table>

Other Adverse Reactions

Less common adverse reactions in ELIQUIS-treated patients undergoing hip or knee replacement surgery occurring at a frequency of 0.1% to <1% include:

- Blood and lymphatic system disorders: anemia, neutropenia
- Circulatory system disorders: arterial thrombosis
- Gastrointestinal disorders: melena, vomiting
- General disorders and administration-site conditions: injection-site reactions, venous puncture-site hemorrhage
- Hematological and lymphoid disorders: hemoglobinuria, thrombocytopenia
- Infections and infestations: otitis media, pharyngitis
- Injury, poisoning, and procedural complications: postprocedural hematoma, wound hemorrhage
- Skin and subcutaneous tissue disorders: alopecia
- Vascular disorders: arteriovenous fistula

Blood and lymphatic system disorders have been observed in clinical studies and in postmarketing surveillance. As with other anticoagulants, the frequency of bleeding may be related to the intensity of anticoagulation and the patient’s risk of bleeding.

Table 5: Bleeding Results in the AMPLIFY Study

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>ELIQUIS</th>
<th>Enoxaparin/Warfarin</th>
<th>Relative Risk (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major</td>
<td>17 (2.7)</td>
<td>50 (7.7)</td>
<td>0.23 (0.09, 0.58)</td>
</tr>
<tr>
<td>CRNM</td>
<td>171 (26.0)</td>
<td>467 (71.9)</td>
<td>0.23 (0.19, 0.28)</td>
</tr>
<tr>
<td>Major + CRNM</td>
<td>188 (28.7)</td>
<td>524 (79.6)</td>
<td>0.23 (0.19, 0.28)</td>
</tr>
<tr>
<td>All</td>
<td>432 (65.5)</td>
<td>1179 (177.1)</td>
<td>0.36 (0.32, 0.41)</td>
</tr>
</tbody>
</table>

* CRNM = clinically relevant nonmajor bleeding.

Events were counted once per patient, whether or not more than one bleeding event occurred in a single patient. Events associated with each endpoint were counted once per patient, but subjects may have had contributory events in multiple endpoints.

Adverse reactions occurring in <1% of patients in the AMPLIFY-EXT study are listed in Table 5.

Table 6: Adverse Reactions Occurring in <1% of Patients Treated for DVT or PE in the AMPLIFY-EXT Study

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>9 (1.0)</td>
</tr>
</tbody>
</table>

Other Adverse Reactions

Less common adverse reactions in ELIQUIS-treated patients in the AMPLIFY-EXT study occurring at a frequency of 0.1% to <1% include:

- Blood and lymphatic system disorders: anemia, neutropenia
- Circulatory system disorders: arterial thrombosis
- Gastrointestinal disorders: melena, vomiting
- General disorders and administration-site conditions: injection-site reactions, venous puncture-site hemorrhage
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Table 7: Bleeding Results in the AMPLIFY-EXT Study

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<th>Enoxaparin/Warfarin</th>
<th>Relative Risk (95% CI)</th>
</tr>
</thead>
<tbody>
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<td>All</td>
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* CRNM = clinically relevant nonmajor bleeding.

Events were counted once per patient, whether or not more than one bleeding event occurred in a single patient. Events associated with each endpoint were counted once per patient, but subjects may have had contributory events in multiple endpoints.

Adverse reactions occurring in <1% of patients in the AMPLIFY-EXT study are listed in Table 7.

Table 8: Adverse Reactions Occurring in <1% of Patients Treated for DVT or PE in the AMPLIFY-EXT Study

<table>
<thead>
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<th>Adverse Reaction</th>
<th>N (%)</th>
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<td>Headache</td>
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Other Adverse Reactions

Less common adverse reactions in ELIQUIS-treated patients in the AMPLIFY-EXT study occurring at a frequency of 0.1% to <1% include:

- Blood and lymphatic system disorders: anemia, neutropenia
- Circulatory system disorders: arterial thrombosis
- Gastrointestinal disorders: melena, vomiting
- General disorders and administration-site conditions: injection-site reactions, venous puncture-site hemorrhage
- Hematological and lymphoid disorders: hemoglobinuria, thrombocytopenia
- Infections and infestations: otitis media, pharyngitis
- Injury, poisoning, and procedural complications: postprocedural hematoma, wound hemorrhage
- Skin and subcutaneous tissue disorders: alopecia
- Vascular disorders: arteriovenous fistula

Blood and lymphatic system disorders have been observed in clinical studies and in postmarketing surveillance. As with other anticoagulants, the frequency of bleeding may be related to the intensity of anticoagulation and the patient’s risk of bleeding.

Table 9: Bleeding Results in the AMPLIFY-EXT Study

<table>
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<tr>
<th>Endpoint</th>
<th>ELIQUIS</th>
<th>Enoxaparin/Warfarin</th>
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Submit Comments for Opioid, Pneumonia Clinical Policies

The following drafts are open for comments until Feb. 15:
• “Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department”
• “Clinical Policy: Critical Issues in the Management of Adult Patients Presenting to the Emergency Department with Community-Acquired Pneumonia”

Submit your comments at www.acep.org/pneumonia-comments and www.acep.org/opioids-comments.

Exclusive Opportunity to Join the ACEP Delegation to Morocco

Discover the challenges and opportunities of global emergency medicine as part of this exclusive, unique program that allows you to immerse yourself in another culture. Learn about Morocco’s health care system during a learning program slated for May 24–30, 2020. Find out more at acep.org/morocco2020.

Nominate Your Peers for ACEP Leadership Awards

ACEP is accepting nominations for the 2020 ACEP Awards Program, which annually honors members distinguishing themselves for leadership and excellence in emergency medicine. All members are eligible to submit nominations in one or more award categories, but a nomination form must be completed for each nomination submitted. Nominations must be accompanied by current curriculum vitae. Nominations are due March 1. Get more information at www.acep.org/leadership-awards.

PAIN AND ADDICTION CARE IN THE ED

ACEP ACCREDITATION

Get Accredited to Provide Pain and Addiction Care in the ED

Be part of the solution and improve your community! Understand how to prevent opioid addiction and treat opioid use disorder in the emergency department. Developed for emergency physicians by emergency physicians, ACEP’s Pain and Addiction Care in the ED (PACED) Accreditation Program ensures that patients receive quality pain management with an emphasis on minimizing exposure to opioids, when appropriate, thus decreasing the risk of opioid harms. Additionally, PACED provides the tools necessary for an emergency department to initiate treatment for patients struggling with opioid use disorder. The PACED program will begin accepting applications in early 2020. Join the interest list at www.acep.org/paced.

MIPS: Upcoming Changes You Should Know About

Many of you are all too familiar with the Merit-based Incentive Payment System (MIPS), the major quality reporting program for physicians under Medicare. Each year the Centers for Medicare and Medicaid Services (CMS) revises requirements for MIPS, and CMS recently finalized requirements for calendar year 2020. Read our regulatory blog at www.acep.org/regsandeggs to learn more about the changes to MIPS coming in 2020 and to get some helpful tips about the program.

ACEP Leaders Meet with AAFP

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Leadership & Advocacy Conference

April 26-28, 2020 | Grand Hyatt | Washington, DC

Join us to celebrate emergency medicine accomplishments while continuing to work for a better political environment for our specialty and patients. Each year we send a stronger message to the United States Congress, train first-timers to educate Members of Congress, and facilitate seasoned participants building upon already-valuable Congressional connections.

