Volume 25, Issue 1 **Spring 2016**

EMpulse

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

Coming Events

2016 Annual Conference
May 5–6, 2016

Resident Forum
May 5, 2016

Sheraton City Centre Hotel, downtown Indy

Inside this Issue

A View from the Top

By James Shoemaker MD, FACEP (INACEP President)

I hope this edition of *EMpulse* finds you and your family happy and content as we anxiously await Spring. The landscape of Emergency Medicine continues to change at both the State and National level and I would like to give you some highlights. In mid-January, members of the INACEP Board of Directors and several EM Residents from the IUSOM Emergency Medicine Residency Program visited the Indiana Statehouse to address several Legislators and lobbyists about bills and pending legislation that could impact the medical community. Worth mentioning were bills addressing signing of death certificates by emergency physicians, methamphetamine legislation, medical malpractice changes and use of INSPECT.

Although their schedules were very busy, some Legislators found time to accommodate our Board. Representative Ron Bacon (R–Chandler, IN) talked to us about his bill addressing the protocol in the preparation of a death certificate. Indiana law states that if the cause of death is known, the physician last in attendance is responsible for signing the death certificate, thus minimizing the delay and allowing families to make burial arrangements in a timely manner. Since Rep. Bacon is keenly aware of the emergency physician's concerns with signing death certificates (more-times-than-not, we do not know the patient or actual cause of death), he has helped to put in place safeguards to minimize this circumstance for EM physicians. House Public Health Committee Chairwoman, Cindy Kirchofer (R–Beech Grove, IN) , also took time to talk with BOD members regarding SB 80 and SB 161, the Senate's pseudo-ephedrine bill. It was truly a pleasure speaking with her and she was keenly insightful and strongly in support of our presence at the Statehouse. Her background as a Risk Manager for Franciscan St. Francis Health gives her a great perspective as the Public Health Chair. Those attending the Statehouse were also privileged to meet with Mike Rinebold, Director of Government Relations for the ISMA, to discuss the implications of the IN Medical Malpractice proposed changes as well as current and upcoming ISMA "calls for action".

> ***It seems that for every "win" in the House of Medicine (e.g. SGR repeal), the government or commercial insurers continue to throw us curveballs and challenges to our reimbursement.***

In case you missed the surprising news, the Medical Malpractice Bill, SB 152, was pulled from the committee hearing by Sen. Brent Steele (R–Bedford, IN). SB 152 proposed increasing Indiana's Medical Malpractice cap from $1.25 million to $1.65 million, tying future increases of the Cap to

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Father, Physician and Husband

by Jonathan Steinhofer MD, FACEP (INACEP Board Member)

As emergency physicians I feel as though we try and do the best we can to keep our personal and professional lives separate. We like the idea of being done with a shift, not being on call, taking off the 'white coat' and going home, feeling that we have no further commitments until the next shift. We try and forget about the elderly dying patient we placed in hospice, the 3 week old infant we had to do a lumbar puncture on, or the death notification we had to deliver. We go home and try and forget about all that. However, I don't think it has anything to do with lack of empathy, it has do with the ability to carry on a successful home life. We simply cannot carry these things home. And, as emergency physicians, I feel we do a very good job with this - otherwise I don't think any of us would be in this specialty. Rarely however, these two worlds come crashing together. Somehow your personal life walks into the ER and you have to deal with it, whether it's yourself, a loved one, a neighbor or a friend calling from across the country about their ER experience, inevitably these worlds will cross. It was just such an experience that happened to me a few months ago that I would like to convey.

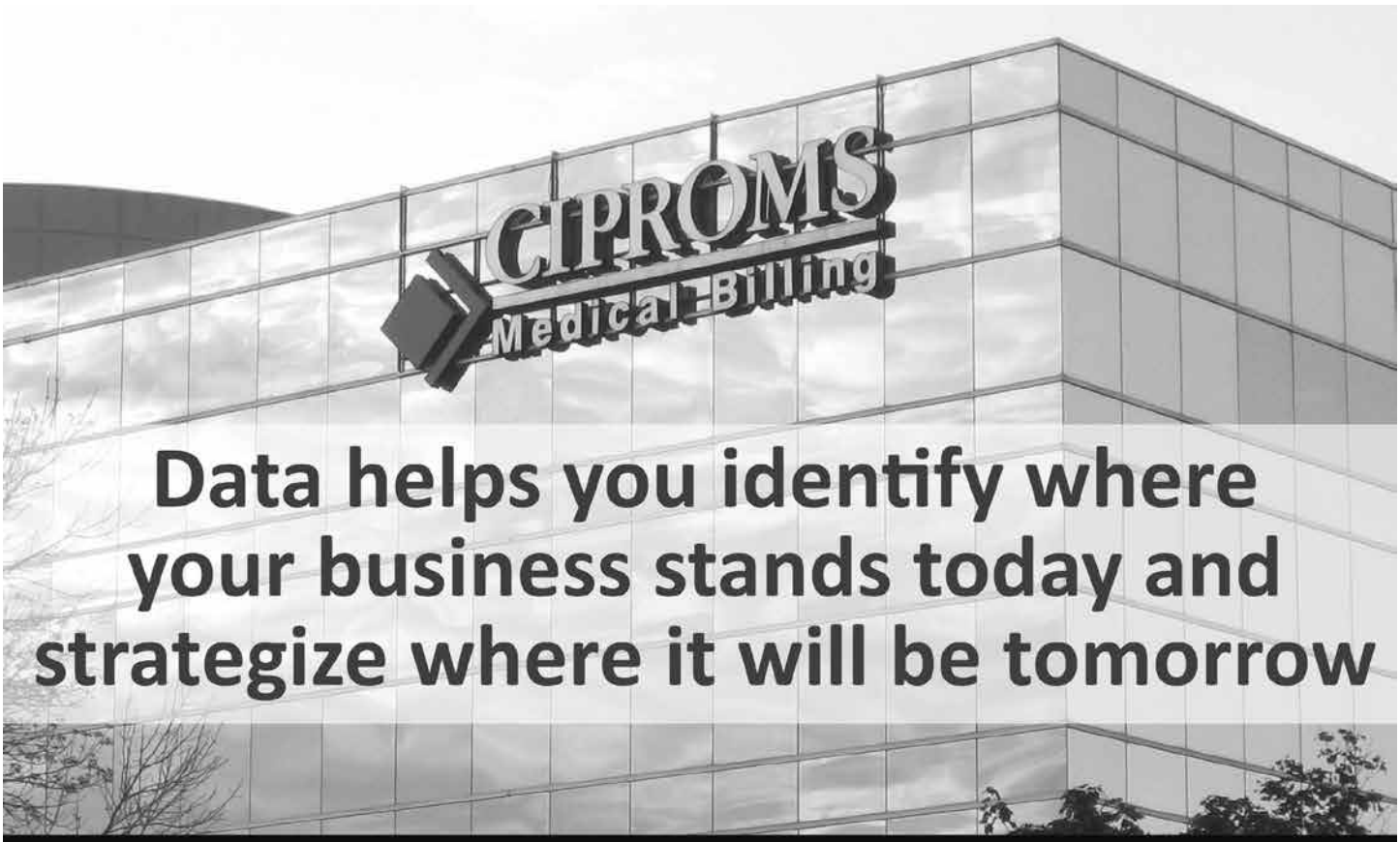
I was excited that night as it was my last of 7 night shifts in a row followed by a week off. A quick 8 hours in the ED, then I'd be off for an entire 7 days, which is honestly what pushes me through that last night. It was a great shift, started busy as always but nothing out of the ordinary. That was, of course, until I got that dreaded call that every physician, husband, and father dreads: "Honey, I'm coming in to the ER, I'm having horrible abdominal pain." I should preface by saying my wife who had called was about 23 weeks pregnant at the time with our first child. As first time parents, we had been having a fairly uneventful pregnancy, your typical ultrasounds, appointments, etc., with little excitement until then. Honestly, it really hadn't registered for me that I was going to even be a father yet. And, as I get the call around 1 am on my cell phone, my mind suddenly goes in a million different directions. What could be going on? Abruption? Miscarriage? Appendicitis? Furthermore what goes through my head was what am I going to do about it. I was now single covered in one of the busiest ER's in Northeast Indiana, with our night shifts never exactly being 'slow' and barely enough time to grab a bite to eat, let alone worry about a pregnant wife.

