What The Hell Has BROWN Been Reading JOURNAL ARTICLES 10/2022

1

Ten Commandments Of Emergency Medicine

- ► Secure the ABCs, but carefully
- Remember Naloxone, Glucose, and Thiamine
- Administer a Pregnancy Test and sometimes a Bedside US
- Assume the Worst
- Do Not Send Unstable Patients to Radiology and Never Alone
- Seek Out the Red Flags
- Trust No One, Believe Nothing including yourself
- Learn From Your Mistakes
- Do Unto Others As You Would Your Family
- When in Doubt, Always ERROR on the Side of the Patient

2



Cefdinir and "Bloody" Stools

- Cefdinir 3rd gen cephalosporin = UTI, OM, pharyngitis and skin infections
- RED colored stools in kids mimics bloody stools
- When combined in the gut with iron containing products
- NO NEED for workup if fecal occult blood test (neg)

4

BY THE NUMBERS: SENSITIVITY OF UNENHANCED CT.ACEP NOW 17072

- ► Aortic Dissection Type A= 94%
- ► Aortic Dissection Type B=71%
- ► Appendicitis 91%
- ▶ Traumatic Blunt Abdominal Injury 64%

5

BY THE NUMBERS: MONKEYPOX ACEP NOW 7/2022

- First Discovered 1958
- ► First Human Case 1970
- Cases in The U.S. as of July 2022 2,891 Sept. 14, 2022 22,774 CDC 9/14/2022
 Washington DC 3.6X per capita rate of all other states
- Washington DC 3.6X per capital rat
 New York highest cases in country
- Symptoms Present in Lab-Confirmed Cases
 - FEVER 100%
 - RASH 95%
 - LYMPHADENOPATHY 85%

Chemical Antonia Multi-Antonia Caragelia Caracteritate (PCC). Specific Revealed Similaria Koenha (A Factor) FCC Is TA approved for reversal of Warfarin and is used of Il labelifor reversal of DOACs. Specific Reveal Agents Should be laced A RIETLATE ACENTS. Uberhorsberg Bieding or Chical Sie Bieding Events Should be Interfeat within Reversal Agent. Immodynamic Interfaulty. Upper Reveal Agents Should be Interfeat within Reversal Agent. Immodynamic Interfaulty. Upper Reveal Agents Should be Interfeat within Reversal Agent. ALL DOACs (Direct Oral Anticoa are recommended if available. tes (PCC). Specific reversal agents

uncontrolled bleeding requiring procedural intervention Critical Sites; airway, brain, pericardium, aorta, spine, eye, closed spaces at

BOTTOM LINE IS TO BRING ALL PILL BOTTLES WITH THE PATIENT

Warfarin, Apixaban, Rivaroxaban, Edoxaban, Dabigatran

7

Critical Issues in the Evaluation and Management of Adults Presenting to the Emergency Department with Seizures. Key Advance: ABEM Ann. Emerg. Med 4/2014

- 1. Emergency Physicians need not initiate antiepileptic medications in the ED for patients with first time provoked or unprovoked seizures.
- 2. Emergency Physicians need not admit patients with first time unprovoked seizures who return to their clinical baseline in the ED.
- ▶ 3. When restarting seizure meds in the ED IV or ORAL is OK.
- 4. Benzodiazepine Refractory Status patients should receive IV phenytoin, fosphenytoin, or valproate. Level B recommendation.
- 5. Level C recommendation IV levetiracetam (may move to B list), propofol, or barbiturates.

8

AVOIDING ROUTINE USE OF SUPPLEMENTAL OXYGEN FOR PATIENTS WITH SUSPECTED ACUTE MYOCARDIAL INFARCTION. Key Advances 2002

► The Routine ED Management of the Patient Suspected of AMI DOES NOT Require Supplemental Oxygen Unless their Oxygen Saturation is less than 90% or the Patient is in Respiratory Distress.