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The Center for Emergency Medical Education (CEME) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The Center for Emergency Medical Education (CEME) designates this live activity for a maximum of 34.75 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Have you ever thought about taking your career in an entirely new direction? Maybe you’re in the community and you want to get back to academics. For me, it was the opposite. This is my story: why I did it, what I do now, and what I’ve learned. My hope in sharing is that it might help you think through what matters to you as you look into the future of your own career in medicine.

After 15 years in academic medicine at the University of Pennsylvania in Philadelphia and George Washington University in Washington, D.C., I took a new job at US Acute Care Solutions (USACS) in September 2018 as its national director of clinical innovation. In all honestly, my move was met with both positive and negative feedback. There were many well-wishers (thank you!) but others with pointed questions: Why leave a successful academic career, particularly given the controversial role of management groups like USACS in emergency medicine?

Well, here is why. The first part of my career was dedicated almost entirely to scholarship—primarily writing papers (I love writing) and writing grants (I love less), teaching, and clinical practice. Along the way, I enjoyed success in publishing, great interactions with colleagues, and satisfaction in advancing science in emergency care. I also had opportunities to work in policy circles around Washington, D.C., and in academic leadership.

Like many of you, I follow the Facebook group EM Docs. In many posts I read, I sense undercurrents of angst and burnout. Discussions abound on desires for life redesign, often through reflections on clinical cases or other remarkable work situations. Sometimes EM Docs posts are disheartening. Many suggest: “This is not what I signed up for!” Yet in reality, that’s mostly wrong. We actually knew the pain points. Maybe we just romanticized emergency medicine or didn’t fully comprehend its cumulative effects. Perhaps it’s not medicine that changes, it’s us who change as we grow and age. To no surprise, your 30-year-old self should have different goals than your 50-year-old self, with greater experience in life’s successes and failures. Call it what you will—midlife crises or another name—emergency physicians regularly re-examine identity, specifically why we do what we do and to what end.

In the 2018 book, Designing Your Life: How to Build a Well-Lived, Joyful Life, authors Bill Burnett and Dave Evans—who also lead the Stanford Life Design Lab—apply design thinking to life and career redesign. The book offers many tools: journaling and self-reflection and a road map for getting “unstuck” through creating and prototyping alternative life plans. The goal of life redesign is to improve job satisfaction and overall happiness across all aspects of life.

### Redesigning My Life

As I read this book, nagging questions started haunting me about my career in academics: Can I do this for the next 20 years? If I do, will I have the greatest impact? Am I still growing and learning?

I wasn’t so sure. Borrowing from a Designing Your Life concept, my work view (ie, why I was working so hard) did not exactly match my life view (ie, what was most worthwhile to me). I had summited my mid-40s, and my pace of learning had slowed. The marginal excitement from the next paper or grant had waned. The reality of complex stakeholders in academics becomes tiresome. I thought to myself. Instead of sitting in an ivory tower writing papers about how to change acute care, maybe I could go and actually try to be a change agent myself. Maybe I could have greater impact in a different role?

My change was not so radical. I did not leave health care or even emergency medicine. I went from one EM community to another, from one platform to another, and from academics to private enterprise (which, in practicality, have similar goals: to provide excellent care at a margin). Instead of just innovating in a single hospital, I am now able to innovate across more than 200 USACS sites and over 6 million ED visits.

Much changed, but much stayed the same, like my ability to produce scholarship through the USACS Research Group and my clinical practice.

So what is my new position? As the USACS national director of clinical innovation, I try to design and implement programs that allow emergency physicians to deliver innovative care, adapt to market changes, remain competitive financially, and operate in novel environments that best leverage our skillset. The goal is to find and implement win-win projects that address age-old struggles in our practice. For example, I am working to implement a system that assesses care experience after discharge and admission with good response rates. This will provide actionable feedback (unlike Press Ganey-like instruments) and allow us to learn more about patients’ recovery and follow-up experiences.

Another area of focus is in novel payment models: programs with private and public insurers that align emergency care and population health, allowing us to take financial risk from (and benefit from) good care decisions and value-based care. This includes efforts aimed at lowering rates of CT scan use when clinically unnecessary and lowering hospital admissions. I am also helping to develop new programs in telemedicine, opioids, and direct-to-business models for USACS.

### Lessons Learned

Reflecting on my personal career redesign and exposure to the business of emergency care, here are a few lessons:

1. **Midcareer change can create tremendous learning.** Aging can bring complacency without change. Career change disrupts habits and can generate dramatic learning (at least, it did for me), particularly when shouldering new responsibilities. For example, I had to learn the language of business (comparing business and academic physician lingo is not unlike comparing Mandarin and English).

2. **Emergency medicine as we know it is under siege.** This may come as no surprise, but broader forces in medicine and health policy are focused on reducing ED visits and keeping patients away from hospitals (and us). Furthermore, there are great efforts underway to reduce payments to physicians through surprise billing legislation and other policies. In the future, we will probably make either somewhat less or a lot less money for seeing patients. It also means we will increasingly see sicker patients and those with self-pay or public insurance. Sorry if you didn’t know that.

3. **Despite this, emergency physicians bring unique value.** When it comes to delivering on value-based care, emergency physicians’ abilities to care for the acutely ill and injured patient are unrivaled. In the changing world of new care and payment models, these skills will become increasingly marketable. Don’t worry, you will always have a job. But you may have to be nimble regarding how and where you practice.

4. **Real innovation in emergency care is really, really hard.** Trying to implement new approaches is entering a shark pit surrounded by landmines. Even innovations that conceptually make all the sense in the world sometimes get crushed because of competing interests or complacency. Do not discount the powerful effect of personalities, those who create barriers versus those who facilitate.

5. **The success formula to innovation is good idea + alignment + the right team + persistence.** Having a good idea is the easy part. Everyone has good ideas. But you have to have an idea that aligns stakeholder interests and is facilitated by the right people. Show return-on-investment and avoid stomping on someone else’s budget. Even getting this recipe right requires persistence because failure is the default and success is the exception.

6. **Business in emergency medicine is not evil.** Feel free to disagree. Great vitriol divides our specialty over how we should organize. Realize that medicine is a business and care cannot be delivered unless there is a business model. In my view, all organizations—large for-profit groups, democratic groups, and nonprofit academic centers—act in their own financial interests within the existing legal framework. I see no angels and no demons. Particularly given lesson 2 above, I find it more fruitful to fight-out than fight-in emergency medicine.

7. **Re-examine your life, and then redesign and pivot if necessary.** When it comes to your life redesign, take all four aspects into consideration: work, play, love, and health. Take stock of where you are and what alternative realities might look like. Along with Designing Your Life, there are a lot of great books out there on the topic. To quote the 1980’s hit Ferris Bueller’s Day Off, “Life moves pretty fast. If you don’t stop and look around once in a while, you could miss it.”

