

EMpulse

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



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A View from the Top



Gina Huhnke, MD, FACEP (INACEP President)

It is with great pleasure that I author my first installment of the View from the Top. I truly consider the role of INACEP President a wonderful honor and thank you for the opportunity to represent the outstanding Emergency Physicians who provide state-of-the-art emergency care to the people of Indiana all day, every day. I am a proud Hoosier who has provided emergency care in this state since graduating from the IU

School of Medicine and IU EM Residency. I look forward to serving you in the coming year and welcome your input and ideas for advancing Emergency Medicine.

First, I would like to congratulate this year's recently elected INACEP Officers: Dr. Chris Ross, Vice President and Dr. Bart Brown, Secretary/Treasurer. Also, I would like to give a special thank you to immediate Past President Dr. Lindsay Weaver who has represented Indiana INACEP on a national and local level with grace and poise while bringing a new level of commitment and organization to the INACEP Board of Directors.

Second, I believe a note about the 45th annual INACEP conference which was held April 26-27 is in order. The conference was well attended by Emergency Physicians, Advanced Practice Providers, Nurses, EMS providers, and IUEM Residents.

Here are just a few highlights:

The first day featured popular speakers from across America. Dr. JT Finnell spoke about the ever expanding role of IT in the world of healthcare delivery. Dr. Jennifer Walthall, Indiana Secretary of Family and Social Services Administration, discussed the important topic of the opioid crisis in Indiana. On a lighter note, author Dr. Edwin Leap tested our knowledge with questions from the Board of Emergistan examination. Now we are all double boarded! The day continued with great educational topics. Needless to say, there were too many wonderful speakers to mention individually, but the reviews were very positive.

The second day began with an interactive session of interesting case presentations from EM physicians with participation from the IUEM residents. Thanks to all of you who were brave enough to present a case and actively participate. After two additional speakers, a hands-on ultrasound lab was conducted with live models to demonstrate and practice skills from FAST exam and pelvic ultrasound to central line placement. The conference is a great way to earn some CME and catch up with a few friends. I am looking forward to next year's educational opportunity.

Lastly, I would like to challenge EM Physicians in Indiana to actively participate in the advancement of Emergency Medicine at the local level. On the horizon for this year's INACEP Board of Directors are important issues such as the opioid crisis, balanced billing, the effects of legislation to repeal and replace Obamacare, and many more issues important to everyday health care delivery. I would ask that you keep abreast of the issues, remain vigilant with your use of addictive substances, recruit ACEP members, and stand up for your beliefs. Most importantly, keep providing high quality Emergency care to all your patients as this action represents us as a whole. Thank you for being there when your patients need you the most.

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A Dental Patient Walks into the ER...

by Dr. Dean Stratman, DDS, founder of 24 Hour Dental Care

Having practiced dentistry for more than 23 years, I've heard my fair share of horror stories about patients' managing their own pain. The things that people do to avoid seeing dentists (including at-home extractions!) are astonishing, dangerous and often end with a visit to the emergency room.

Last year, the Harvard School of Public Health, in conjunction with others in the field, released a report detailing the results of eight polls designed to collect patients' perspectives on U.S. healthcare. I was saddened but not surprised by the results.

The findings suggest that nearly 47 percent of patients who receive care in the emergency room do so because other facilities are not open or they're unable to secure an appointment, among other reasons. As a result, nearly one-quarter of respondents visited the ER for minor, non-emergency issues like toothaches because they were unaware of other options.

What this study and my own experiences confirm are that there is an untapped opportunity for ERs and after-hour dental clinics to drastically improve patient care by working together. We are all in the business of treating pain and should view each other not as competition, but as additional resources for ensuring that patients receive the best treatment as quickly as possible.

Trips to the emergency room for severe toothaches or dental injuries often result in temporary fixes for pain and advice to seek treatment from a dentist during traditional office hours. Instead of referring patients with dental emergencies to seek treatment at the convenience of a traditional dental office, ER physicians can and should redirect them to after-hours

emergency dentists who can solve the underlying cause of the pain.