Luckily my parents live close by and were able to drive my wife, who was in excruciating pain, to the ER. Since she was 23 weeks they took her directly to labor and delivery, and I was lucky enough to find a Spectra-link phone and run across the hall to see that she was still breathing and give her a kiss before I needed to get back to my full emergency room with 10 in the lobby.

It's 2 am and I'm supposed to be compassionate to the drug seeking back pain patient, the snotty nosed kid who has a fever and the 95 year old lady who comes in with 'generalized weakness'. Now maybe everyone else can separate their emotions better at a time like this, however at 2 am, having worked 7 nights straight, my wife in L&D screaming in pain, I have to say I was struggling to focus. I'd worked my way through four or five patients when I got a call from her obstetrician that it 'didn't appear to be OB related' and that they were sending her to the ER. Another flux of emotions, ecstatic that everything was ok with the baby, however still worried about what could be wrong with my wife, and more over dreading the fact that I was now going to have to treat her.

I was alone in a solo covered busy ED at 3 a.m. with my 23 week pregnant wife screaming in pain. So now what? What would you do? Call in a partner to help cover? Even if I could find someone who was awake, off, and sober, it would have been at least an hour before someone would have been able to get in. So I went in, and tried to separate the 'Father, Physician, and Husband' in me. I did a thorough exam (minus the pelvic) and history and did my best to be the non-biased physician. And in all honesty it became pretty clear that she had ureteral colic. She had had kidney stones previously and had described a sudden onset of flank pain with nausea. And so I had a working diagnosis, I ordered my labs, urine and both renal and fetal ultrasound, and went on to see other patients. But now I also carried the dilemma of how I should be treating her. Would you give your 23 week pregnant wife narcotics for her pain? Nubain? What kind and how much of antiemetics? How much fluids? All of a sudden I was second guessing myself on a diagnosis I'd treated hundreds if not thousands of times. Keep in mind however that during this time a cardiac arrest comes in, followed by a neonatal fever that requires me to place a central line and do a lumbar puncture.

Eventually the diagnosis was simple enough, she did have a small stone, improved with fluids and pain control and after checking on her a few times an hour she was feeling improved enough to go home around 8 am when my shift was ending. However that night begs the question that we as emergency physicians I think try and aspire to with each and every patient: How would you treat this patient if she was your wife, your child, your mother? In the end I think all of us would say that we treat all of our patients the same, but just consider how you think you would do with treating your pregnant wife who is lying on a gurney in agony? How would you deal with that and the drug seeking patient in the adjoining room who has been to the ED 12 days this month already? Would you treat them both the same?



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Expand Your Point-of-Care Ultrasound Skillset: Focused ENT Sonography

Introduction

Pain of the head and neck region, odynophagia, facial swelling, and neck swelling are common causes of presentation to acute care facilities. The history and physical examination findings are commonly inadequate for diagnosis. Focused ear, nose and throat (ENT) sonography has emerged as a valuable diagnostic tool for the rapid evaluation of facial and neck symptoms. Ultrasound can distinguish abscesses from cellulitis and/or lymphadenitis in patients with superficial facial swelling. Ultrasound can also be utilized to diagnose a variety of other pathologic conditions such as lymphadenitis, salivary gland pathology, and other neck masses. Intraoral ultrasound can be used for quick bedside evaluation for peritonsillar abscess (PTA) and procedural guidance during PTA drainage. Ultrasound is also a useful modality for the rapid evaluation of patients with facial trauma to diagnose facial fractures. This can be particularly useful in clinical settings where CT and x-ray are not available.

General Scanning Technique

Higher frequency linear transducers (7.5 MHz or higher frequency if available) enhance image resolution and are ideal for evaluation of the superficial ENT structures. When evaluating an area of interest that is very superficial, an acoustic standoff pad can be used to improve image resolution. Identification of adjacent structures, such as vessels nerves, can help minimize procedural complications. Always scan the opposite side or adjacent area for comparison. Endocavitary transducers combine the benefits of high frequency transducer with a small footprint that can be placed in direct contact with the tonsils.

