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EMpulse

Official Publication of the Indiana Chapter of American College of Emergency Physicians

The 2017 INACEP Annual Conference will be held at the Marriott North Indianapolis Hotel April 26 -27, 2017

Look for registration information late fall

Inside this Issue

A View from the Top

By Lindsay Weaver MD, FACEP (INACEP President)

If you are anything like me, you may have grown weary of the media coverage for this presidential election. It seems that every day brings another inflammatory story. Few seem relevant to daily life. Almost none discuss the problems and issues we see in our emergency departments. It is safe to say, the presidential nominees have never had a young woman, unresponsive and dying from an overdose, dropped off at the front door of their work. They have never cared for a retired schoolteacher in heart failure because he couldn't afford the copay for his medications. They have never told a mother and father there is nowhere for their son to go for his severe depression and active suicidal thoughts. The focus on tax records and possible illnesses may even lead you to feeling entirely removed from the political process. Add on top of that an ever-growing number of government requirements and demands on our daily workflow. You may feel helpless and that there is nothing you can do to influence change. However, I assure you it is not true! I have personally seen the physician voice make a real difference for emergency care here in Indiana. No matter where you fall with your political beliefs, you can be the difference maker for your patients, your practice and the future of emergency medicine. While our ability to affect the presidential election is limited to our vote (please vote!) at least here in Indiana, you do have a real opportunity to have your ideas and concerns heard.

The next several months will be interesting. Please think about what you want the future of emergency medicine to look like for you, your patients and Indiana and consider showing up and speaking up.

It is easy. You have to show up and speak up. You cannot influence change if you are not there. In my experience, politicians at all levels are interested in the experience and expertise of physicians. They recognize the unique perspective emergency physicians have as the safety net of the healthcare system. They also acknowledge they could find themselves as our patient at anytime. If there was ever a time to get involved, the time is now. Here in Indiana, the long-standing chair of the Senate Health Committee, Senator Patricia Miller, retired this past year. She was a big supporter of physicians and was sympathetic to the concerns of Indiana ACEP. It is unclear who will take over Senator Miller's role, but it is imperative that we are there to introduce emergency medicine in Indiana to the new chair. We must also be there to offer support and our expertise as new issues are brought to the attention of our legislature.

Since 2010, Indiana ACEP has co-hosted a legislative reception with the Indiana University Emergency Medicine residency. Legislators, including those from the house and senate

continued on page 11

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What's Normal About Normal Saline?

by Matt Sutter MD, FACEP (INACEP Board Member)

0.9% saline (so called normal saline) for intravenous infusion is used extensively in emergency departments around the world. I've personally ordered it given thousands of times, as have most of the readers of this article. It's only recently that I've given thought as to whether it's the best choice for my patients.

The first reported IV saline infusions were given in the 1830's in England during cholera epidemics. It was thought that injecting "hyper-oxygenated salts" into the venous system would restore the "black blood of cholera" to its normally oxygenated state. A saline solution was trialed in a dog and soon thereafter used in human patients. The saline solutions quickly showed great promise, saving a number of lives at the time. The solutions were a varied mix of sodium chloride, sodium carbonate, sodium bicarbonate and others. Most of these solutions were hypotonic, but the "hyper-oxygenated salt" theory was quickly replaced with an attempt to create artificial serum.

The first recorded use of the words "normal saline" were in 1888 in the Lancet referring to a solution of sodium chloride, phosphate and bicarbonate. It bore no significant resemblance to 0.9% saline. The first solution similar to 0.9% saline was in 1896 by the Dutch chemist, Hartog Hamburger. Hamburger had performed a number of in vitro studies of red blood cell lysis that suggested that an isotonic fluid might be best for human use.

Despite being isotonic, 0.9% saline is not otherwise particularly physiologic. It contains 154 mEq/L of Sodium and 154 mEq/L of chloride with an osmolarity of 308. The pH as delivered is quite acidotic at about 5.5. It reliably produces a metabolic acidosis (although not because of the solution pH but rather because it dilutes the buffering bases in serum). There is also concern about the high level of chloride in saline compared to serum. Chloride rich solutions are linked with renal vasoconstriction and associated with higher rates of kidney failure in critically ill patients.