Though ERs are often the most-equipped to treat a variety of serious injuries and ailments, dentists are better trained to treat untimely and non-life-threatening dental emergencies. Our experience and access to a specific set of tools ranging from detailed x-ray equipment, to filling materials and specialized handpieces that hospitals rarely have on hand helps us to tackle the root (pun intended) of most dental emergencies on-site. Like hospitals, most after-hours emergency dental clinics also accept the uninsured and underinsured.

Strategic partnerships between ERs and after-hour dental clinics will keep personnel and resources available for other, more pressing emergency situations while minimizing hefty ER bills for dental patients who are often left with limited treatment options.

To develop a better relationship with emergency dental clinics in your area, it's as easy as a phone call or email to initiate a conversation and build positive rapport. Know the names and locations of the nearest after-hours emergency dental clinics so that patients who arrive with tooth pain can be redirected to a more appropriate solution.

Let's all work together to provide our patients with the best care possible.

Congratulations New INACEP Board

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New Members

Riel Sarno MD

Paternalism in ER, or How We are Parents to our Patients

by Lauren Stanley MD, FACEP (INACEP Board Member)

One definition of the word “paternalism” is: the system, principle, or practice of managing or governing individuals, businesses, nations, etc., in the manner of a father dealing benevolently and often intrusively with his children.

The word “paternalism” often carries negative connotation in today’s society, in which independence and autonomy are so highly valued, sometimes above all else. Certainly, these are essential values, and should never be ignored. However, I would argue that there are times in which the expertise and advice of a well-trained professional (ie, emergency physician) are equally valuable, and that those are times in which paternalism can be a virtue. The above definition reminds us that paternalism implies a fatherly or parental concern for individuals; in some ways, we act in a parental role in our physician-patient interactions.

There are many ways in which we are paternalistic as emergency physicians, and I would venture to say that being paternalistic is important, if not necessary, to doing our jobs well in certain situations. We provide answers, advice, counseling, and instructions to our patients, and sometimes reprimand them; we do so with compassion and under the assumption that we are offering the best of our knowledge/experience for their benefit, just as a parent would. The following are some examples of ways in which our role as emergency physician parallels that of a parent:

- When we teach overly anxious parents of a febrile infant or toddler that the fever won’t hurt their child, that it’s ok to give acetaminophen and ibuprofen: we are not providing sophisticated medical advice, but simple wisdom that will probably bring more comfort to the parents than the otherwise well child.
- When we use a “tough love” approach with patients who have drug addiction: we care for them with professionalism and compassion, but also “get real” with them and confront them with the truth, that they will die of their illness if their behavior doesn’t change. We give them the tools to get help, but ultimately, they have to decide on their own to make a change.
- When we can’t sleep the night after a rough shift, unable to get a particular patient out of our minds, reviewing the case over

and over in our mind’s eye, wondering if the patient is ok and whether or not we should have done something differently: we are akin to the parent of a troubled teen/young adult who keeps his parents up at night worrying.

- When we counsel the family members of a dying grandmother that it’s ok to let her go, that it’s ok to stop the painful and invasive procedures: we are handing down a little piece of our understanding of end-of-life care that comes from seeing so many similar situations over years of practice. We are guiding and empowering the family to make a compassionate and loving decision that they may not have had the strength to make if not for our support.
- When a suicidal or homicidal patient demands to leave our ED and we detain them against their will, we are leveraging

our authority for their behalf. Sometimes, the right thing to do is to deny a patient’s personal rights, if that patient poses a significant threat to himself or others. Parents do not allow their children to do something that is clearly dangerous to them.

- When we witness a younger physician or nurse successfully complete a procedure that we have helped to teach, and have seen them attempt and/or fail before, we feel that swelling of pride that parents must feel when their child masters a new skill.