Peritonsillar Abscess

Peritonsillar abscess (PTA) is the most common deep infection of the head and neck, most commonly affecting young adults [1]. PTA typically forms in the superior pole of the tonsil [2]. Clinical differentiation of PTA from peritonsillar cellulitis can be difficult, leading to the need for imaging or for blind needle aspiration (3). Blind needle aspiration has a reported false-negative rate of 10-24% and the risk of complications including puncturing the carotid artery (4). Intraoral ultrasonography can be rapidly performed at the patient's bedside. Other benefits include lack of ionizing radiation and low cost compared to CT. Prior studies have demonstrated the ability of the emergency physician to effectively use intraoral ultrasound for both the diagnosis of PTA and procedural guidance for needle aspiration [4,5,6].

Scanning Technique – cover the endocavitary probe with a gel filled glove or condom and place directly over the area in question after adequate topical and systemic analgesia. Systematic scanning in both sagittal and transverse planes should be performed. The normal tonsil is visualized as a small (10–20 mm) homogeneous oval structure with a low-level echo texture (Figure 1A). Peritonsillar cellulitis appears as an enlarged tonsil (>20 mm) with a homogeneous echo texture (Figure 1B). A peritonsillar abscess most commonly seen as a hypoechoic or complex cystic mass, typical of most abscesses (Figures 1C, 1D). The carotid artery is identified as an anechoic tubular structure postero-lateral to the tonsil, usually within 5-25 mm of a PTA.

PTA Drainage -- an 18 gauge, 2 inch needle can be inserted under ultrasound guidance. (Figure 2). This allows tracking the entire course of needle and preventing complications such as puncturing carotid artery.

Facial Abscesses

Bedside ultrasound can identify whether an abscess is present, and is reliable in detecting the stage of infection in patients with superficial facial swelling.[7,8,9] Real-time ultrasound guidance can be used to drain an abscess. Following drainage, ultrasound can also help to determine if adequate drainage was accomplished.

Abscesses can take on a variety of sonographic appearances. Abscesses that are mostly liquefied tend to have a more hypoechoic or anechoic appearance. The most common appearance of an abscess is a hypoechoic mass relative to adjacent structures (Figures 3A, 3B, and 3C). Necrotic debris or tissue appear as complex masses with variable echogenicity. Septae and gas may also be found within the abscess (Figure 3C). Gentle pressure on an abscess may reveal swirling of the liquid components. Color Doppler may reveal hyperemia adjacent to the abscess cavity and absence of flow within it. Identify adjacent structures like arteries, veins, and nerves to assist with drainage.

Lymph Node Pathology

Normal lymph nodes are oval in appearance with length to AP ratio >2 and homogenous echo texture. The hilum of a normal lymph node appears echogenic. The Doppler- flow shows vessels branching radially from the hilum with no flow in the periphery [10] (Figure 4a & 4b). Local infection or inflammation of the pharynx, salivary glands, and scalp often causes tender enlargement of neck lymph nodes. The lymph nodes are still oval in shape but increased in size, and predominantly hypoechoic compared to the adjacent structures. The vascularity is still confined to the hilum on Doppler (Figure 4A and 4B).

An abnormal lymph node is round in appearance with heterogeneous echo texture and no echogenic hilum (Figure 4C). Other abnormal sonographic findings include cystic areas (intranodal necrosis) and calcifications. Irregular flow is seen with Doppler, completely in the periphery of lymph node in some cases. Matting or clumping of lymph nodes can also be seen.

Sialolithiasis/Sialoadenitis

Infection of the parotid gland can occur from viral (usually mumps virus) or bacterial (usually Staphylococcus) pathogens. Sialoadenitis in adults is often associated with sialolithiasis. > 80% of salivary concretions are localized in the submandibular gland or Wharton's duct, while approximately 15% of cases occur in the parotid gland or Stensen's duct. Sublingual lithiasis is rare. [11] The accuracy of ultrasound in the diagnosis of sialolithiasis is approximately 90% .[12]

Scanning Technique—the salivary gland's echogenicity and size should be assessed in transverse and longitudinal planes (with the head turned to the other side) and compared with the contralateral side. Evaluate for increased vascularity and ductal dilatation.

Sonographic Findings—salivary glands appear as homogeneous echogenic organs. Normal intra glandular salivary ducts and the Stensen's duct are generally not visualized. They may be seen on ultrasound when dilated, however. Wharton's duct is seen clearly when it is abnormally dilated, but may also be visualized in some normal cases.

The acutely inflamed salivary gland is diffusely enlarged and hypoechoic (Figures 6A and 6B). Other sonographic findings include localized ductal dilatation, retention cysts, and enlarged intra glandular lymph nodes. Using Doppler, hyperemia of the gland can be visualized. Sialolithiasis can be identified by visualization of the calculus, seen as a bright curvilinear echo line with posterior acoustic shadowing with associated dilation of the salivary ducts [13,14] (Figures 5B and 5C).

Thyroglossal Duct Cyst

Thyroglossal duct cyst is an epithelial-lined cyst located in the neck midline or near midline, between base of the tongue and thyroid. A majority of the cysts are related to the hyoid bone. The sonographic appearance is variable and is typically seen as an anechoic, well-circumscribed cyst (Figure 7A and 7B). Repeated infections or hemorrhages due to prior aspirations may result in a heterogeneous appearance.

Facial Fractures

Ultrasound has been used to evaluate for fractures in the nasal bones and other facial fractures.[15,16] Ultrasound has demonstrated high accuracy in the diagnosis of nasal bone fractures with sensitivity ranging from 90% to 100%, specificity of 98–100% [17,18]. Scanning Technique and Findings – image the area of interest in at least two orthogonal planes, typically the long and short axes. The sonographic findings include disruption of the cortical line and the step-off associated with the fracture. (Figures 8A and 8B).

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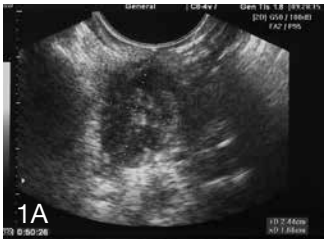
Expand Your Point-of-Care Ultrasound Skillset, continued: Focused ENT Sonography – FIGURES

1. PTA Illustration and Images



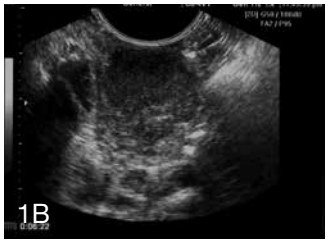
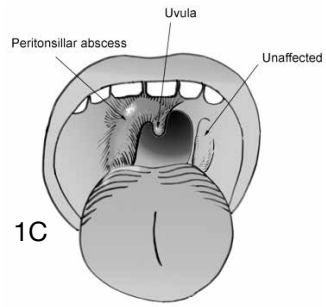


Figure 1A. Normal tonsil seen as an oval structure with homogeneous low-level echoes. Figure 1B. Peritonsillar cellulitis. Enlarged tonsil with a homogeneous appearance (solid arrow). Carotid artery seen in the far field (open arrow).