While there are no randomized controlled trials to guide practice, some recent retrospective articles show an association with 0.9% saline and worsening mortality and morbidity. Raghunathan, et al., (Critical Care Medicine 2014) reports a lower risk of in-hospital mortality in critically ill sepsis patients who were resuscitated with balanced fluids rather than saline. Shaw, et al, (Annals of Surgery 2012) showed lower mortality and fewer major complications after open abdominal surgery in patients receiving Plasma-Lyte compared to those getting 0.9% saline. Marik, in Annals of Intensive Care, goes so far as to dub aggressive saline resuscitation as "Iatrogenic salt water drowning". In addition, he calls use of 0.9% saline, a liberal fluid resuscitation strategy, and CVP > 8 the "Deadly Trio".

So what's a simple Emergency Physician to do? We've seen the pendulum swing towards high volume fluid resuscitation for sepsis. While I don't think there's any convincing evidence that small amounts of 0.9% saline worsen patient oriented outcomes, I've become very uncomfortable with giving 3-4 L of "normal" saline. Ringers lactate and Plasmalyte certainly seem to be more physiologic and avoid the metabolic acidosis in patients who may have other reasons to be acidotic (like shock). So, while I'm not completely swearing off saline, I'm certainly looking at other options.

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Why is saline so acidic (and Does It Really Matter?) Reddi. International Journal of Medical Sciences (2013) 10(6): 747-750.

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Major complications, mortality and resource utilization after open abdominal surgery: 0.9% saline compared to Plasma-Lyte. Annals of Surgery. 2012 May;255(5):821-9.

Association between the choice of IV crystalloid and in-hospital mortality among critically ill adults with sepsis. Critical Care Medicine. 2014 Jul;42(7):1585-91.

Iatrogenic salt water drowning and the hazards of a high central venous pressure. Marik. Annals of Intensive Care 2014 4:21.

INACEP would like to congratulate one of our own,

John McGoff, MD, FACEP

on becoming the first Emergency Physician to be elected as:

President-Elect of the IN State Medical Assoc.

He has served as Speaker of the House for the ISMA for 3 years, and has previously served as President of the Indianapolis Medical Society and as President of INACEP.

Congratulations John!

2016 Fred Osborn Award Winner – Chris Burke, MD

In 2010, the Indiana ACEP board established an "Excellence in Emergency Medicine" annual award in memory of Dr. Fred Osborn who passed away in 2009. Dr. Osborn, along with being a top quality person, contributed extensively to the practice of emergency medicine in his group, hospital, community and the state. As such, an award was established in his memory to be presented annually at the Indiana ACEP Education Conference each spring. The individual nominees are evaluated in regard to their leadership skills, involvement and contributions at the community, regional and state level.

The 2016 winner of the Fred Osborn Award for Excellence in Emergency Medicine is Chris Burke MD, FACEP. John McGoff MD, FACEP presented this prestigious award to Dr. Burke at the Indiana ACEP conference in May. Below are excerpts from the nomination applications that Dr. McGoff & Dr. Chris Ross sent to us when nominating Dr. Burke for this award:

Dr. Burke's contributions locally, at the state level and nationally are well known amongst the EM Community. He is a past INACEP president, a former head of the national ACEP Reimbursement Committee and is frequently called upon to weigh in on complicated financial matters with regards to EM practice. Whenever an issue comes up in the state legislature regarding billing or reimbursement, he is one of the first people sought out to give an opinion.

Dr. Burke is exactly what you want in a leader. He clearly places the interest of the group and of Emergency Medicine as a whole ahead of himself. He has graciously committed a large portion of his time voluntarily over the past two decades to ensure fair reimbursement for EM physicians here in Indiana and nationwide. For this, we all owe Dr. Burke thanks.