As I have reflected on this topic, I realize how my own father, also an emergency physician,

unknowingly illustrated benevolent paternalism to me 20 years ago. I recall spending time with my dad while he was at work; this was before the days of unending paperwork and background checks just to step foot into the ED as a volunteer. I was simply “the ER doc’s kid” and had essentially a free pass to observe the goings-on of his community emergency department. It was quickly apparent that my dad’s tone of voice and overall countenance were sometimes eerily similar with his patients as with us, his three children. With a difficult, disrespectful patient, his tone and stern gaze could make even the unruliest patient sit still and listen (or at least stop yelling for a few minutes). With a small child with a broken arm, his gentle,

Although I am only getting started in the adventure of being a parent within my own family, I am already somewhat experienced at guiding, counseling, reassuring, teaching, and yes, sometimes reproaching my patients in the emergency department.

easy demeanor managed to calm them and he even managed to elicit a smile when he used a goofy voice or other distracting technique. At the time, it seemed odd that my dad would use some of the same tricks with his patients as with us, but now I realize and appreciate that he cared for his patients enough to treat them like they were his family. I will never be certain if he learned how to deal with his patients because of the lessons learned from raising three children, or vice versa.

As I consider the concept of whether (and when) it is appropriate to be paternalistic as a physician, I have come to realize that I act as a parental figure to many of my patients already, despite the fact that many of them far exceed me in age! Although I am only getting started in the adventure of being a parent within my own family, I am already somewhat experienced at guiding, counseling, reassuring, teaching, and yes, sometimes reproaching my patients in the emergency department. We can call this "paternalistic" or not, but I have come to believe that it is simply part of being a good "ER doc."



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Legislative Update

by Lou Belch, Lobbyist for INACEP

The 2017 Session of the Indiana General Assembly adjourned Sine Die just after Midnight on April 21. Of the 1,261 bills introduced in this session, 272 passed the General Assembly. Governor Eric Holcomb signed 271 bills into law and vetoed one. The vetoed bill allowed governmental entities (state and local) to charge a fee for public records requests that take more than 2 hours to honor.

There were several issues INACEP was involved with this session. Please note that the summaries of new laws here highlight the portion of the law that impacts emergency medicine, but may not include all provisions of the legislation.

There were two bills of interest concerning Opioid prescribing:

SEA 226

Senate Enrolled Act (SEA) 226 limits the prescribing of opioids to a seven-day supply for:

- Adult patients the first time the prescriber issues an opioid prescription
- An individual under 18 years of age

There are exceptions to the above limits if the prescription is issued for the following:

- Cancer
- Palliative care
- Medication assisted treatment for substance abuse
- Any condition exempted by rule of the Medical Licensing Board of Indiana
- If in the professional judgment of the prescriber the patient requires more than the limits above.
 - To use the professional judgment provision or the palliative care provision the prescriber must document in the patient's medical record that *"a prescription for a drug other than an opioid was not appropriate and the patient is in a palliative care program or the prescriber's professional judgment is the reason for the exemption."*

SEA 408

The bill as introduced would have required a query of INSPECT prior to issuing a prescription for any amount of an opioid. That provision was removed after intense opposition by the Indiana State Medical Association and other physician groups. The passed law requires agencies to report any grant funding to the Legislative Council. It also seeks the establishment of a study committee to further discuss issues of integration of INSPECT into electronic health records and mandatory querying.

HEA 1278

There were several discussions regarding surprise or balance billing. INACEP members John McGoff MD, FACEP and Chris Burke MD, FACEP as well as Andrea Halpern from CIPROMS were helpful in removing many of the provisions of the bill that were onerous to emergency physicians. The new law requires notice to patients who are referred to check their network to see if the provider is in network. There are exceptions to that notice provision for single episodes of care. Although discussed, no provisions were made in the bill relating to balance billing or limiting payments to out of network providers. These issues will almost certainly return next year.

The Legislative Council meets toward the end of May to assign topics to interim committees. INACEP will attend that meeting and inform the membership as necessary.

Legislative Dinner Thanks

On Monday April 10, 2017, the INACEP Board of Directors hosted a dinner with Indiana state legislators to discuss issues current to emergency medicine. The evening, including cocktails and dinner, was a chance to meet and get to know our state representatives on an individual basis. The event was considered a resounding success by all who attended.