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**DR. PINES** is the national director of clinical innovation at US Acute Care Solutions and professor of emergency medicine at Drexel University in Philadelphia.
2020 Course Topics

- Unusual Antibiotic Side Effects
- MRI vs. CT in the ED Setting
- Challenges of Managing Pediatric UTIs
- Emerging Issues in Anticoagulation
- Chest X-Ray, Ultrasonography, or CT?
- Headache – ACEP 2019 Guidelines
- LPs in Febrile Infants 29-60 Days Old?
- Suicidal Risk: Assessment and Intervention
- Cardiovascular Pearls, 2019
- DKA and Hyperglycemia Update
- Sore Throat: Still Trying to Get It Right
- Sexual / Racial / Ethnic Disparities in the ED
- ACS & PE – ACEP 2019 Guidelines
- Psychiatric Patients: Medical Evaluation
- Challenges of Atrial Fibrillation - Part 1
- Challenges of Atrial Fibrillation - Part 2
- Otitis Media Doesn’t Cause Fever
- Sepsis 2019: Hot Off the Press
- Pearls From Risk Management Monthly
- Pearls From ED Leadership Monthly
- Urologic Imaging Guidelines
- Pediatric Vomiting and Diarrhea
- Trauma 2019: Hot Off the Press
- Myths in Emergency Medicine
- Controversies in EMS
- ATS / IDSA Updated Pneumonia Guidelines
- Visual Diagnosis Challenges - Part 1
- Visual Diagnosis Challenges - Part 2
- Important Recent EM Literature - Part 1*
- Important Recent EM Literature - Part 2*
- Optimizing ED Operations*
- Diagnostic and Therapeutic Controversies*

*Topics listed with an asterisk (*) are 90-minute faculty panel discussions; all other topics are 30 minutes.

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Not So FAST!

Consider the evidence behind trauma ultrasound during pregnancy

by CASEY WILSON, MD; AND LEXUS DICKSON

During your busy shift, you get a call that a 27-year-old G3 P2 female who is 28 weeks pregnant has been involved in a motor vehicle collision. She was the restrained driver in a front-end 25-mile-per-hour collision with airbag deployment. The obstetrician-gynecologist team has tasked you with “clearing” the patient from a trauma perspective before she comes to the labor and delivery floor for monitoring. She complains of some abdominal discomfort. On exam, she has no seatbelt sign. You reach for your trusty ultrasound machine to perform a focused sonography for trauma (FAST) exam and obtain all the necessary views. Then you ask yourself, is the FAST exam even applicable in pregnancy?

Background
Trauma is a leading cause of nonobstetric maternal mortality and affects up to 7 percent of all pregnancies. Both major and minor trauma increase the risk of a pregnancy loss, but pregnant trauma patients are more likely to sustain serious abdominal injuries than nonpregnant trauma patients. The overall fetal loss rate from trauma is reported to be anywhere from 1 percent to 34 percent. The fetal loss rate with penetrating abdominal injuries is far higher, at 73 percent. Additionally, life-threatening traumatic injuries to a pregnant patient should always be considered a life-threatening condition for the fetus because maternal death almost always results in fetal death.

EMS Trends in the U.S. Remain Stable

Source: Emergency Department Benchmarking Alliance (EDBA) Annual ED Survey

NUMBER of EDs REPORTING
1,910
MEMBERSHIP COMPOSITION
1,782 GENERAL EDs
106 PED EDs
22 SPECIALTY EDs
Because of the risks to both the mother and fetus, emergency and trauma physicians will want to be confident in their physical assessments of pregnant patients with traumatic injuries. Generally, ultrasonography is a preferred imaging modality for this patient population due to lack of radiation exposure. However, the FAST exam, one of the most commonly used assessments to look for free intraperitoneal and pericardial fluid from internal trauma, may be unreliable in pregnant patients.

Limitations of the FAST Exam

The most obvious aspect of the FAST exam that may be different than usual is the pelvic portion of the exam, which can be challenging due to the anatomical changes that accompany pregnancy. Of particular concern is the evaluation of the pouch of Douglas for the presence of hemoperitoneum, which requires special and more advanced ultrasound training than for nonpregnant patients.

The common cause of maternal hemorrhage is nonfetal maternal traumatic injury in placental abruption. This is sometimes assessed during the FAST exam, often when attempting to establish ongoing fetal heart motion, during the FAST exam, often when attempting to establish ongoing fetal heart motion, during the FAST exam, often when attempting to establish ongoing fetal heart motion, during the FAST exam, often when attempting to establish ongoing fetal heart motion, during the FAST exam, often when attempting to establish ongoing fetal heart motion.

Brown and colleagues found the sensitivity of screening sonography for use in pregnant patients with blunt abdominal trauma to be 80 percent (95 percent CI, 28–100 percent) but only used five patients to determine this value. Although their reported specificity was 100 percent (95 percent CI, 96–100 percent) for 96 patients without abdominal injury, Brown et al concluded that they “cannot make strong conclusions about sensitivity on the basis of this small study.”

In a 10-year retrospective study of ultrasound evaluations in pregnant abdominal trauma patients, Meisinger and colleagues determined the sensitivity and specificity of their institution’s extended FAST exam to be 85.7 percent and 99.7 percent, respectively. Howev-

er, their sensitivity value was calculated based on the findings of only seven patients, and the researchers attributed their higher sensitivity value to the greater training of their sonographers.

A study by Richards and colleagues had the largest number of positive cases (n=22) from which a calculation for sensitivity of the FAST exam could be estimated. They found the sensitivity to be 61 percent, the lowest of all the studies. This low sensitivity compelled them to conclude that the FAST exam “does not rule out intra-abdominal pathology.” Their specificity was 99.4 percent for 288 out of 305 patients. Taken together, the sensitivity values in the existing literature, which were calculated based on small sample sizes and have large margins of error, cast concern on the validity of the FAST exam’s reliability in detecting signs of blunt trauma within pregnant patients. However, the high specificity in these studies suggests that the presence of positive findings may be enough information to act upon.

Conclusion

The utility of the FAST exam in pregnant trauma patients has yet to be fully validated by existing research and may prove a challenge for providers who are less experienced in ultrasonography. As is the case with many applications of bedside ultrasound, positive findings appear to be quite reliable (ie, high specificities). However, false negatives remain a concern. More research is required to determine the true sensitivity of the FAST exam in this patient subset and to address potential challenges. Researchers continue to emphasize that ultrasound should not be used in place of a diagnostic computed tomographic examination in the treatment of pregnant patients with a high suspicion of internal injury.

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Brown and colleagues found the sensitivity of screening sonography for use in pregnant patients with blunt abdominal trauma to be 80 percent (95 percent CI, 28–100 percent) but only used five patients to determine this value. Although their reported specificity was 100 percent (95 percent CI, 96–100 percent) for 96 patients without abdominal injury, Brown et al concluded that they “cannot make strong conclusions about sensitivity on the basis of this small study.”

In a 10-year retrospective study of ultrasound evaluations in pregnant abdominal trauma patients, Meisinger and colleagues determined the sensitivity and specificity of their institution’s extended FAST exam to be 85.7 percent and 99.7 percent, respectively. Howev-

er, their sensitivity value was calculated based on the findings of only seven patients, and the researchers attributed their higher sensitivity value to the greater training of their sonographers.

A study by Richards and colleagues had the largest number of positive cases (n=22) from which a calculation for sensitivity of the FAST exam could be estimated. They found the sensitivity to be 61 percent, the lowest of all the studies. This low sensitivity compelled them to conclude that the FAST exam “does not rule out intra-abdominal pathology.” Their specificity was 99.4 percent for 288 out of 305 patients. Taken together, the sensitivity values in the existing literature, which were calculated based on small sample sizes and have large margins of error, cast concern on the validity of the FAST exam’s reliability in detecting signs of blunt trauma within pregnant patients. However, the high specificity in these studies suggests that the presence of positive findings may be enough information to act upon.

Conclusion

The utility of the FAST exam in pregnant trauma patients has yet to be fully validated by existing research and may prove a challenge for providers who are less experienced in ultrasonography. As is the case with many applications of bedside ultrasound, positive findings appear to be quite reliable (ie, high specificities). However, false negatives remain a concern. More research is required to determine the true sensitivity of the FAST exam in this patient subset and to address potential challenges. Researchers continue to emphasize that ultrasound should not be used in place of a diagnostic computed tomographic examination in the treatment of pregnant patients with a high suspicion of internal injury.