9

CRITICAL ISSUES in the EVALUATION and MANAGENENT of ADULT PATIENTS PRESENTING to the EMERGENCY DEPARTMENT with ACUTE HEADACHE.

 Use the Ottawa Subarachnoid Hemorrhage Rule: R/O SAH
 ED patients with normal neuro exam and peak headache severity within one hour of pain onset.

Presence of any criteria requires emergent neuroimaging.

- 1. <u>></u>40 years
- 2. neck pain or stiffness
- 3. witnessed LOC
- 4. onset with exertion
- thunderclap headache
 limited neck flexion on exam

10

HEADACHE CONTINUED

- Preferentially use non-opioid medications in the treatment of acute primary headaches and ED patients.
- A normal non-contrast head CT (minimum third generation scanner) performed within six hours of symptom onset in an ED headache patient with a normal neurologic examination, maybe used to rule out nontraumatic SAH.
- Perform lumbar puncture or CT angiography to safely rule out SAH in the adult ED patient who is still considered to be at risk for SAH after a negative non-contrast head CT result.

11

HEART SCORE IN ED PATIENTS WITH CHEST PAIN. KEY ADVANCES ABEM 2022

- Emergency physicians are recommended to use the HEART score and pathway as a clinical decision aid. Depending on local and individual patient resources, patient with a low (0-3) HEART score may be discharged from the ED with follow up.
- Subjects with a low HEART score (0–3) have less than 3% (2.5%) risk of MACE (major adverse cardiac event) at six weeks after presentation.
- HEART= History, ECG, Risk Factors, and Troponin
- MACE= acute myocardial infarction, stroke, cardiovascular death, unstable angina, and heart failure. (definition may vary somewhat.)

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13

Critical issues related to opiates in adult patients presenting to the emergency department KEY ADVANCES

- When possible, treat opioid withdrawal in the ED with <u>buprenorphine or methadone</u> as a more effective option compared with non-opioid-based management strategies such as the combination of alpha-2 adrenergic agonist and anti-emetics. Preferentially treat opioid withdrawal in the ED with <u>buprenorphine</u> rather than methadone.
- Preferentially prescribe <u>non-opiate analgesic</u>, therapy rather than opiates as the initial treatment of acute pain in patients discharged from the ED. For cases in which opiate medications are deemed necessary, prescribe the lowest effective dose of a short acting up early for the shortest time indicated.

- Ponot routinely prescribed opioids to treat an acute exacerbation of non-cancer chronic pain for patient's discharge from the ED.
 Do not routinely prescribe, or normally caused to be <u>co-prescribed</u>, a simultaneous course of opioids and benzadiazepines (as well as other muscle relaxants/sedative hypnotics) for treatment of an acute episode of pain in patient's discharge from the ED.

14

Emergency department selection of acute ischemic stroke patients for potential endovascular reperfusion therapy. KEY ADVANCES ABEA 2022

- Emergency physicians should evaluate every acute (<24 hours since symptom onset) stroke patient as a potential candidate for mechanical thrombectomy.
- Randomized trials have shown that the patient most likely to benefit from mechanical thrombectomy has an NIH stroke scale 2.6, evidence of a large enterior circulation vessel acclusion with salvageable brain tissue on advanced imaging and are functionally independent at baseline.

ACUTE STROKE Continued...

DAWN INCLUSION
 Adult with NIHSS ≥10
 Disability mRS*** ≤ 1 prior to acute stroke
 No evidence of any cerebral hemorrhage on CT or MRI
 No evidence of infarct involving >1/3 middle cerebral artery territory
 DEFUSE INCLUSION
 Adult with NIHSS ≥6
 Disability mRS***≤_2 prior to acute stroke (functional for all ADLs)
 Endovascular treatment can be initiated between six and 16 hours of
 stroke onset.

***Modified Rankin Scale BOTTOM LINE: FIND OUT LAST KNOWN NORMAL

16



17