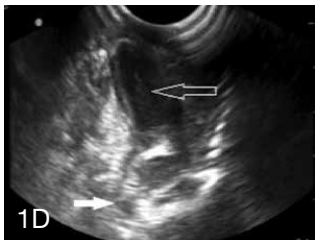


Figure 1C. An illustration of gross clinical appearance of a peritonsillar abscess (PTA). Figure 1D. The appearance of a PTA obtained with an endocavitary probe. The hypoechoic area within the tonsil is the abscess cavity (open arrow). The internal carotid artery can be seen in the far field (solid arrow). Color Doppler can be applied as needed to differentiate the artery (not demonstrated in this image). PTA illustration *(Courtesy of Michael Blaivas, MD).*

2. PTA Drainage

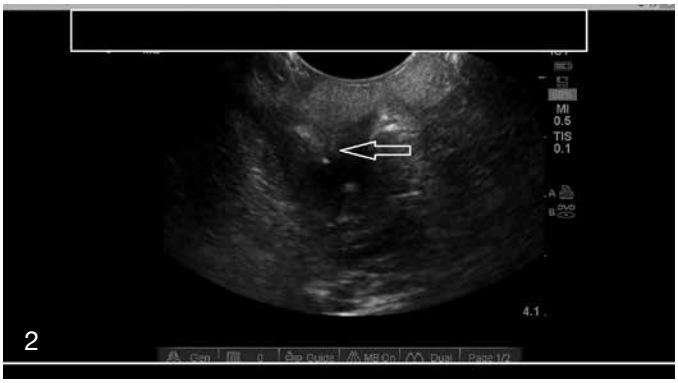
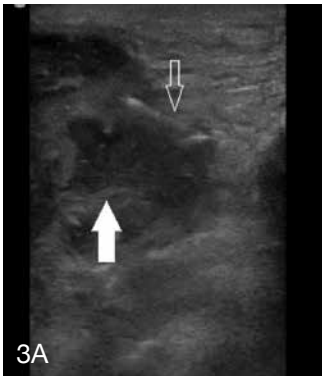


Figure 2. Ultrasound guided PTA drainage. The hyperechoic needle can be seen entering the abscess cavity.

3. Neck Abscess



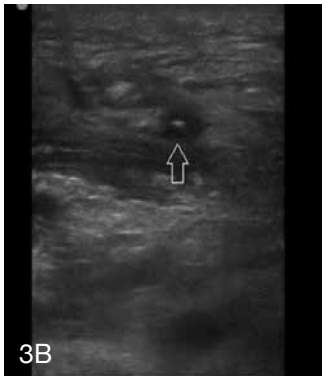
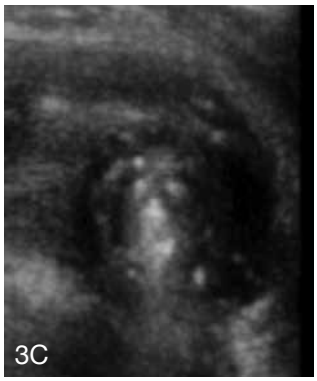
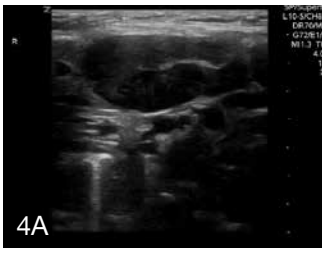
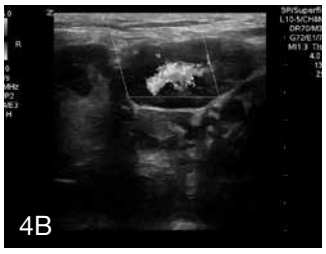


Figure 3A. A complex fluid collection in the neck (solid arrow) of a patient who reported use of IV drugs. A needle fragment was found in the superior portion of the abscess (open arrow). Figure 3B. A transverse image of the needle fragment (open arrow) surrounded by anechoic fluid. Figure 3C. A complex fluid collection with internal gas. The acoustic mismatch from the gas within the abscess appears as brightly echogenic spots with irregular "dirty" shadowing.

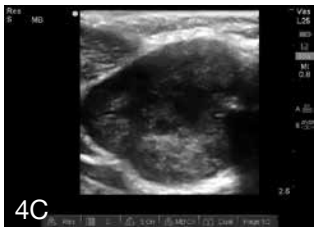


4. Lymph Node Pathology

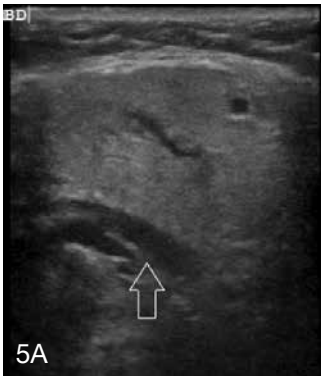


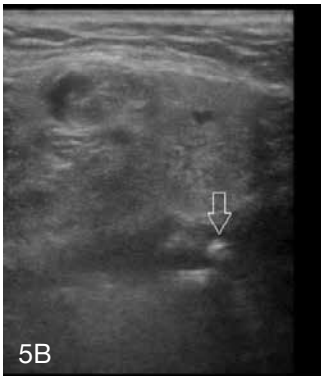


Figures 4A and 4B. An oval shaped reactive lymph node with an increase in size, predominantly hypoechoic, and vascularity is still confined to hilum. Figure 4C. Abnormal lymph node with heterogeneous echotexture and cystic areas. *(Courtesy of Michael Blaivas, MD)*

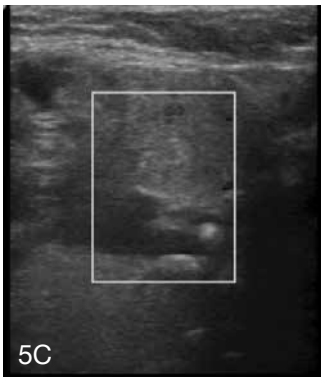


5. Sialolithiasis

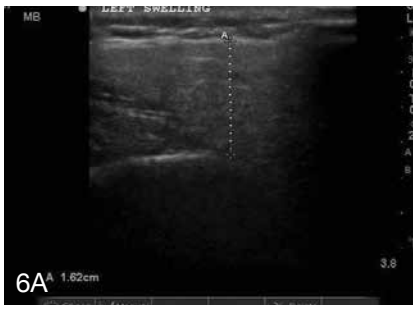




Images of the submandibular gland of a patient presenting with acute left lower face pain and swelling. Figure 5A shows the proximal portion of Wharton's duct (arrow), which was dilated. Following the duct distally, figure 5B reveals the echoic obstructing calculus (arrow), with posterior acoustic shadowing. Color Doppler was applied (Figure 5C), revealing no flow in the duct. Doppler can be used to help differentiate ductal structures from vessels.