The INACEP board of directors would like to especially thank our Gold Level Sponsors. Without your support of IEMPAC, this event would not have been possible!

Dallas Peak MD, FACEP

Pamela Peak MD, FACEP

Randall Todd MD, FACEP

Lindsay Weaver MD, FACEP

St. Vincent Emergency Physician Group

A Reflection

by Elisabeth Vreede Greenberg, MS-III at Marian University College of Osteopathic Medicine, Evreede846@marian.edu

This year's political climate has pushed many issues into the limelight, with one of the most pressing being Lesbian, Gay, Bisexual and Transgender (LGBT) rights; particularly the importance of healthcare provider cultural awareness when treating these individuals. Indiana organizations such as OutCare Health, which is LGBT specific, and IU School of Medicine have been tackling this issue by providing cultural competency for current and future providers in Internal and Family Medicine. As a student, I have had many opportunities to speak at these events and learn from experts, but I've often found myself wondering how I can apply this knowledge to a future career in Emergency Medicine.

To begin to answer this question, I searched for general information about what disparities our LGBT patients face. LGBT individuals, particularly those who identify as Transgender, are more likely to be impoverished and lack health insurance meaning the Emergency Room serves as a critical access point for receiving healthcare. In addition, many individuals delay seeking healthcare due to fear of stigmatization in regard to their gender and/or sexual orientation. Identifying what stigma means in this particular setting can be more nuanced and can include instances where the physician is insensitive and/or displays discomfort with the patient's preferred orientation¹. A common example of this mistake is misgendering a patient, such as addressing a trans-female as "he" or "they" on rounds when the individual prefers female pronouns. This is often compounded by a lack of provider knowledge of specific healthcare disparities that affect LGBT individuals such as greatly increased risk of mental illness, substance abuse, and sexual assault.

To put this into perspective, I looked at the composition of the Indianapolis population. According to a 2015 Gallup Poll, Indianapolis ranked #18 out of 50 with 4.2% of residents identifying as LGBT in an area the size of Indianapolis, Carmel, and Anderson, IN². The population of these areas was equivalent to 1,971, 274 in 2014, which equates to approximately 83,000 Hoosiers. To me, this represents a large number of members in our community who may have felt stigmatized when visiting the local emergency room.

These mistakes that medical providers commonly make are not due to malice, but rather lack of knowledge secondary to a lack of information provided in medical training. A 2010 study surveying 137 US medical schools indicated that the median hours of education on these topics is 5, with 33% of

schools reporting 0 hours of education³. If students did receive LGBT-specific education, a majority of the content was on STDs and HIV/AIDS, although the content ranged dramatically by medical school. While this trend is slowly changing for future providers like me, this is a significant barrier for physicians in practice. The impetus for learning these topics is thrust upon them, which is a daunting task given the wide breadth of information that is available and it is difficult to discern what is important to one's particular medical practice.

Thankfully, there is a growing list of local and national resources that providers can utilize to obtain continuing education on this topic. My favorite online resource is the world-renowned Fenway Institute, which provides online webinars on topics ranging from cultural competency to EMR customization specifically for the LGBT population. Indiana-specific resources include OutCare Health, Indiana Youth Group, Transgender Wellness Alliance, and Eskenazi Transgender Health and Wellness Clinic, all of which provide cultural competency training for providers and/or specifically treat LGBT patients. As Emergency Medicine providers, or in my case an aspiring Emergency Medicine provider, it is important to pursue this avenue of medical training to provide the best care to our evolving patient population.

Conflicts: Elisabeth is the Director of Cultural Competency for OutCare Health based in Indianapolis, IN.