Because of the risks to both the mother and fetus, emergency and trauma physicians will want to be confident in their physical assessments of pregnant patients with traumatic injuries. Generally, ultrasonography is a preferred imaging modality for this patient population due to lack of radiation exposure. However, the FAST exam, one of the most commonly used assessments to look for free intraperitoneal and pericardial fluid from internal trauma, may be unreliable in pregnant patients.

Limitations of the FAST Exam

The most obvious aspect of the FAST exam that may be different than usual is the pelvic portion of the exam, which can be challenging due to the anatomical changes that accompany pregnancy. Of particular concern is the evaluation of the pouch of Douglas for the presence of hemoperitoneum, which requires special and more advanced ultrasound training than for nonpregnant patients.

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KNOW AN EMERGENCY PHYSICIAN WHO SHOULD BE FEATURED IN “FACEPS IN THE CROWD”? SEND YOUR SUGGESTIONS TO ACEPNOW@ACEP.ORG.

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NEDRA VINCENT, MD, FACEP

Nedra Vincent, MD, FACEP, has been practicing emergency medicine for 33 years, most recently as an EM physician partner in Mountain View Emergency Physicians Medical Group in Southern California. She fell in love with horses as a young girl and competes at least four times per year in the sport of three-day eventing. Her favorite part is cross country, which involves a miles-long course with 20–30 obstacles to jump. She calls it a “true adrenaline rush,” similar to her work in the emergency department. Dr. Vincent is expanding her equine interests by becoming a medical official for an international sport horse event in Southern California and starting to dabble in sport horse breeding. She loves the physicality of riding and says being around horses helps her relax. “Burying my face in a horse’s neck is therapeutic.”

MARCUS SIMS II, DO, FACEP

Marcus Sims II, DO, FACEP, is a facility medical director for National Medical Professionals in Pearland, Texas. He started flying lessons when he was 13 years old after he and his brother, Chance Sims, DO, a fellow emergency physician, caught the flying bug from their dad. He rekindled his love of flying in August 2018, obtaining his instrument rating in November 2019 and becoming a private pilot in December 2019. Dr. Sims flies Cessna 172s and Piper Arrows and dreams of owning his own plane one day. He said that being an emergency physician is similar to being a pilot in that “both [professions] require you to remain at the top of your game.” It’s a true family affair for the Sims clan: The brothers love to fly together for quick trips to visit their dad in West Texas, and Dr. Sims takes his four sons flying whenever he can.

Evan Fusco, MD, FACEP, is medical director for Mercy Care Management, based in St. Louis. A longtime Dungeons & Dragons fan who was always fascinated with medieval sword fighting, he started studying historical European martial arts (HEMA) eight years ago. He was drawn to the “cer- ebral” nature of HEMA, and his group studies a wide range of topics, allowing him to learn aspects of the medieval time period beyond martial arts. “I really like the fact that we’re not just bashing one another and playing ‘pretend,’” he said. “We are studying, learning, arguing over nuances,” which reminds him of the literature debates in emergency medicine. He says both EM and HEMA put you at the edge of your abilities and reveal/punish your missteps in different ways. “This is a break from the ED world for me, a very different type of challenge.”

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More than 12,000 ACEP members have achieved Fellow status with the College and use the FACEP designation with pride! Here, we highlight ACEP Fellows who have fascinating hobbies and passions outside the emergency department.

FACEPs IN THE CROWD

**NEDRA VINCENT, MD, FACEP**

**MARCUS SIMS II, DO, FACEP**

**EAVAN FUSCO, MD, FACEP**

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Chlamydia and Gonorrhea Testing Best Practices

Tips for testing adults and adolescents in the emergency department

by REBECCA BARRON, MD, MPH; STEPHEN LIANG, MD, FACEP; WILLIAM WEBER, MD, MPH; AND ELAINE JOSEPHSON, MD, FACEP

Chlamydia and gonorrhea are the most common and second most common notifiable diseases in the United States, respectively. Rates of both sexually transmitted infections (STIs) have been increasing in recent years. Emergency physicians are on the front lines of diagnosis and treatment of these infections. The ACEP Public Health and Injury Prevention Committee recently issued an information paper on best practices for diagnosing chlamydia and gonorrhea in adult and adolescent patients. Here are highlights from the most current and evidence-based recommendations.

Testing for chlamydia and gonorrhea may be warranted in a range of circumstances, and clinicians should take into consideration patient, provider, and test characteristics when determining how to proceed. Patients with symptoms of infection (whether genital, extragenital, or disseminated), sexual contact with infected individuals, and high-risk demographics may all require testing. Empiric treatment based on clinical suspicion is reasonable when test results are not readily available and/or when follow-up is unlikely. In addition, patients diagnosed with chlamydia or gonorrhea should be offered testing for other STIs, such as syphilis and HIV. Of note, test of cure (ie, attempts to detect therapeutic failure) is generally not necessary.

Historically, microbiological culture was the gold standard for diagnosing chlamydial and gonorrhreal infections. This method has been largely replaced by nucleic acid amplification tests (NAATs), which have...
Now Medical Editor in Chief Jeremy Faust, MD, MS, MA, FACEP, to discuss the role of JACEP Open and his vision for this new home for critical emergency medicine research.

JF: What niche does JACEP Open fill, and what kind of articles are you looking for?

HW: The goal of JACEP Open is to represent the full spectrum of science and knowledge. Submissions from the entire spectrum of science that might be related to emergency medicine research and practicing research are welcome.

JF: That doesn’t sound too different from Annals of Emergency Medicine. So why a new journal?

HW: It’s clear that there is more than enough high-quality material to fill Annals, so we really need another venue beside Annals to showcase the best of the best. We see JACEP Open as a second venue for authors to showcase their best work. We hope that, eventually, the world will see Annals and JACEP Open as a partnership representing the leading edge of research for our specialty.

JF: When you’re starting a brand-new academic journal, how do you convince authors to submit?

HW: One of our highest priorities is to ensure that this is an author-friendly experience. For example, we have great flexibility in the structure of papers. We aim to have a rapid editorial process. For an ideal paper, the peer-review to publication process can be as short as six weeks, and that time frame might be even shorter in the future as we become more adept and streamline our processes.

JF: When authors choose to submit to a journal, prestige is a consideration. How do you attract the best work to a new journal that won’t have an impact factor for several years?

HW: Yes, this is a new journal, and it doesn’t have an impact factor yet. However, it is backed by ACEP, and it is published by Wiley. Our editorial board is filled with incredibly accomplished and diverse experts from all around the world. And so this is a journal with a lot of credibility from the outset. It’s run by a terrific staff with tons of experience and international scientific credibility. Also, the author experience will be enhanced by some of our open access features. We expect to have Medline indexing by the end of 2020. And we expect all articles to be retroactively indexed. Ultimately, we expect an impact factor in 2021.

JF: Other than the fact that JACEP Open is free to the readers, what are the other advantages of open access?

HW: Because we are an open access journal, as soon as an accepted paper has completed its production and goes online, it is immediately discoverable by the world. It’s immediately discoverable by internet search engines. When treating life-threatening or uncontrolled bleeds in patients on apixaban or rivaroxaban, the rapid reversal is within reach.
sensitivities of up to 100 percent and specificities of 97 percent for diagnosing chlamydia and gonorrhea. For chlamydia testing in women, endocervical and vaginal swabs likely perform equivalently. However, both are superior to urine specimens in terms of sensitivity. Interestingly, self-obtained vaginal swabs perform as well as clinician-obtained swabs and are generally preferred by patients. In men, urine specimens (ideally first-catch) perform at least as well as urethral swabs while maximizing patient comfort.