6. Sialoadenitis



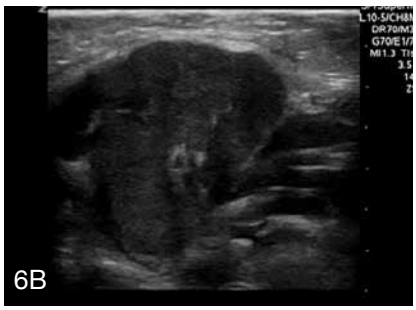
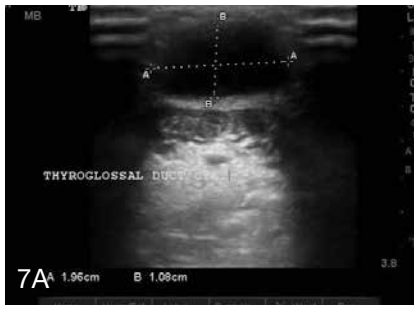
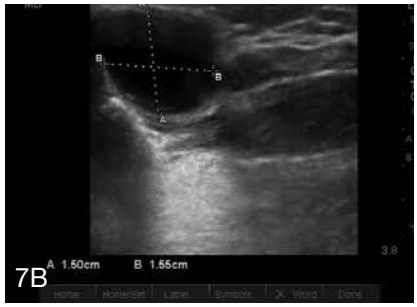


Figure 6A. Parotitis. The acutely inflamed gland is enlarged and hypoechoic. Figure 6B. Submandibular gland inflammation. The gland is heterogeneous with dilatation of the salivary ducts.

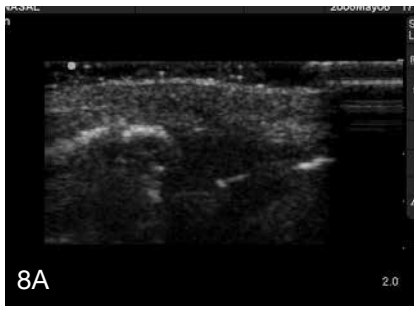
7. Non-Abscess Neck Mass — Thyroglossal Cyst





Figures 7A and 7B. An anechoic, well-circumscribed thyroglossal duct cyst with increased through transmission seen in short and long axes *(Courtesy of Jim Tsung, MD)*

8. Facial Trauma



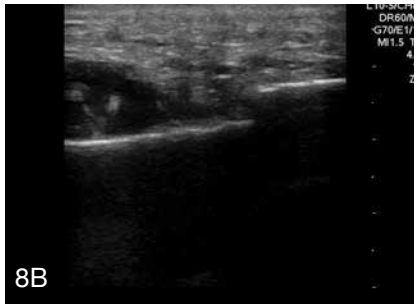


Figure 8A. Nasal bone fracture. Step off seen in the image *(Courtesy of Jim Tsung, MD).* Figure 8B. Mandibular fracture. Cortical disruption seen in the image.

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A View from the Top, *continued*

continued from page 1

the Consumer Price Index and allowing a patient to commence a medical malpractice action without submitting a complaint to the Medical Review Panel if the patient seeks damages not greater than $75,000. Current law states that if the amount is greater than $15,000 the Medical Review Panel must be called. Many Indiana physicians responded to the ISMA's "call for action" and contributed to this outcome. One of the hallmarks of Indiana's incredible medical climate for practice are the protections afforded to us by our State's 'gold standard' medical malpractice laws (i.e., requirement for a Medical Review Panel and damage caps) that shield physicians from frivolous law suits and cap damages to ensure our medical community remains attractive and affordable for physicians and health care providers. Don't be fooled by SB 152's current status – the law will be addressed and attacked again as we work towards some changes to ensure its constitutionality and viability. INACEP is fortunate to have the expertise of Lou Belch, President of Health Care Practice for the Corydon Group, as our lobbyist. He is integral in listening to the views of our Board and advocating on our behalf.

It seems that for every "win" in the House of Medicine (e.g. SGR repeal), the government or commercial insurers continue to throw us curveballs and challenges to our reimbursement. As one example, read the recent blog post from Myles Riner: (http://www.ficklefinger.net/blog/2016/02/04/anthem-declares-war-on-emergency-medicine-in-california) addressing Anthem's pre-payment reviews of all Medicare Advantage CPT 99285 charts. This is clearly not a level playing field due to EMTALA and our legal obligation to perform medical screening exams and stabilize all-comers to our emergency departments. The National ACEP Reimbursement Committee is aware of this practice and will follow it to ensure fairness in payment for services rendered by EM physicians in Indiana and throughout the country. On another front, Kevin Klauer, DO, EJD, FACEP wrote an outstanding opinion piece in the January 2016 *ACEPNow* (Vol 35) addressing the overly critical representation of the emergency department in the Institute of Medicine's 2015 publication "Improving Diagnosis in Healthcare" (http://www.nap.edu/catalog/21794/improving-diagnosis-in-health-care). Dr. Klauer succinctly outlines his concerns as they relate to Emergency Medicine, all-the-while highlighting the important issues addressed in the IOM's report. Clearly, the emergency department is a high risk environment and the ever-increasing pressures to pinpoint diagnoses in a "timely" manner and not make any mistakes is a huge undertaking. The IOM mentioned the emergency department 48 times in their report and did not mention EMTALA or its obligations once!