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Fred Osborn Award Winner: John McGoff MD, FACEP

by Chris Burke MD, FACEP

It was my honor to present this year's Fred Osborn award winner at our annual conference. He is a life-long Hoosier, graduating from North Central High School, Indiana University, and IU's School of Medicine in 1984. He completed his Residency in EM at Thomas Jefferson in Philadelphia, and served as Chief Resident

In 1986-'87. This is where he also met and married his wife, Karen. After strongly considering taking a job with Dave Van Ryn in Elkhart, along with some of my own "arm-twisting", he accepted an offer from Community and joined me there in 1987.

His introduction into group leadership was a little "non-traditional". In 1989, after being told that our group's cash flow had come to a halt, he discovered that no charts had been billed for over 3 months. As he often does, he took matters into his own hands. With the aid of his father's station wagon, he loaded 15,000 paper charts into the back. Together, we then criss-crossed the country looking for a new billing vendor that could process those charts and restore our cash flow ASAP. As a result, he was voted group Chairman in 1990, and he served in that capacity until 2002.

While at Community, he has served on multiple hospital committees, including Med Exec, credentials, and QA, and was

elected by the Medical Staff to the Community Health Network Board of Directors from 2006- 2010.

He has an incredible commitment to and passion for organized Medicine. At the local level, he has been actively involved with the Indianapolis Medical Society, where he has served as State Delegate since 1993, Board of Directors since 2002, and as IMS President in 2008-'09. He has been just as involved with the ISMA, where he served as ACEP Representative from 1992-'96, multiple committees and commissions, Board Trustee from 2012-'14, House of Delegates Speaker from 2014-'16, and in September was the first EM Physician elected to the position of President-Elect for the ISMA. At National ACEP, he has served on the Practice Management Committee, Steering Committee (4 years), and Reimbursement Committee (4 years). Representing INACEP, he served as Councilor from 1990-2006, Chair of Legislative/Reimbursement Committee from 1991-'96, and was Chapter President in 1992-'93. Additionally, for the past 25 plus years, he has been a fixture at the Statehouse, continuously advocating on behalf of Emergency Medicine.

In addition to Medicine, this year's award winner has a passion for the military. His career started while in Med School, where



John McGoff MD, FACEP and Chris Burke MD, FACEP



John McGoff MD, FACEP (center) with brothers Kevin (left) and Jim (right)

he joined the Air National Guard in 1982. He served as Chief of Aerospace Medicine at the 122nd TAC Fighter Wing, Ft Wayne, IN from 1985-'92, and from 1992-2007 was the Commander, 181st Medical Group, Terre Haute, IN. In 2008, he served as Chief of Emergency Services at the 332nd Joint Base in Balad, Iraq. In 2010, he received his General's star, and was named Brigadier General, Indiana Air National Guard, where he served as Chief of Staff from 2010 – 2015. He carries the rank of Chief Flight Surgeon, and has flown over 600 hours in multiple fighter jets. He has been deployed everywhere in the world, including Turkey, Bahrain, Jordan, Germany, Korea, Japan, Guatemala, Slovakia and even Antarctica! At his military retirement in November, he received multiple awards and honors, including a Presidential Award of Service from George Bush, and The Sagamore of the Wabash from Indiana's Governor.

If that wasn't enough, he has been very active in politics. He was elected as Marion County Coroner in 1997 and again in 2000. He was GOP candidate for Secretary of State in 2002, and was

a candidate for US Congress (5th District) on 3 occasions. He served on both Governor Mitch Daniels and Mike Pence's Policy + Transition teams. He's been actively involved with the Indiana Organ Procurement Organization since 1999, serving numerous roles, including its Board of Directors. Most recently, he's been a member of the Indiana Medical Licensing Board, serving from 2002- 2006.

As is clearly evident, this year's Fred Osborn award winner embodies SERVICE - to his group, his hospital, INACEP, National ACEP, the house of medicine, his party, his community and his country. For those of us who knew Fred, we know that he'd be thrilled to welcome this year's recipient into this select group of honorees named in his honor. Although his wife was disappointed in not being able to attend, his family was represented by Jim and Kevin, his two brothers.

Please join me in congratulating the 2017 Fred Osborn Award winner, Dr. John "The General" McGoff.