For gonorrhea testing in women, endocervical swabs appear to perform best, while in men, urethral specimens are nearly as good as urethral swabs. Gram stain from a urethral swab is an option for confirming the diagnosis in symptomatic men but not for excluding it. NAATs can be used to evaluate for both chlamydia and gonorrhea extragenital infections, though not all are approved by the U.S. Food and Drug Administration for this purpose. Finally, microbiological culture is still useful in determining antibiotic susceptibility when gonococcal resistance is suspected.

Development of improved point-of-care testing for chlamydia and gonorrhea is underway and has the potential to improve the diagnostic and therapeutic capabilities of emergency physicians in this area.

References

DR. BARRON, DR. LIANG, DR. WEBER, and DR. JOSEPHSON are members of the ACEP Public Health and Injury Prevention Committee.
HW: In our first weeks we've been open for business, there have been nearly 100 submissions, far exceeding our hopes. A portion of the papers are those that had been transferred from the *Annals of Emergency Medicine*, but we have had a large number of papers that have come in directly.

**JF:** Can you address some of the concerns people have about the system in which authors are paying publication fees? And what about authors who can’t afford that?

**HW:** Open access journals often involve an article publication charge, and *JACEP Open* works along the same model. There are several factors authors should consider when weighing the pros and cons of an article publication charge. First of all, we ensure a quality experience in exchange for this publication charge. We aspire to have articles going through the editorial and production process very quickly and for the article to be widely accessible throughout the entire world on a very rapid basis.

In addition, I think the reality of biomedical publishing is that many journals are charging publication fees now, including some print [non-open access] journals. Some journals are not very open and upfront about their fees. It’s not uncommon for an author to not have any idea what the vast majority of medical journals move to a model where there’s some type of publication charge to authors.

Regarding affordability, there is a waiver system available, and the authors can apply for special consideration in cases of economic hardship. This is rapidly becoming the norm in this space for those who have financial hardships or cannot afford the publication charge.

**JF:** Something readers may not know about you is that you’re an accomplished violinist and orchestral musician. We both share a love of music! I’m wondering whether you think that your background as a violinist makes you a better editor.

**HW:** Writing a medical paper is exactly like composing a piece of classical music. I work with my students a lot using the same analogies. If you are a classical music fan, you’ll recognize that we love classical music because of the beauty of its traditional forms. The sonata form has an introduction, a theme, a second theme and development, and then a repeat of those themes. The reason we love Mozart and Beethoven is partly due to the structure. The reason we love Schubert and Brahms is partly due to the structure. The reason we love Chopin and Debussy is partly due to the structure.

Although all those composers lived in different times and wrote in different styles, there are analogies. If you are a classical music fan, you’ll recognize that we love classical music because of the beauty of its traditional forms. The sonata form has an introduction, a theme, a second theme and development, and then a repeat of those themes. The reason we love Mozart and Beethoven is partly due to the structure. The reason we love Schubert and Brahms is partly due to the structure. The reason we love Chopin and Debussy is partly due to the structure.

**JF:** How is it going so far in the early months? Are you getting a lot of submissions? How many are coming as direct submissions, and how many are coming as direct submissions from the *Annals* pathway, *Annals* sisters, *JACEP* Open?

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**JF:** How is it going so far in the early months? Are you getting a lot of submissions? How many of those submissions are coming in directly as a result of the new open access model, the authors actually retaining the rights to the work. I think open access journals often involve an article publication charge, and *JACEP Open* works along the same model. There are several factors authors should consider when weighing the pros and cons of an article publication charge. First of all, we ensure a quality experience in exchange for this publication charge. We aspire to have articles going through the editorial and production process very quickly and for the article to be widely accessible throughout the entire world on a very rapid basis.

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**JF:** Finally, I think we all want to know how the name *JACEP Open* came about. Can you tell us the history there?

**HW:** Readers might be fascinated to know that the original name of Annals of Emergency Medicine was, in fact, the *Journal of the American College of Emergency Physicians* (*JACEP*). In putting the new journal together and going through a long list of candidate titles, we realized that linkages to the College and our partners at *JACEP* were extremely important as well as acknowledging our linkage with *Annals of Internal Medicine*, which is clearly our big brother. We homed in on those key factors and decided to name the journal *JACEP Open*.
When we encounter overt racism and other forms of discrimination in the workplace, we expect our colleagues of all backgrounds to stand strongly against it. After all, this is the 21st century. But there is a perception, even among many of our allies, that a relative paucity of leagues of all backgrounds to stand strongly against racism may not realize how to know how to just don’t... TheOfficialVoiceofEmergencyMedicine

Anyway? What Is a Microaggression

Microaggressions are “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative...sights and insults.” The “micro” portion of the expression refers to the perception by the aggressor, not in the hurtful portion of the expression. “Micro” involves perceptions of microinsults, microinvalidations, microassaults, microinsults, microinvalidations, and microaggressions.

These remarks or attacks have a name: microaggressions. These “micro” actions can have big impacts, but simple strategies can interrupt them. The power dynamics of the relationships of the players involved also influence how the recipient may feel about responding to the microaggression, both in real time and later. Relationship dynamics can range from colleague-colleague and clinician-patient to supervisor-supervisee. Each situation is unique, with complexities that are difficult to fully understand, thus making their downstream effects more difficult to mitigate. This is why we need to band together to respond to microaggressions when they happen.

What We Can Do

There are many good reasons to confront a microaggression, both for the offender and the offended. These include helping the offender (who often did not mean to cause harm) realize their bias, changing behavior, and setting a norm that the behavior is neither tolerable nor acceptable. People tend to judge themselves by their intentions. If they consider themselves to be thoughtful and kind, then the intent of their comment may conflict with its impact and its unintended consequences. When speaking out against a microaggression, we have to be aware that the person being called out can be expected to react in a range of ways, from anger, denial, and minimization to guilt or apology. These are all natural reactions. That is why one of the bystander strategies for combating microaggressions is to take action as they occur. Here are some strategies for interrupting and interrupting microaggressions:

- Ask a clarifying question.
- Come from a place of curiosity, then listen actively and openly.
- Tell others about your experience: “I noticed that...”
- Encourage others to consider the impact of their words or actions: “How do you think people feel when...?”
- Own your response: “When I hear your comment, I think/feel...”
- Identify next steps and request appropriate action: “I’d appreciate if you would not...”

For those in supervisory positions, several actions can be taken to help create a workplace environment that minimizes microaggressions. First set expectations for a safe learning or workplace environment. Second, encourage staff and trainees to speak up when they feel uncomfortable about a situation. Third, if you experience a microaggression, share your story so that others may feel more comfortable sharing their stories. Finally, use of “interrupting microaggression” strategies should be consistently encouraged and modeled to set an example for others in the workplace.

While microaggressions may seem small, they are not. Fortunately, it does not take heroic efforts to stop them from causing immediate and downstream hurt and diminishing the quality of our workplace. However, it takes awareness and willingness to act. Working together, we can prevent the macro effects of microaggressions and decrease their prevalence in the process.

“The Equity Equation” is curated by Dara Kass, MD, and Uché Blackstock, MD. References

Discovery and Deposition Primer

Practice and strategy are critical for providing testimony at deposition

by GITA PENSA, MD

“I was going through the depositions and really stressing myself out. Not eating. Not sleeping. And I got pregnant at that time and miscarried shortly after, and obviously causality is difficult to prove, but I always thought that was part of the reason why.”