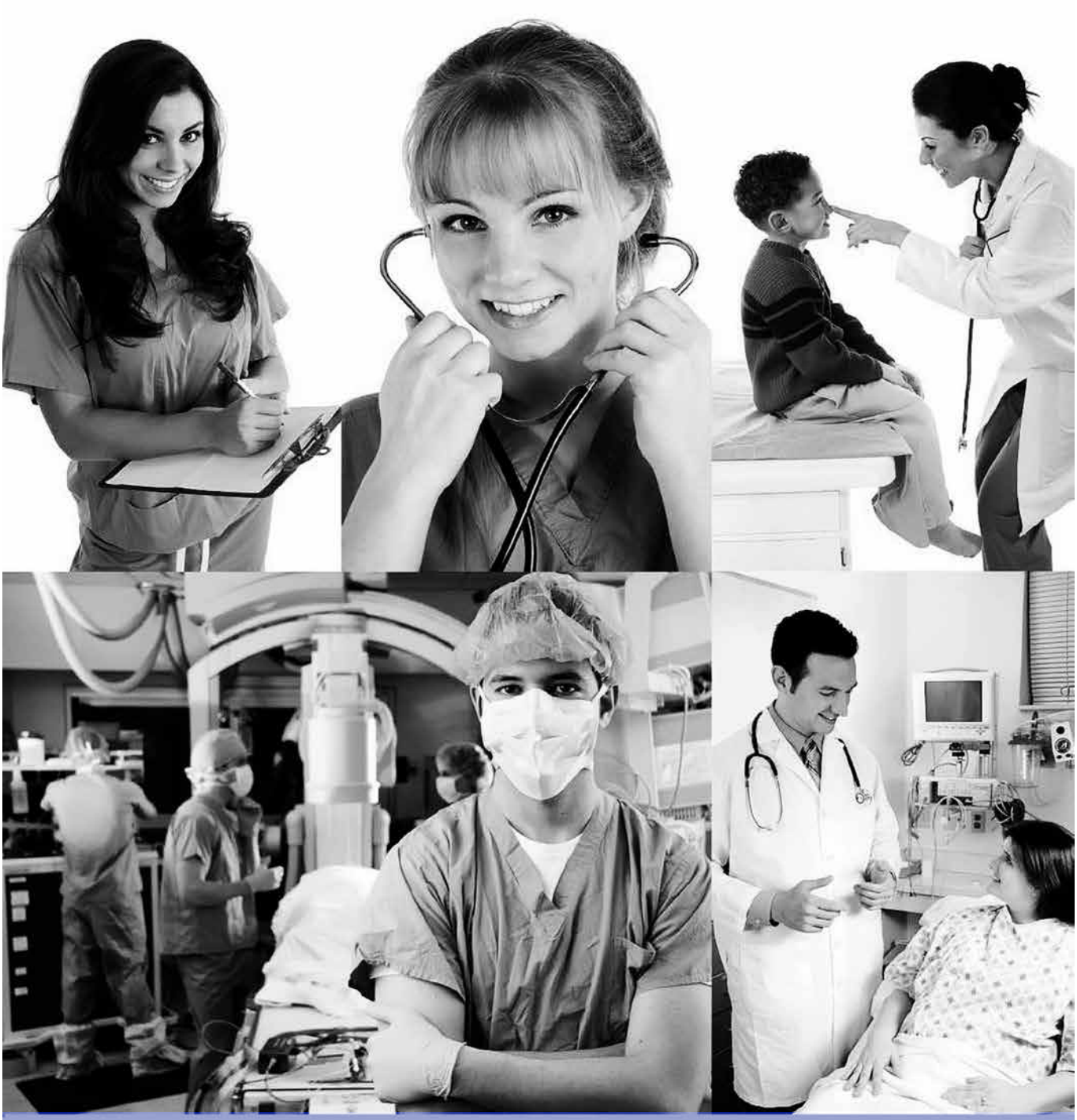
Dr. Burke is a recognized leader in emergency medicine in the state of Indiana and on a national level. His diligence has resulted in significant contributions to the financial benefits of all Hoosier emergency physicians. As a good friend of Dr. Osborn, I can attest that this award would truly be a culmination of a fabulous career in emergency medicine.

Congratulations Dr. Burke!!!

Please be thinking about leaders you know and work with who would be potential nominees for next year's award. Details and nominating template are available in this EMPulse.

From left to right: Kristyn, Jennifer, Andrew, Dr. Chris Burke, Lauren and Margie Burke

John McGoff MD, FACEP presenting Chris Burke MD, FACEP with the Fred Osborn Award



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Jeffrey Brakora MD
Matthew Connelly MD
Daniel Holt MD
Edgar Petras MD
Nicholas Pettit DO

Regular Members:

Tyler Arnold MD

New INACEP Fellows

Congratulations to the following INACEP Physicians that are becoming Fellows:

Sheila Kay Pittenger MD, FACEP - Fort Wayne, IN

Gregory Pittman MD, FACEP - Cordon, IN

Jonathan Schmitz MD, FACEP - Indianapolis, IN

Lindsay Weaver MD, FACEP - Indianapolis, IN

100% ACEP Groups

The following IN Groups are 100% ACEP.