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Volunteer Faculty Teaching Awards

Dr. Cherri Hobgood, Chair and Rolly McGrath Professor, Department of Emergency Medicine at the IU School of Medicine presented the 2017 Volunteer Faculty Teaching Awards at the Indiana American College of Emergency Physicians Conference on April 26th.

The Volunteer Faculty Teaching Awards were created to recognize the outstanding efforts of faculty members during the Emergency Medicine Clerkship at Indiana University. These annual awards honor faculty members who inspire learners and motivate them to work hard and achieve more than they thought possible.

The 2017 recipients are:

Robert Cantor, MD

Richard L. Roudebush VA Medical Center
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IU School of Medicine-Indianapolis

Anthony Collins, DO

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IU School of Medicine-Fort Wayne

Anar Desai, MD

Methodist Hospital, Northlake Campus
Volunteer Clinical Assistant Professor of Emergency Medicine
IU School of Medicine-Northwest-Gary

Peter Kamhout, MD

Union Hospital
Volunteer Clinical Assistant Professor of Emergency Medicine
IU School of Medicine-Terre Haute

George Kim, MD

Saint Joseph Health System
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IU School of Medicine-South Bend

Gladys Lopez, MD

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Volunteer Clinical Assistant Professor of Emergency Medicine
IU School of Medicine-Evansville

Ryan Wallace, MD

Indiana University Health Ball Memorial Hospital
Adjunct Clinical Assistant Professor of Emergency Medicine
IU School of Medicine-Muncie

Christine Waller, DO

Indiana University Health Arnett Hospital
Volunteer Clinical Assistant Professor of Emergency Medicine
IU School of Medicine-West Lafayette

Andrew (Drew) Watters, MD

Indiana University Health Bloomington Hospital
Adjunct Clinical Associate Professor of Emergency Medicine
IU School of Medicine-Bloomington

Congratulations to this year's award recipients. We thank them for their commitment to medical education.

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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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Case Report: A Cold, Swollen Joint in a Limping Child

by Joanna Manghelli, DO, & Sheryl Allen, MD

Case

The patient was a four-year-old previously healthy male who presented to a pediatric emergency department with acute onset atraumatic right knee pain and swelling. He was in his usual state of health until the night before when he complained of right knee pain. The next morning he refused to ambulate on that leg. The patient's mom had noted a viral syndrome two weeks prior which self-resolved.

On presentation, the patient was afebrile and well-appearing. His right knee was swollen and tender to palpation without erythema or warmth. He was able to fully range the knee with discomfort and limped on the right leg. X-rays of the knee and hip were unremarkable. Labs were significant for leukocytosis of 18k and elevated ESR and CRP. MRI of the right knee was negative for osteomyelitis or abscess. He was admitted to the pediatric infectious disease team.

What is the diagnosis?

The following day, the patient's right knee effusion resolved, and he complained of left ankle pain and swelling. He also developed a systolic murmur and fever. An EKG showed 1st degree AV block and an echocardiogram showed normal cardiac anatomy and function. The diagnosis of acute rheumatic fever was confirmed with high serum streptococcal antibody (ASO 1,150 Todd units) and positive rapid strep test. He was started on scheduled NSAIDs and amoxicillin 50 mg/kg divided bid for a total of 10 days. For prophylaxis, he was given IM penicillin. He was discharged two days after admission without complications. He will need antibiotic prophylaxis until age 21.

Discussion

Acute rheumatic fever (ARF) is thought to be an immunologic response to a precedent group A beta-hemolytic streptococcal (GAS) pharyngitis. It occurs as a delayed sequela 2-4 weeks after the pharyngitis, commonly of those aged 5-15. The Jones criteria is used for the diagnosis of ARF (Table 1).

Although there has been a decreased incidence of acute rheumatic fever in developed countries, it is still the leading cause of cardiovascular death in young children in developing countries. In contrast to post-strep

glomerulonephritis, the treatment of GAS pharyngitis can prevent the sequela of acute rheumatic fever. It is important to note that other locations of GAS infections (skin, soft tissue) do not lead to ARF.