—Interviewee, “Doctors and Litigation: The L Word” podcast

After being served with papers initiating a malpractice lawsuit, the deposition is often the next stress-inducing event in the litigation timeline. Most physicians are unfamiliar with depositions at all, let alone how to perform skillfully during one. An apt analogy is the EM oral boards: Imagine going into that exam (which is in no way similar to your usual practice environment or written exams) without any knowledge of the structure of the exam or strategies for success. Regardless of your clinical skills, you might fare poorly because of your lack of “boardsmanship.” Depositions are similar, and preparation for them—both the practical and psychological aspects—is key to increasing the odds of a favorable outcome in your case.

The Deposition Process

Depositions are just one part of the discovery process, the stage of civil litigation that occurs after the lawsuit is initiated. In certain states, discovery begins only after the plaintiff submits an offer of proof or affidavit of merit, demonstrating that the case has been reviewed by a physician or panel that deems it legitimate. Unfortunately, there is almost always an available “expert” physician willing to craft a theory of negligence in exchange for a tidy sum. During discovery, parties on both sides gather information to help develop their arguments. Several facets of discovery usually precede depositions, including requests for admissions (getting each side to agree on sets of facts that will not be in dispute during the case), interrogatories (questions each side directs to the other in written form), and requests for production of relevant documents or records. Often, there is an intermittent involvement of the court, as each side will inevitably be dissatisfied with the answers or documents produced, which then serves as the impetus for filing motions that compel divulgence of further information. Each motion will be ruled on by the judge after hearing arguments from both sides. Naturally, this takes time; in some cases, the discovery process can last years. While your attorney will be working steadily, your involvement in these steps is less significant, other than answering the interrogatories with your attorney and reviewing any documents your attorney provides.

The deposition is where you first take center stage. A deposition is the sworn testimony of a witness conducted by opposing counsel, often taking place in their office. The plaintiff, defendant(s), additional witnesses, and medical experts hired for their opinion are all deposed separately. Videotaped depositions are less common than simply transcribed ones; you will be notified ahead of time if it will be recorded. Every word will be taken down by a stenographer and turned into a printed book of testimony that can be reviewed, parsed, and subsequently leveraged. Your words will be quoted back to you at trial, sometimes in out-of-context excerpts framed in a way to paint you in the least positive light. This is why it’s so important to develop skills in answering questions truthfully, succinctly, and in the words of your choosing—not the plaintiff’s attorneys. Attorneys have been trained in methods of tricking you into saying things that you don’t really mean. Practice, know-how, and boardsmanship—learning those tricks—will keep you in the driver’s seat of your own testimony.

Almost as important as your words is your demeanor in a deposition. Both sides—your own attorney and the plaintiff’s—will be sizing you up in terms of how you would appear to a jury when under pressure. Are you angry? Do you appear arrogant or callous? Or do you instead appear confident and caring? Regardless of the quality of your care, if it appears you will be unlikable to a jury, the plaintiff’s attorney will do their best to bring you to trial or hold out for a very large settlement. Emotional control is of utmost importance—and easier to achieve if you have been managing your stress.

There are many books about litigation that help demystify depositions and explain with examples how to skillfully answer tough questions. ACEP also has some online preparation tools, including a video with ACEP Past President Greg Henry, MD, FACEP, and a downloadable list of frequently asked questions at deposition—questions that can turn into traps for the unaware—along with examples of how to adeptly handle these challenges. Here are just a few tips to get you started. (Note: this is not exhaustive, and you should defer to your attorney’s advice.)

Before Deposition

• Talk to peers and friends. Seek support. It’s helpful to talk to someone who has been through it. Self-care is a priority.
• Read a book on malpractice litigation; most have advice on deposition preparation.
• Know the details of your chart well, including all nursing, staff, and EMS notes. You will be given a copy at deposition to reference, but you should already know the details. Anticipate how you will answer tough questions about what was documented.
• Practice answering questions truthfully and succinctly with your attorney, without offering extra information. Speak in specific medical terms; do not try to “teach” the opposing counsel. Do not be demeaning.
• Discuss with your attorney whether to do any research on the relevant medical issues, and keep all research as an “attorney-client work product.”
• Discuss how you will handle questions about co-defendants in advance. In general, deposition is not the time for finger-pointing. Do not access or review their records, or you may be deposed about them; review only what your attorney provides you (in which case, you may keep it confidential within attorney-client privilege).

During Deposition

• Pay attention to your attorney. They may object to certain questions and may also give you nonverbal clues when they sense a trap. Physicians have even described their attorneys stepping on their toes under the table!
• Pause and reflect before answering. This helps you focus and gives your attorney an opportunity to object if necessary. Only answer once the question is complete and you know exactly what is being asked; ask for clarification if needed. Some examples:
  • If the attorney asks you run-on questions, ask for them to be broken down.
  • If the attorney lists data before the question, ask to see the data to confirm it and then clarify the question. Stop looking at the data before you begin to answer.
  • Be wary of hypothetical or vague questions—they want you to generalize yourself into a corner.
  • Beware the double-negative question—ask the attorney to rephrase until it’s clear, or answer in a full sentence that says exactly what you mean.
• Saying “you don’t know” or “you weren’t there” is preferable to vague recollections.
• Do not agree to calling any text or journal article “authoritative.”
• Take breaks when you need them. It’s usually a long day.
• When the deposition ends, do not talk about it with your attorney until you are well away from the building.
Ankles and Ultrasound

POCUS can help you evaluate and aspirate

by ARUN NAGDEV, MD

Septic arthritis of the ankle is an uncommon but devastating clinical entity representing 3 percent to 14 percent of all septic arthritis cases. Diagnostics can prove challenging, especially because systemic symptoms like fever and chills are present in fewer than 50 percent of cases. This forces clinicians to rely on nonspecific and often insensitive physical exam findings, such as pain with joint movement and axial loading.

In cases of clinical suspicion of a joint infection, point-of-care ultrasound (POCUS) is an ideal bedside tool to determine the presence of joint capsule effusion. Also, POCUS allows a safe and simplified method for joint aspiration.1–3

Ultrasound Examination of the Ankle

Using POCUS for ankle joint assessment starts with good positioning. Place the patient in the supine position with their foot in mild plantar flexion so that the sole rests against the bed. If possible, palpate the anterior tibialis tendon on the anteromedial aspect of the foot. This landmark is easily noted in most patients and acts as an easy starting point when using ultrasound to evaluate the tibiotalar joint.

The goal is to image just under the anterior tibias tendon or just medial to it. The space between the anterior tibias tendon and medial malleolus is free from tendons or arteries, allowing for an unobstructed evaluation of the ankle joint as well as a safe location for aspiration. We recommend using a high-frequency linear transducer because of the shallow depth of the tibiotalar joint (see Step 1).

We also recommend imaging the nonaffected ankle first to determine a true normal. Place the transducer over the distal tibia (with the probe marker oriented caudally) and visualize the bright hyperechoic line of its bony cortex. Slowly slide the transducer toward the ankle until you are over the space between the tibia and talus (see Step 2). A joint capsule effusion will be an anechoic (dark) fluid collection just above the tibiotalar joint and is clearly seen on ultrasound. A superficial cellulitis and/or abscess can be easily differentiated from a deep joint effusion due to its location close to the overlying skin (see Step 3).