Elkhart Emergency Physicians, Inc.

Emergency Physicians of Indianapolis

Indiana University Health Physicians

Professional Emergency Physicians, Inc.

Congratulations and Thank **you** to these groups for their support of ACEP!

New National INACEP Headquarters

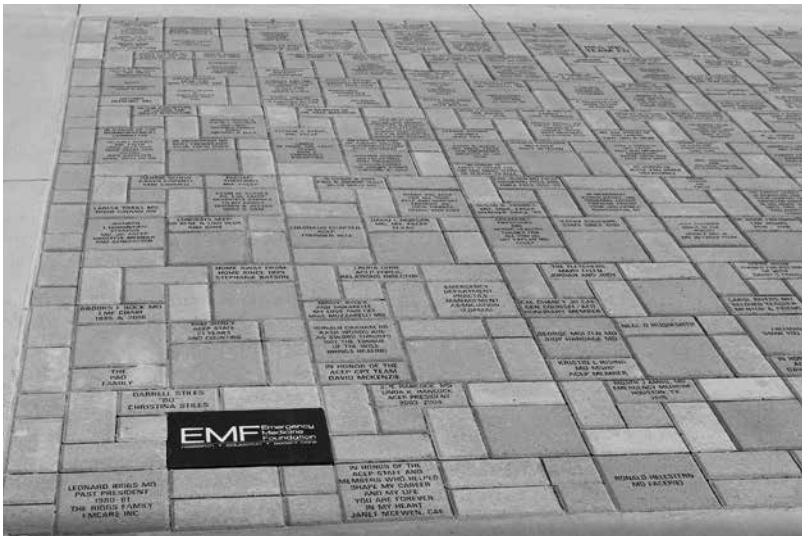
The National ACEP headquarters was located in the same 30,000 square foot building for 30 years and in that time the College's membership, finances, and activities tripled in size. ACEP staff more than doubled. There became a serious need for a more energy-efficient building that did not require as many repairs, that utilized current technology, that had more amenities for visitors, room for meetings and conferences, and most importantly was adequate in space to allow the ACEP staff to do the critical work to support their growing membership and mission.

After extensive analysis by ACEP's management team, Finance Committee and Board of Directors, the College purchased six acres of land in June of 2014 and broke ground on a new 60,000 square-foot facility near Dallas-fort Worth airport in April 2015.

On Tuesday, September 12, 2016, ACEP held the grand opening of their new headquarters, and INACEP Board member JT Finnell MD, FACEP was in attendance.

Thanks Dr. Finnell for providing the following photos:

James Cusick MD, FACEP Council House Speaker, JT Finnell MD, FACEP, Tony Cirillo MD, FACEP



Just outside your new headquarters is your EMF Paver Walkway, which is paved with your contributed pavers demonstrating your perpetual support for your Emergency Medicine Foundation. Pavers are still available for those who would like to permanently place their name at your new headquarters. Go to: https://www.emfoundation.org/brick/default.aspx.

JT Finnell MD, FACEP and ACEP Board Member Paul Kivela MD, MBA, FACEP

Front of the new National ACEP Headquarters, 4950 W. Royal Ln. , Irving, TX 75063

Legislative Update

by Lou Belch, Lobbyist for INACEP

Things at the Indiana State House are quieting down as members of the General Assembly turn their focus on the November election. All 100 seats in the House of Representatives will stand for election as will 25 members of the Senate.

The Interim Study Committee on Public Health, Behavioral Health, and Human Services has met once thus far to study its assigned topics. The first meeting included a detailed discussion on heroin use in the state of Indiana as well as medication assisted treatment. Members of the Committee seem poised to recommend additional funding for treatment, and are less interested in additional regulation on prescribers. INACEP lobbyists will continue to monitor this Committee.

INACEP Lobbyists met with House Insurance Committee Chairman Rep. Martin Carbaugh (R-Ft. Wayne) at his request. Chairman Carbaugh is interested in exploring the issue of balance or surprise billing. Balance or surprise billing occurs when a patient is seen at an in-network facility and is treated by an out-of-network provider. Usually the patient's insurer does not honor assignment of benefits, and the provider bills the patient for the care.

Several States have addressed this issue in a number of ways. Ranging from an outright ban on the practice to a fee schedule. The Chairman would like to strike a balance between the patient's interests and the right of the provider to negotiate a fair contract. INACEP will be working with the Indiana Hospital Association and the Indiana State Medical Association to come to a satisfactory conclusion.