Major Criteria	Minor Criteria
Arthritis (migratory)	Fever
Carditis	Arthralgia
Subcutaneous nodules	Elevated ESR or CRP
Erythema marginatum	Prolonged PR interval
Sydenhams chorea	Evidence of antecedent GAS infection*
* positive throat culture or antigen test or elevated antistreptococcal antibody titer	

Table 1: Jones criteria, updated 1992 (2 major or 1 major + 2 minor)

The approach to the limping child includes a broad differential including infection, trauma, rheumatologic, inflammatory, and neurologic etiologies. History should include onset and duration, preceding or intercurrent illnesses, and associated signs and symptoms. Diarrhea should prompt the diagnosis of reactive arthritis, upper respiratory symptoms should prompt toxic synovitis, and recent pharyngitis is suggestive of ARF.

A thorough physical exam should be performed, including

range of motion exercises, strength and sensation, and special tests if warranted. Diagnostic tests should be tailored to the history and physical exam. Routine labs to consider are CBC with differential, ESR/CRP, joint fluid aspiration, and blood cultures if the patient appears toxic. Imaging could include plain radiographs, ultrasound, CT or MRI. If ARF is suspected, antistreptolysin O titer and throat cultures should be obtained.

Arthritis is the most commonly found major criteria and typically presents as a warm, red, swollen joint. The migratory arthritis seen with ARF is also seen with gonococcal arthritis and Lyme disease, so a careful social history should be obtained. When ARF is suspected but not confirmed, it is important to withhold NSAID and aspirin therapies, as these may prematurely abort the migration of arthritis making the diagnosis more difficult. Prolonged PR



interval is a common but nonspecific finding of ARF. Routine Doppler echo should be obtained to determine pathologic vs physiologic valvular disease.

After the diagnosis of acute RF is confirmed, first line therapy includes antibiotics to eradicate GAS (regardless of throat swab), NSAIDs or aspirin for arthritis, and potentially steroids if severe carditis is present.

Acute rheumatic fever requires chronic management. Prophylaxis is needed every 28 days, with penicillin G IM being the most reliable route. If no carditis is present, prophylaxis is required for 5 years or until age 21. If persistent cardiac disease is found, prophylaxis should be continued until age 40, or potentially life-long. Prophylaxis antibiotics decrease the risk of acute rheumatic heart disease and recurrence of rheumatic fever.

Conclusion

A limping child with a cold swollen joint is a rare presentation of ARF. A detailed history is pivotal in the diagnosis of ARF, as it

requires a high index of suspicion. Anti-inflammatory medications should be withheld until the diagnosis is confirmed. Long-term antibiotic prophylaxis is required, as there is a high recurrence rate if prophylaxis is not adhered.

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OBITUARY

Dr. Susan Ann Stephens, 71, of Carmel, passed away March 7, 2017 she was a graduate of Indiana University and Indiana University School of Medicine. Susan was board certified in three specialties, Family Practice, Internal Medicine and Emergency Medicine. She was an incredibly talented and highly respected Emergency Physician, colleague and friend. Sue was a clinical instructor of Emergency Medicine and an exemplary role model and inspiration for hundreds upon hundreds of students during her more than twenty years of practice with St. Vincent Emergency Physicians Inc. She exemplified the best in all of us, honest, direct, caring, quick-witted, committed to family, friends and education. We will miss her, but we are better people and physicians because she was part of our lives.

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ACEP Scientific Assembly

Washington DC

October 29—November 1, 2017

INACEP Annual Conference

Indianapolis

April 25 & 26, 2018

Leadership & Advocacy Conference

Washington DC

May 20-23, 2018



Indiana Chapter
American College of
Emergency Physicians

630 N. Rangeline Road
Suite D
Carmel, IN 46032

Phone: 317-846-2977
Fax: 317-848-8015
Email: indianaacep@sbcglobal.net

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317-846-2977

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sue@inacep.org
317-846-2977