In patients with an obvious effusion of the joint capsule overlying the tibiotalar joint, the clinician can progress to performing the ultrasound-guided aspiration or call a consultant for assistance. Clinical judgment is needed to determine the need for aspiration because other noninfectious entities can produce joint capsule swelling (eg, gout, arthritis, etc.).

Ultrasound-Guided Ankle Arthrocentesis

Joint aspiration is an aseptic procedure (similar to lumbar puncture and central venous access). We recommend covering the transducer with a sterile probe cover. Use the ultrasound to again locate the joint capsule effusion, making sure the ultrasound screen is in your direct line of sight (ie, the system should not be located behind you—your ergonomics and comfort matter). Once the space is located, we recommend placing either a center line or M-mode line to confirm the middle of the transducer is directly over the joint capsule effusion. A skin wheal of 1–2 cc of anesthetic should be placed just adjacent to the medial aspect of the ultrasound transducer (see Step 4). This will be the location for the aspiration needle entry.

Stabilize the ultrasound transducer with your nondominant

CONTINUED on page 22
hand and have an 18–20-gauge 1.5 in. needle attached to a 5-cc syringe ready for aspiration. Because this is an out-of-plane technique, the operator will not be able to visualize the needle entering the joint capsule. However, in our opinion, this is easier overall given the limited space of the tibiotalar joint. Puncture the skin just medial to the midline of the transducer using a very steep angle (just below 90º). The clinician should aspirate as the needle is inserted into the joint capsule because the needle tip may not be clearly visible (see Step 5).

Note: In the photographs for Steps 4 and 5, the sterile cover is not placed over the transducer. These images are to demonstrate transducer and needle positioning.

Summary
POCUS evaluation for joint capsule swelling of the ankle can be an important adjunct in the diagnostic evaluation of a patient with a painful and warm lower extremity. A simplified ultrasound technique for visualizing joint capsule swelling of the medial tibiotalar joint can be rapidly performed at bedside. With this critical information, the clinician can more confidently decide whether to perform an ultrasound-guided joint aspiration (or call a consultant for assistance) to determine the presence of a septic joint.

References

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“Can We Pay You $100 to Not Get a CT?”
A recent study asked the question

by KEN MILNE, MD

The Case
A 24-year-old female enters the emergency department after experiencing a brief loss of consciousness after being hit while playing ice hockey. She feels fine and on evaluation has no complaints of any neurological symptoms, vomiting, or other injury. Her Glasgow Coma Scale score is 15; there is nothing to suggest an open, depressed, or basilar skull fracture; and she has no amnesia.

Despite the lack of indication for a computed tomography (CT) scan according to the Canadian CT Head Rule (CCHR), she insists on getting a scan “just to be safe.” You’d like to reassure her in an effort to decrease the risks associated with unnecessary testing and to control costs.

Background
The CT scan has become one of the most important diagnostic tests used in the emergency department. It facilitates the rapid identification of several life-threatening conditions. However, there is evidence that it can be overutilized. One specific problem is the overuse of head CTs. A retrospective study demonstrated that more than one-third of head CTs were not indicated based on the CCHR.

One way to decrease unnecessary head CTs is to use clinical decision instruments like the CCHR or the NEXUS Criteria. Despite the validation of these clinical decision tools, adaptation by physicians and acceptance by patients can meet resistance. Despite the validation of these clinical decision tools, adaptation by physicians and acceptance by patients can meet resistance.

A new study by Iyengar et al looked at ED patients given a hypothetical low-risk head injury case and assessed the impact a financial incentive as well as varying levels of risk and benefit had on their preference for having a CT scan.

Clinical Question
Can a patient’s preference for unnecessary head CT be influenced with financial incentives in conjunction with potential risk and benefit education?


• Population: Adult patients presenting to an academic emergency department.
• Exclusions: Patients with chest pain, head trauma, altered mental status, or contact precautions; patients treated in the resuscitation bays.
• Intervention and Comparison: A hypothetical low-risk head trauma scenario was presented. The clinical scenario suggested against imaging according to the CCHR. Three aspects of the scenario were randomized:
  • Benefit: Presented as either 0.1 percent or 0.01 percent.
  • Risk: Presented as either 1 percent or 0.1 percent.
  • Incentive: Patients were offered either no money or a $100 financial incentive to forgo the unnecessary CT. Multiple formats were used to present the potential risks and benefits, including percentages (0.1 percent), ratios (1 in 1,000), and visual depictions.
• Outcome:
  • Primary Outcome: Percentage of patients who would choose to get a CT scan.
  • Secondary Outcome: Multiple regression analyses to control for potential confounders.

Authors’ Conclusions
“Providing financial incentives to forego testing significantly decreased patient preference for testing, even when accounting for test benefit and risk. This work is preliminary, hypothetical, and requires confirmation in larger patient cohorts facing these actual decisions.”

Key Results
A total of 913 patients were enrolled. The median age was 45 years, and 46 percent of the population was female. The vast majority of this population identified as Caucasian and had attended at least some college. Overall, 54 percent of patients chose to get a head CT. The percentage of patients who chose to get a head CT decreased when the education and information provided by the clinicians was paired with the offer of $100. Subjects were also more likely to choose foregoing CT when the reported potential benefit was decreased or when the reported potential risk was increased.

• Primary Outcome:
  • When the potential benefit was reported as 0.1 percent, 49.6 percent of subjects wanted a CT; when the potential benefit was reported as 0.01 percent, 58.9 percent wanted a CT (odds ratio [OR], 1.48; 95 percent confidence interval [CI], 1.13-1.92).
  • When the risk was reported as 0.1 percent, 59.3 percent of people wanted a CT; when the risk was reported as 1 percent, 49.2 percent wanted a CT (OR, 0.66; 95 percent CI, 0.51-0.86).
  • When no money was offered, 60 percent of people wanted a CT; when $100 was offered to forgo the CT, 48.3 percent of subjects wanted a CT (OR, 0.66; 95 percent CI, 0.49-0.83).

• Secondary Outcomes: When adjusted for various potential confounders including age, gender, race, income, level of education, and prior history of health problems, the results remained consistent.

Evidence-Based Medicine Commentary
1. External validity: The vast majority of this population was highly educated and Caucasian. There was also a high percentage (24 percent) who worked in health care. This might impact the external validity to other practice populations.
2. Health literacy: The authors did a good job explaining the potential risks and benefits of each scenario in multiple ways. However, in the group told the CT would confer a potential benefit of only 0.1 percent, with a 1 percent harm, 50 percent of people still wanted a CT scan. That means even among subjects who were explicitly told their chance of harm was 10 times their chance of benefit, half still wanted a head CT. This may suggest that the patients did not really understand the meanings of these numbers or that the immediate potential benefits described to them were seen as more valuable than delayed potential harms.
3. Unintended consequences (ie, increases in ED visits for low-risk head injuries): Would offering cash result in a perverse incentive for a patient to present multiple times to the emergency department with a reported low-risk head injury in the hopes of getting $100 not to get a scan? This would have

CONTINUED on page 26
change our behavior, the only thing that mat-
ters is real-world data on what works to support us. 
Here, I will concentrate on the clinically rele-
vant outcome data for various indications and 
practical aspects comparing IV to oral 
antibiotics. Once armed with this knowledge, 
we should feel more comfortable prescribing 
and turning to surgery is easier. The risk of suicide for veterans is 
50% higher than for non-veterans. The highest rate of 
American veterans die by suicide each day is 17 veterans. 
In one study, 93% of veterans think the VA should offer 
voluntary ways for at-risk veterans to reduce their access to 
firearms. The West has the highest rate of veteran firearm suicide rate in the past decade (23% for non-veterans). 
Purchasing firearms is closely followed by the South. 
Firearms suicide fatality rate is 85% (5% with other methods). 
Gun ownership increases the risk of suicide 3x. 
Of veterans own guns (20% of non-veterans). 