INSPECT

INACEP has been working with the INSPECT program staff to develop an initiative for Emergency Department Integration. The State is working with a vendor to create a program to integrate INSPECT into EHRs. The vendor will charge a onetime $7,500 connection fee and $50 annual fee per provider. In working with Governor Pence's staff and INSPECT program staff, INACEP has negotiated for the State to pay the annual fee for up to 30 providers at every facility and to fund the onetime connection fee for emergency departments in the State that apply for available grant funding awarded to the INSPECT program by the CDC. The program is being piloted by Deaconess Hospital in Evansville. Gina Huhnke, MD, FACEP, Vice President of INACEP, is participating in the pilot. Once completed, the program will go live.

Watch the EMPULSE and the website **www.inacep.org** for more information.

Fred Osborn Award Nominations Format

In 2010, the Indiana ACEP board established an annual award in memory of Dr. Fred Osborn, who passed away in 2009. Dr. Osborn contributed extensively to the practice of emergency medicine and to his group, hospital, community and the state. As such, the Fred Osborn Excellence in Emergency Medicine Award was established in his memory to be presented at the annual Indiana ACEP Education Conference.

The recipients of the award to date have been as follows:

2010 - Peter Stevenson MD, FACEP of Evansville, IN
2011 - David VanRyn MD, FACEP of Elkhart, IN
2012 - Thomas Madden MD, FACEP of Bloomington, IN
2013 - Thomas Gutwein MD, FACEP of Fort Wayne, IN
2014 - Tom Richardson MD, FACEP of Danville, IN
2015 - Randall Todd MD, FACEP of Indianapolis, IN
2016 - Chris Burke MD, FACEP of Carmel, IN

The Indiana ACEP board is now accepting nominations for this year's consideration. The individual nominees will be evaluated in regard to their leadership, involvement and contributions to their emergency medicine group, hospital, community and state. To nominate a worthy physician, please submit a single typed page detailing the qualifications of a deserving emergency physician whom you know which includes the information included in the template below.

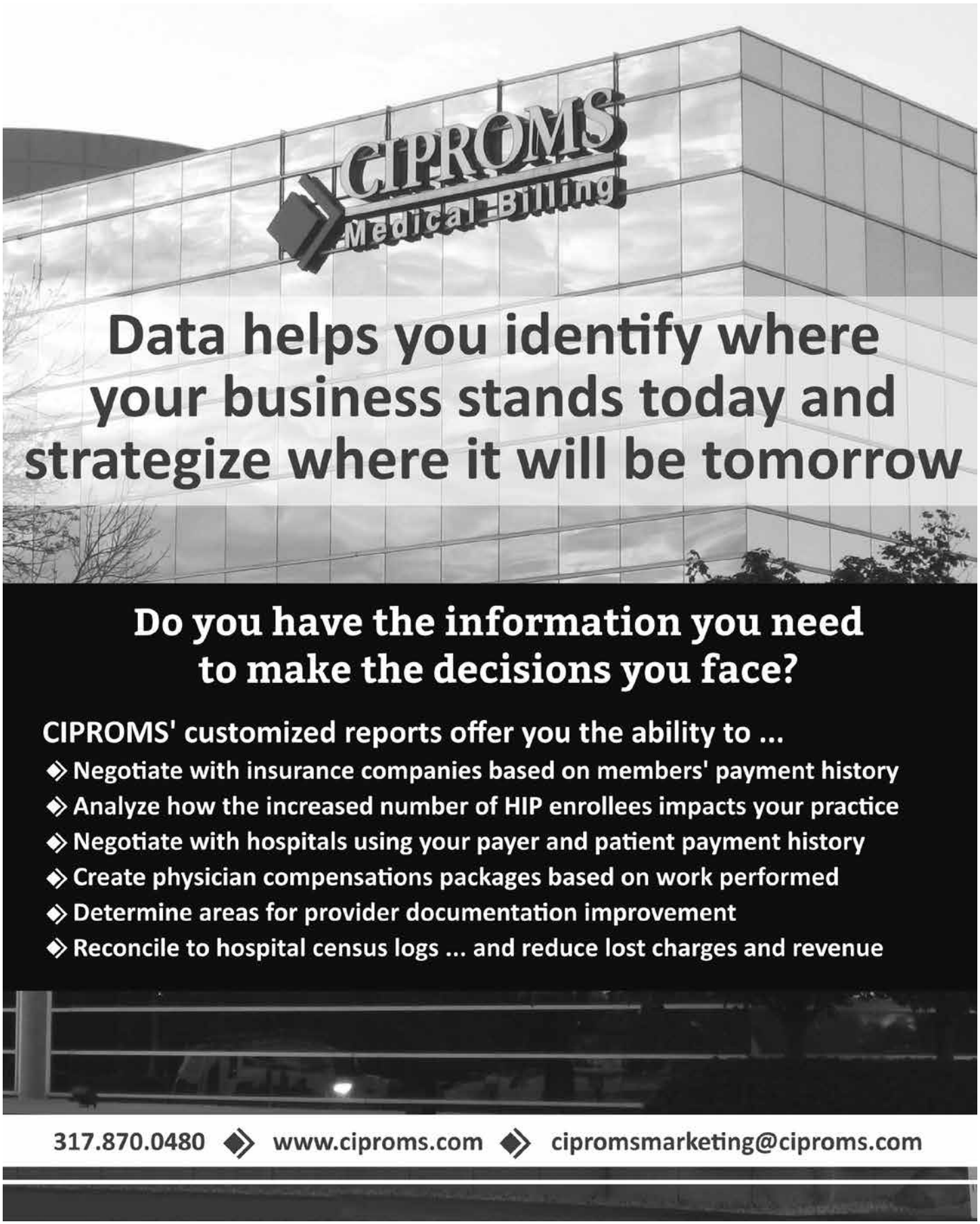
The nominated person must be an emergency physician currently practicing in the state of Indiana and be a current member of Indiana ACEP. The person making the nomination however need not be a member of ACEP nor a physician.