These are just a few of the ongoing issues facing our specialty. Advocacy on behalf of our specialty is essential to ensure fairness and representation as the landscape of medicine continues to change and payors continue their assaults on our reimbursement and bottom-line. I, along with several other members of the INACEP Board, will be attending ACEP's Leadership and Advocacy Conference in Washington, DC in mid-May. In this outstanding forum, ACEP leadership and members will discuss issues facing our specialty and how we can make a difference in outcome. We will be afforded the opportunity to meet with our Legislators on Capitol Hill and try to make a difference for emergency physicians everywhere.

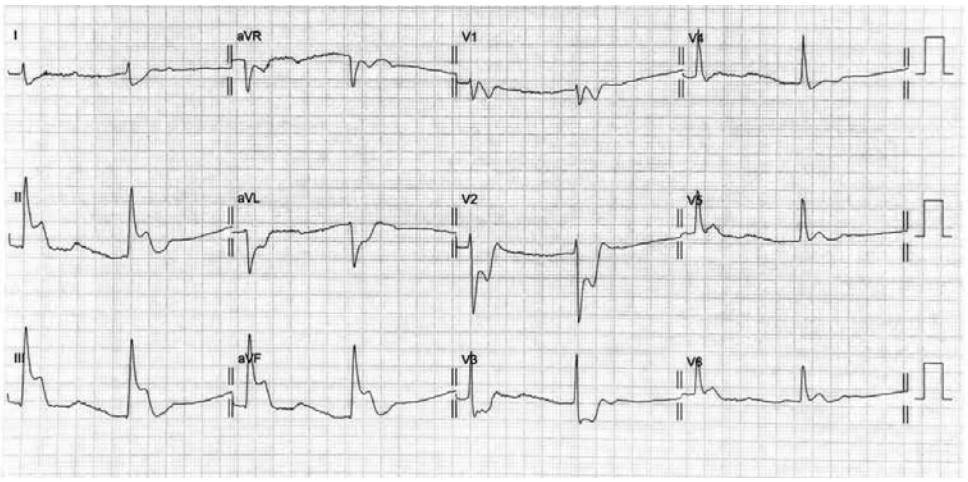
On behalf of the INACEP Board, we thank you, our membership, for allowing us the opportunity to represent you and to work to ensure that our specialty remains vibrant and fulfilling. And, we hope that you will all be able to join us May 5–6, 2016 for the next INACEP Annual Conference!

Case Report: Bee Ischemia

by Elaina DiOrio, MD; Rian Fisher, MD, EMS Fellow; Dan O'Donnell, MD, FACEP, Indiana University School of Medicine

Overview

HPI: You're working a busy shift when you get a call from paramedics who are 5 minutes from your facility with a 65 year-old male. He has a history of CAD with prior stents and COPD who has been stung by a swarm of bees. His wife reports he came inside after working in the yard and was diaphoretic. He collapsed on the floor and had a seizure. She denies any history of anaphylactic reaction. He is hypotensive (78/52), moaning, and cannot provide any additional history to the paramedics. The local protocol for severe anaphylaxis in your county is Benadryl (IV/IM), albuterol nebulizer, and two rounds of IM epinephrine. If the patient is still hypotensive, paramedics may give epinephrine 1:100,000 IV push, and titrate to effect. This patient has not received any of these interventions. However, before you can question the medics about their anaphylaxis treatment, they report his 12-lead EKG shows a massive inferior ST-elevation MI.



Exam Findings & Workup

Physical Exam: Upon arrival to the ED, he is profoundly diaphoretic, altered (GCS 8), hypotensive, and receiving respiratory assistance with a bag-valve mask. His pupils are equal and he withdraws all extremities to pain. There is no cardiac murmur and his lung fields are clear without wheezing. No rash or other skin changes are noted.

Work-up: The patient is urgently intubated in the ED and given aggressive fluid resuscitation. His EKG was repeated and is shown above. Echocardiography showed normal left ventricular function and no focal wall motion abnormalities. The troponin was elevated at 0.7. Interventional cardiology was also consulted, and they recommended serial troponins and a cardiac catheterization when more stable.

Diagnosis

Coronary artery vasospasm in the setting of anaphylaxis

Management

The patient was given aspirin prior to intubation, as well as nitroglycerin and IM epinephrine. The troponin level peaked at 1.0 and subsequent EKGs showed resolving ST elevation. The patient was extubated the next day and a catheterization on day 5 of his hospital stay showed patent stents and no significant occlusions. He was discharged and instructed to follow up with allergy and immunology specialists to undergo further testing of bee and wasp allergies. The patient was continued on his beta-blocker.

Discussion

Acute ST-elevation MI is a rare complication of an anaphylactic reaction. The exact pathophysiologic mechanism is unclear, although it is proposed that mast cell degranulation and release of cytokines cause coronary artery vasospasm. This "cardiac anaphylaxis" is more common in individuals with underlying ischemic heart disease, but it has been reported in young adults with normal coronary arteries[1]. Mast cell release also affects platelet aggregation and coagulation pathways and can predispose one to coronary artery thrombosis. Anaphylaxis can also unmask subclinical coronary artery disease. Although this is a complicated clinical situation, it is recommended to adequately treat the anaphylaxis, give aspirin, and consult a cardiologist. It is important to remember that there are no absolute contra-indications to giving epinephrine to patients with anaphylaxis, even those with a history of coronary artery disease, and a delay in time to administering epinephrine has been linked with increased mortality.[2]

REFERENCES:

1. Sampson, H.A., Mendelson, L., Rosen, J.P. (1992). Fatal and near-fatal anaphylactic reactions to food in children and adolescents. N Engl J Med, 327(6):380.
2. Soar, J., et al. (2008). Emergency treatment of anaphylactic reactions--guidelines for healthcare providers. Working Group of the Resuscitation Council. Resuscitation; 77(2):157.

Legislative Update

by Lou Belch, Lobbyist for INACEP

As this article is being written there are around three weeks remaining in the 2016 Session of the Indiana General Assembly. Please note that all of the bills being discussed have not had final disposition. The next *EMpulse* will update the new laws passed this session.

HB 1088, which allows death in an emergency department of the hospital to be referred to the coroner if the emergency physician is unable to certify cause of death, has passed the Senate Health and Provider Services Committee. The bill is eligible for final action in the Senate next week.