**VETERANS & FIREARM INJURY**

**EVERY DAY 17** veterans die from suicide

**VETERANS HAVE 50% HIGHER risk of suicide than other Americans**

**33% INCREASE IN VETERAN FIREARM SUICIDE RATE IN THE PAST DECADE** (23% for non-veterans)

**THE WEST HAS THE HIGHEST RATE OF VETERAN FIREARM SUICIDES, FOLLOWED CLOSELY BY THE SOUTH**

**FIREARMS SUICIDE FATALITY RATE 85%** (5% with other methods)

**3x OF VETERANS OWN GUNS** (20% of non-veterans)

**IN ONE STUDY, 93% OF VETERANS THINK THE VA SHOULD OFFER VOLUNTARY WAYS FOR AT-RISK VETERANS TO REDUCE THEIR ACCESS TO FIREARMS**

Compiled by Andrea Austin and Megan Ranney, MD, MPH, for AFFIRM Research (www.affirmmaresearch.org). Visit ACEPNOW.com for the sources of these statistics.

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48 hours of oral antibiotics. They then are 
needlessly switched to IV antibiotics. There 
is no evidence to support this practice. Treat-
ment failure of simple cellulitis should only 
be entertained after a 48- to 72-hour trial of 
oral antibiotics. Even in many of these cases, 
switching classes of oral antibiotics is suffi-
cient. IV antibiotics are not the automatic an-
terior to “treatment failures.”

**Community-Acquired Pneumonia**

One of the most common reasons for hospital 
admission is pneumonia. Several RCTs study-
ing treatment approaches in both adults and 
children with community-acquired pneumo-
nia have been performed. In comparing oral 
and IV antibiotics, there are no data to support the notion of an 
advantage to IV therapies in most cases.2,3,4 
A Cochrane review confirms this.5

**Febrile Neutropenia, Osteomyelitis, and Endocarditis**

Let’s step it up a bit and consider antibiotic 
route for cancer patients with febrile neutro-
penia. Many of us reflexively obtain blood 
cultures and initiate broad-spectrum antibi-
otic coverage for these patients without bat-
ting an eyelash. And yet again, a Cochrane 
review of 22 RCTs found that, in patients who 
were hemodynamically stable without evi-
dence of organ failure or obvious source of 
infection, oral antibiotics (or an early switch 
to oral antibiotics) is an acceptable alter-
vative to IV antibiotics.5 Both the mortality 
and treatment failure rate were similar between 
groups.

How about osteomyelitis? You guessed it—a Cochrane review of five RCTs found no 
statistically significant difference in remis-
sion rates between oral and IV antibiotics 
for patients with chronic osteomyelitis, and 
a recent RCT of more than 1,000 patients with 
bone or joint infection in The New England 
Journal of Medicine found that the one-year 
failure rate was similar between patients treated with six weeks of oral antibiotics 
compared to IV antibiotics of the same du-
ration.6,7

Finally, both an RCT from 1996 and a re-
cent one from 2019 found no advantage of 
oral over IV antibiotics in patients with en-
docarditis—the former compared oral directly 
to IV in drug users with endocarditis, while 
the latter compared patients with left-sided 
endocarditis in stable condition who had 
been on IV antibiotics for 10 days either con-
tinuing IV antibiotics or switching to oral an-
tibiotics.8,9,10 All-cause mortality, unplanned 
cardiac surgery, clinically evident embolism, 
and relapse of bacteremia were no different 
between groups.

**Bacteremia**

Surely, all patients confirmed to have bacte-
remia require at least five days of IV antibiotic treatment. Is nothing sacred? But again, in a recent study of almost 5,000 hospitalized patients with Enterobacteriaceae bacteremia, 30-day mortality was no different between patients who received oral step-down after an appropriate clinical response compared with continued IV antibiotics.6 The authors also found that early transition to oral antibiotics decreased hospital length of stay.

Complications, Efficiency, and Cost
Some patients are admitted to hospital for “IV antibiotics” when they can be safely discharged home on oral antibiotics. The cost savings to the health care system as well as decreased risk of nosocomial infections by avoiding admissions are considerable.7,8 There are validated decision tools to help us safely discharge such patients on oral antibiotics for a variety of conditions.9,10

Naturally, IV antibiotics are generally more expensive than their oral antibiotic equivalents. However, it isn’t only the direct cost of the drugs that needs to be taken into account, but also the indirect costs of using IV antibiotics compared to oral antibiotics. A United Kingdom study looking at nondrug costs of IV antibiotic therapy for patients admitted to hospital with pneumonia or intra-abdominal infections showed that preparation and administration of antibiotics was more time-consuming in those receiving IV antibiotics compared to those receiving oral antibiotics. Use of IV antibiotics is associated with significantly higher workload and additional costs that sometimes were more than the cost of the medications themselves.11 In the ED, it takes longer to administer IV antibiotics than oral medicines. Additionally, there are complications of IV antibiotics to consider, including extravasation injury, phlebitis, as well as local or systemic infection.12 The risk of bacteremia caused by a peripheral IV can be as high as 0.8%. Even antibiotic-associated diarrhea and secondary infections with Closstridium difficile have been shown to be more prevalent in ED patients given a single dose of IV antibiotics before being discharged on oral antibiotics compared to oral antibiotics alone.13

Take-Home Message
Taken together, these data support the argument that if we used oral antibiotics for most common infections in the ED, we could safely improve throughput and efficiency and decrease our patients’ suffering. So, next time you are faced with a stable noncritically ill patient with a UTI, cellulitis, pneumonia, osteomyelitis, or febrile neutropenia (who is not vomiting and has low aspiration risk), ask yourself whether IV antibiotics are necessary.

If we all chose oral antibiotics most of the time in these situations, we could improve ED efficiency and overcrowding, prevent complications associated with IV insertion, and save our health care system money while safely and effectively providing excellent care for our patients. Meet with your ED group to integrate oral antibiotics choices into your electronic medical records. That alone is likely to help nudge us and our colleagues in the right direction.

Chung C, Andrew Morris for his contribution to the EM Cases podcast that inspired this article.

References

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to be considered.

4. **Health inequities**: There are many examples of health inequities in society. Offering money not to have an unnecessary test may add to this problem. A $100 cash incentive may influence a patient at the lower end of the socioeconomic spectrum compared to a patient at the higher end. Do we really want to reinforce or increase health care gaps based on money rather than the potential benefits and harms of the intervention?

5. **Financial incentive**: Who would pay the $100 financial incentive? Would it come from the hospital? Private or public insurance providers? Would it be deducted from the patient’s copayment? (In this study, the cash was intended to be a reduction in one’s expected copayment.)

6. **Bottom line**: Money, potential risks, and potential benefits can all influence a patient’s behavior in requesting an unnecessary head CT scan.

**Case Resolution**

You explain to your patient that it is very unlikely she has a serious head injury based on the CCHR. After discussing the risks of a head CT scan and the negligible chance of benefit, she is happy to forgo the scan. Appropriate concussion discharge instructions are provided.

Thank you to Dr. Justin Morgenstern, an emergency physician and the creator of the excellent #FOAMed project called First10EM.com, for his help with this review.

**Remember to be skeptical of anything you learn, even if you heard it on the Skeptics’ Guide to Emergency Medicine.**

**References**


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