All submissions are due by December 31st, 2016 and are to be submitted electronically to sue@inacep.org.

Nominations must include the following information:

- Name of Nominating Person
- Name of Nominee
- Date of Nomination
- Nominee's Positions of Leadership
- Nominee's Involvement / Contributions to their Group
- Nominee's Involvement / Contributions to their Hospital
- Nominee's Involvement / Contributions to their Community
- Nominee's Involvement / Contributions to their State
- Additional Comments

Please limit submissions to a single, typed page detailing the qualifications of a deserving emergency physician whom you know. **Please remember:** The individual nominees will be evaluated in regard to their leadership, involvement and contributions to their emergency medicine group, hospital, community and state.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Case Report: Taeniasis

by Nathan Whitmore MD, Emergency Medicine Resident PY3 and Audrey Herbert MD, Assistant Professor of Clinical Emergency Medicine, IU School of Medicine

Overview

HPI: A 22-year-old French-speaking woman presents to the ED after noticing a worm hanging from her anus. She brought the worm with her to the ED in a container. She notes one week of non-bloody diarrhea with associated abdominal cramping for several months. She moved from Niger to the US sixmonths ago. She denies any exposure to animals, livestock or raw or undercooked foods. She does not eat pork, but does eat beef.

Exam Findings And Workup

Physical Exam: The patient was a well-appearing, 70 kg-female with normal vital signs. Her conjunctiva and mucus membranes were clear and normal in appearance with no pallor. Her abdomen was soft, non-tender, non-distended, and no hepatosplenomegaly or masses. On rectal exam, there were no worms present. Examination of the Styrofoam container contents revealed a one-meter long tapeworm.

Work-up: The diagnosis of a tapeworm infection was obvious in this case. However, since the treatment is dependent of the species type, the tapeworm was sent to pathology for species determination. A CBC with a differential cell count was drawn to assess for anemia and eosinophilia, but did not reveal evidence of such.

Diagnosis

Taeniasis.

Management

Infectious disease was consulted and the decision was made to defer treatment until the species was determined by pathology. The tapeworm was sent to pathology and outpatient follow-up with infectious disease was made. The patient was seen in clinic two weeks later where it was believed the patient's source of taeniasis was due to T. saginata based on the patient's denial of pork consumption and affirmed consumption of beef. The final pathology report was not yet available at the clinic visit but she was treated with a single 600 mg dose of praziquantel. Follow-up was on an as needed basis. Eventually, the pathology report revealed the source of the patient's taeniasis was ultimately due to T. solium despite the patient denying pork consumption. Unfortunately, at the time of this case report, there were no additional follow-up appointments in the patient's electronic medical record.