HB 1263, the telemedicine bill, was also heard in the Senate Health and Provider Services Committee. The bill was held for amendments and will likely pass. There continues to be broad support of the concept of expanding telemedicine. Sen. Miller has suggested that she will have an amendment that the Indiana malpractice laws and standard of care will govern the telemedicine encounter. Further, the bill will require the record of the telemedicine encounter be shared with the patient's self-designated physician.

There were discussions behind the scenes all session to make changes to the Indiana Medical Malpractice Act. While the issue was technically still alive, it is not likely to pass this session without the agreement of the Indiana State Medical Association who has not agreed to any increases. Legislative leaders, particularly in the Senate, have pushed hard to amend the Act, going so far as to make it one of their legislative priorities.

BULLETIN BOARD

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 2015 Ad Deadlines are: February 23, May 25, August 23 and November 22 (subject to change). Publication dates are approximately March 15, June 15, September 15 and December 14, 2015.

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Featuring Indiana Emergency Departments: Medical Associates, LLP

by Douglas Tannas MD, FACEP

This issue's featured emergency medicine group is Medical Associates, LLP, affiliated with the Community system in central Indiana. Dr. Chris Burke provided us with information about the group and hospitals. Dr. Burke told us that Medical Associates is the oldest EM group in the state, formed in the late 1960s. Twenty-nine emergency physicians and twenty midlevels form a democratic partnership. In the Indianapolis area, they staff Community Hospital East (84k visits/year), Community Hospital North (63k visits/year), and the Indiana Heart Hospital (5k visits/year). At the beginning of 2016, the group also began staffing Community Howard Regional Hospital in Kokomo (26k visits/year).

Department chairs are Drs. Jeremy Gagan (Community North and IHH), Paula Wilahm (Community East), and Rob McAllister (Howard). Dr. Burke served as Managing Partner of the group from 1991 until this year, when Dr. B.P. House assumed that role. Contacts within the group include Dr. House with respect to recruiting and Dr. Eric Vonderohe regarding disaster planning. Dr. Vonderohe has also served as EMS Director for 20 years.

In their Indianapolis facilities, the group adopted EPIC as an enterprise EMR system in 2013. Dr. Burke commented that "The transition from dictated records to an EMR was initially a little bumpy, but employing scribes from day one has proven to be invaluable. They have become an integral part of our team. Most everyone is very comfortable using the EPIC system, and productivity is at least back to 'pre-EMR' levels, if not above. At Howard, we are unfortunately stuck with using Cerner for 2016, before they transition over to EPIC next year, but the use of scribes there as well has helped significantly."

Medical Associates members serve as preceptors for the Butler University physician assistant program, and also precept two third-year medical students from Marian Medical School in the ED at Community East each month. They also work with residents in the family practice program at Community, and a residency in psychiatry will be starting in the next year.

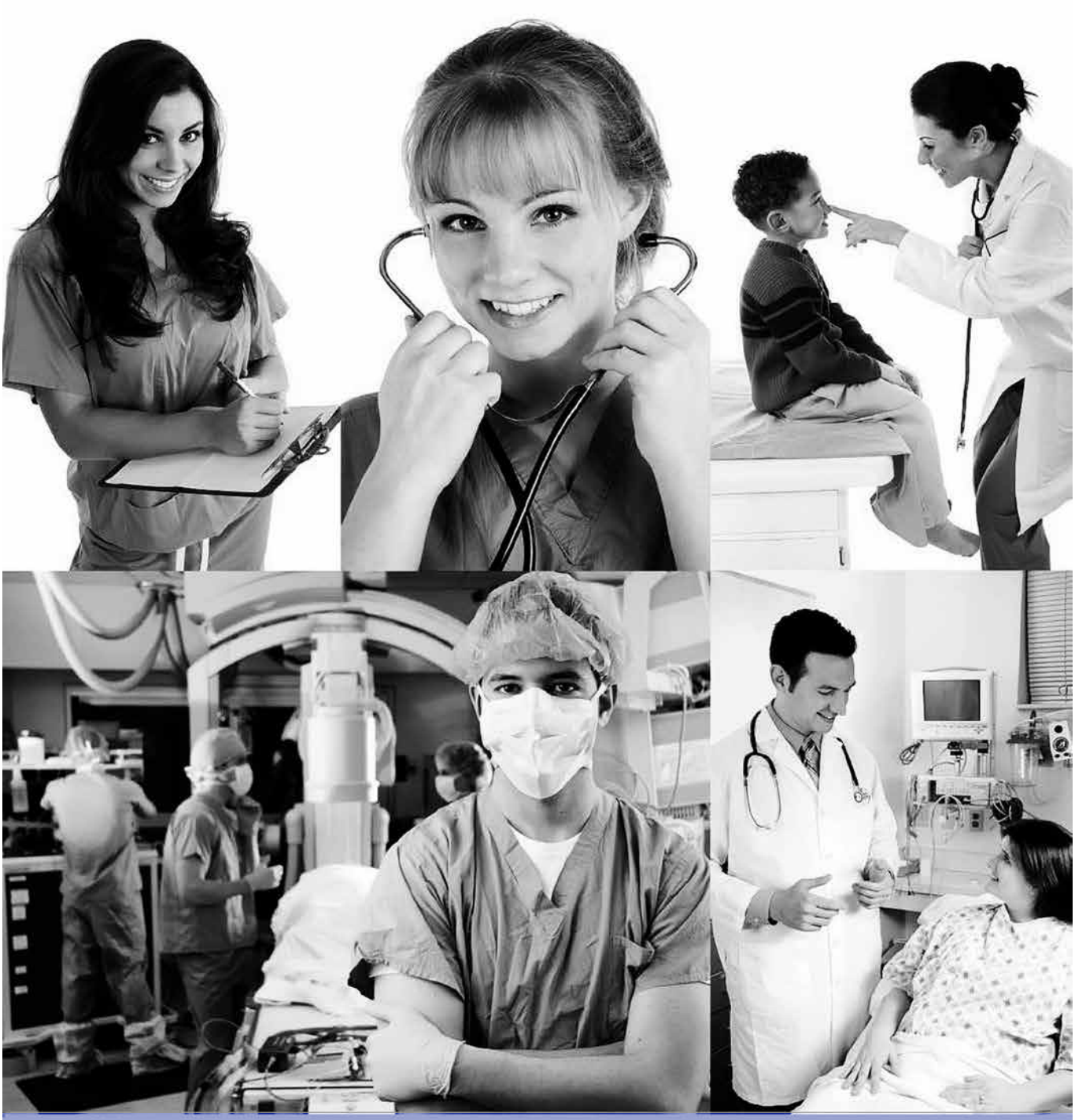
Regarding challenges faced by the group, Dr. Burke said, "As we look to future growth, our biggest challenges (like most other EM groups in Indiana) will be in recruiting high-quality EM physicians".