Fig. 1 Tapeworm in Styrofoam container

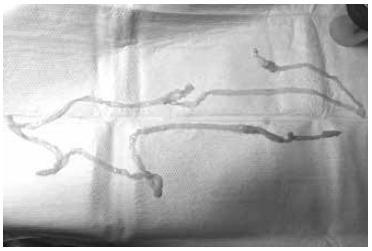

Fig. 2 Removal of tapeworm from container revealed its true size.

Discussion

There are three species of taeniasis (tapeworm) for which humans are the only definitive hosts. T. saginata, T. solium, and T. asiatica. Taeniasis occurs worldwide1, but is most common in areas where the consumption of undercooked pork and beef take place. The typical lifecycle begins when livestock become infected upon ingesting vegetation contaminated with eggs or gravid proglottids. Once infected, the worms spread hematogenously from the intestine to muscle. Embedded in muscle, the worms develop into cysticerci, which can subsequently infect humans if ingested in the form of undercooked meat. Once consumed by humans, the cysticerci release multiple protoscolices with each protoscolex having the potential to become the head of an adult tapeworm. Intestinal tapeworms have the potential to survive for years in the small intestine all the while releasing proglottids in the stool. Clinical manifestations of taeniasis vary from patients being asymptomatic to experiencing episodes of nausea, vomiting, or abdominal pain.

Praziquantel is the treatment (off-label) of choice for all intestinal tapeworm infections2, 3. The dose is dependent on the species5 and in the case of T. solium (pork tape worm) a single dose 5-10 mg/kg is recommended6. A lower dose of 2.5 mg/kg has been demonstrated to be effective in the treatment of T. saginata (beef tapeworm) infection6. Niclosamide is an alternate treatment that can be used if praziquantel is not available . A single dose of 2 grams for adults, 1 gram for children weighing 11-34 kg, and 1.5 grams for children weighing greater than 34 kg is recommended1. Of note, niclosamide is not available in the United States.

Conclusion

In the majority of cases, patients who present to the ED in the United States with taeniasis can have treatment deferred until the culprit species can be determined. Patients should have the initial workup started in the ED and referred to infectious disease as an outpatient if applicable. Otherwise, a single dose of an anticestode such as praziquantel will cure most cases.

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Organizations or individuals that want their message to reach emergency physicians in Indiana will find the ***EMpulse*** their number one avenue. The ***EMpulse***, published four times per year, is mailed to members of the Indiana Chapter of the American College of Emergency Physicians. This highly focused group includes emergency physicians, residents and students.

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The ***EMpulse*** is published 4 times per year. The **2016 Ad Deadlines** are: February 21, May 22, August 21 and January 8, 2017 (subject to change). Publication dates are approximately March 15, June 15, September 15 and January 25, 2017.

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A View from the Top

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health committees, have visited our emergency departments and participated in open discussions about healthcare in Indiana. IUEM residents and Indiana ACEP members have given presentations to legislators regarding psychiatric boarding, opiate abuse, on-call physician shortage, the lifeline law and INSPECT to name a few. We have also played an integral role in forming and passing legislation. Last year, Representative Bacon authored a bill to address Indiana emergency medicine physicians' concerns about the Indiana death certificate statute. Indiana ACEP members met with legislators and testified in committee concerning the difficulty of assessing cause and manor of death in the ED. The Indiana ACEP endorsed bill was made into law on March 21, 2016.

What exactly can you do? First of all, vote. Second, let us know your concerns and what you are seeing on a daily basis. Indiana ACEP members alerted us to the problems surrounding death certificates across the state. We immediately took action and were able to pass legislation within a few months. Third, consider contributing to a Political Action Committee (PAC.) You can make a contribution to IEMPAC through our website at www.inacep.org. This year, Indiana ACEP will host a dinner with key legislators for groups and individuals that contribute to the Indiana ACEP PAC. It will be an opportunity to speak one on one with legislators about what you see on a daily basis. Fourth, join us in Washington DC for the annual ACEP Leadership and Advocacy meeting as an opportunity to speak to national legislators. Lastly, do not hesitate to visit, call or email your elected legislators. Again, in my experience, they do pay attention to your concerns and opinions as a recognized leader in your community.

The next several months will be interesting. Please think about what you want the future of emergency medicine to look like for you, your patients and Indiana and consider showing up and speaking up.

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