Thanks to Drs. Burke and House and to their colleagues at Medical Associates for being featured in this edition of *EMpulse*! Please let any member of your Board of Directors know if there is any way in which we can better serve you and your patients. We hope to see all of you at the annual conference in May!

Left to Right: John McGoff, Blaine Farley, David Hillhouse, Katy Ash, Morris Gieselman, Ron Eich, Jeremy Gagan, Paula Wilhelm, Josh Armbruster, Eric Vonderohe, Chris Ross, and B.P. House.

If you would like your group to be featured in a future issue, please contact me at: dtannas@iuhealth.org.

As always, please let any member of the Board of Directors know if there is any way in which your Indiana ACEP chapter can better serve you and your patients.



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2016 Conference & Resident Forum Update

by Lindsay Weaver MD, Education Director

Don't Miss It! Big, Exciting Changes to the Annual Indiana Emergency Medicine Conference May 5 and 6

We have many innovative educational opportunities planned for the 44th Annual Indiana Emergency Medicine Conference. The conference will be held at the Sheraton City Centre Hotel in downtown Indianapolis. The first day of conference is packed with nationally recognized speakers including Dr. Joe Martinez, who received glowing evaluations from last year's conference. We will be hearing from Dr. Matthew Dawson, who was ranked as the best outside speaker for the IU Emergency Medicine residency in 2015. ACEP president Dr. Jay Kaplan will also be joining us to lecture and give an update on national ACEP. All this will be rounded out by local toxicology legend Dr. Brent Furbee.

Immediately following lectures that day will be a Resident Forum from 4:45 to 6:30 p.m. at the Sheraton hotel. **(ATTN: Please note, this time is a change from previously distributed information.)** Groups are invited to come and meet with residents just beginning their job search to discuss community practice and the process of looking for and securing a job. Heavy hors d'oeuvres and cocktails will be served. If your group is interested in participating please contact Sue Barnhart at sue@inacep.org for details.

After the riveting lectures and meeting potential new colleagues, enjoy one of the many fabulous restaurants in downtown Indianapolis or try a local craft beer and indulge in farm-to-table dishes in the Mass Ave Arts District. Indy will be gearing up for the 100th running of the Indianapolis 500, so the atmosphere downtown is sure to be festive.

The second day of the conference will be run entirely differently than in years past. We decided to take advantage of the state of the art IU Health Simulation Center at Fairbanks Hall. Conference attendees will spend one half of the day at the simulation center and the other half of the day attending lectures at the Sheraton. At the simulation center, participants will move between different stations to learn and practice hands on skills including advanced airway techniques, ultrasound and trauma, pediatric and medical resuscitation. Attending a simulation session at any other conference would require you to pay hefty additional fees but we are including it in the price of the conference! Our noon lecture will be a presentation from the MESH coalition on preparing and planning for an active shooter in a health care center. The lectures will feature local experts Dr. Elizabeth Weinstein and Dr. Jeff Kline and an interactive "Stump the Professor" session.

Resident Forum Time Change

The Resident Forum will be held immediately following the lectures on Day 1 of the conference:

May 5,
4:45 p.m. – 6:30 p.m.

This is a change from previously distributed information.

Please consider sponsoring and sending a team of providers including physicians, nurse practitioners, physician assistants and nursing staff to this year's conference. The lectures and simulation sessions are aimed at being all-inclusive and fostering an interdisciplinary approach.

Lastly, stay in Indianapolis and join your colleagues for the nation's largest mini marathon, the One America 500 Festival Mini Marathon held on May 7. We hope to see many of you there for CME and catching up with old friends! Sign up online at http://inacep.org/2016-conference/.

REGISTRATION FORM FOR:

44rd Annual Indiana ACEP Emergency Medicine Conference
Thursday & Friday, May 5 & 6, 2016

Name:_____ ACEP Membership # *(if applicable)*:_____

Title/Position:_____ Hospital Affiliation:_____

Home Address:_____ City:_____ State:____ Zip:_____

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Choose one:	
Handbook on paper	❑
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Choose one:	
Friday SIMS lab morning session	❑
Friday SIMS lab afternoon session	❑
Late Fee *(if received after 4/4/16)*	$25 ❑
TOTAL	_____

*If paying by credit card, go to **inacep.org**.*

1-DAY REGISTRATION

Please check one of the following:

	THURSDAY	OR	**FRIDAY**
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Residents – separate form will be sent			
Intern /Med Student	$10 ❑		$10 ❑
Choose one:			
Handbook on paper			❑
Handbook on flash drive			❑
If attending Friday only, also choose one of the following:			
Friday SIMS lab morning session			❑
Friday SIMS lab afternoon session			❑
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LOCATION:
The Sheraton Indianapolis City Centre Hotel, 31 West Ohio St., Indianapolis, IN 46204 (Downtown Indy). This hotel is within easy walking distance to theaters, restaurants and popular nightspots.

LODGING: A block of rooms has been reserved at the **Sheraton Indianapolis City Centre Hotel** for the special rate of $149 per night. To reserve your room please call the Sheraton directly at **317-635-2000** or **888-627-8186**. Our group is the "American College of Emergency Physicians – Indiana Chapter".

PARKING: Parking at this hotel is offered at a discount rate of $20 per day.

CANCELLATION POLICY: A full refund will be given, provided cancellation is received by April 4, 2016. *A processing fee of* **$20** *will be charged for cancellations received after this date.* **No Shows will be charged full registration amount.**

INACEP reserves the right to conduct its courses based on minimum enrollment. Should cancellation be necessary, it will be done not less than 10 days prior to the course date and each registrant will be notified by email or fax and a full refund following. The Indiana Chapter of the American College of Emergency Physicians is not responsible for any cost incurred due to cancellation of a program, such as airline or hotel penalties.

Make check payable and mail to: **Indiana ACEP, 630 N. Rangeline Rd. Suite D, Carmel, IN 46032**

HOTEL WILL ONLY HOLD ROOMS THROUGH APRIL 4, 2016, SO REGISTER EARLY!

EMpulse

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