Volume 31, Issue 3 **Fall/Winter 2022**

EM pulse

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

SAVE THE DATE
51st Annual INACEP Emergency Medicine Conference

April 13, 2023

NCAA Conference Center and Hall of Champions

REGISTRATION OPENING SOON!

Inside this Issue

A View from the Top

Daniel Elliott MD, FACEP, FAAEM

Greetings members!

I hope this letter finds you all doing well. It has been a busy couple of months for INACEP and I'm sure it has been a busy time for all of you given the recent volumes and the abundance of pediatric illnesses, especially RSV.

Since our last newsletter, the Indiana legislature had its Special Session which enacted restrictions on abortion access. Our chapter worked in conjunction with ISMA and other specialties' organizations throughout the Special Session to represent our physician members' interests. We advocated for the protection of the patient-physician relationship and opposed criminal penalties that could apply to physicians practicing under the standard of care. Unfortunately, the law passed by the legislature did not address our concerns. We remain worried about the law's implications and will continue to work with our colleagues at ISMA and ACOG to monitor the effects that this legislation has on patient care.

This past September, our Chapter sent councilors to the national ACEP Council meeting. Dr. Lindsay Zimmerman summarizes the annual meeting in more detail later in this newsletter, but we had another successful Council with active involvement of our councilors and a memorial resolution submitted from our chapter in the honor of the late Dr. Carey Chisholm. Numerous resolutions were ultimately passed addressing a wide array of topics from reproductive healthcare access to scope of practice to opiate use disorder treatment options.

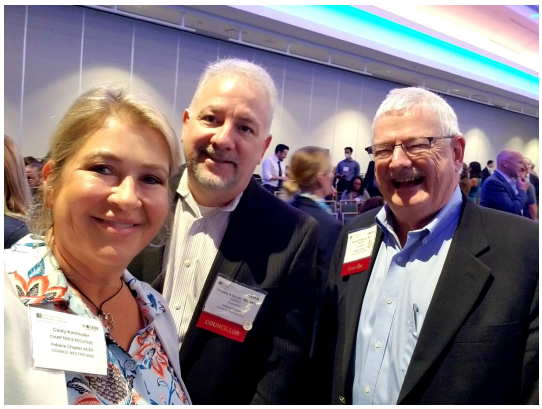
For this upcoming state legislative session, our chapter leadership plans to spearhead legislation that will require on-site physician coverage in Emergency Departments across the state. One aspect of the scope of practice discussion has always been how much physician oversight is needed to ensure patient safety. Our chapter will continue to advance the standard that all Emergency Departments in the state should have 24/7 on-site physician coverage. We plan this winter to continue to educate our legislative colleagues about why this requirement is necessary.

Finally, I understand the strain that many of our members have been under recently with the increased volume of pediatric patients due to respiratory illness. This influx of kids combined with the ongoing inpatient mental health services shortage and delays in EMS transfer continues to exacerbate the challenge of boarding patients in our Emergency Departments. We have been in communication with our partners at the state level about ways to help mitigate these problems and will continue to help find solutions for all of our Hoosier patients. This topic will remain a priority to our chapter leadership so that our members can provide the best possible care to our patients.

As always, don't hesitate to reach out to me or the Board if you ever have a concern or issue that you would like our chapter to address. Stay safe and stay well!

2022 ACEP Council Update

Representatives from Indiana ACEP attended the annual national council meeting September 29-30 in San Francisco, California. Dr. Christopher Kang was welcomed as the next president of ACEP and emphasized his focus on physician well being in the next year as well as addressing workplace violence in his opening speech. Dr. Aisha Terry was chosen as the 2022 President-Elect. The national board members newly elected and re-elected this year were Dr. Kristin McCabe-Kline, Dr. Jeffrey Goodloe, Dr. Ryan Staunton, and Dr. Gabe Kelen. The Indiana Chapter ACEP submitted Resolution 6 (22): In Memory of Carey D. Chisholm, MD, which was adopted by the council and board. We were very proud to have Dr. Chisholm recognized for his dedication and his contributions to the emergency medicine community and his impact on education at Indiana University.



Michael Bishop, MD (rt), Timothy Burrell, MD (ctr) and Executive Director, Cindy Kirchhofer, take time out from Council for a photo op.

Council resolutions covered a wide array of topics, and this year's participants engaged robust discussions on reproductive health, staffing rural emergency departments, and further defining roles of physicians when working in conjunction with nonphysician providers. Several resolutions were adopted, a few of which are highlighted below.

Council Resolution 24: Access to Reproductive Health Care Services
This resolution reads as follows: Resolved, that ACEP supports equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Council Resolution 39: Signage at Emergency Departments with Onsite Emergency Physicians This resolution encouraged the advertisement of onsite board-certified or -eligible physician coverage in emergency departments where care is delivered.

Council Resolution 45: Onsite Supervision of Nurse Practitioners and Physician Assistants
This resolution asked for revision of the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department". The statement had stated that "The only CMS-designated facilty types in which supervision of a PA or NP by an emergency physician may be provided "Offsite" by telehealth means are as follows: Critical Access Hospitals (CAHs), Rural Emergency Hospitals (REHs)." This resolution was to clarify that onsite emergency physician supervision of nonphysician providers is the gold standard for care in the ED.

The full list of resolutions can be found on acep.org. The council meeting was an invigorating exchange of ideas and good discussion. If you are interested in attending the Council session as a Councillor or Alternate Councillor in future, Please contact any of the board members. We are happy to welcome new voices.

Lindsay Zimmerman, MD, FACEP

Legislative Update

by Lou Belch, The Corydon Group

With the legislative Special Session over, the typical legislative interim study committees met over summer and fall. The process is somewhat informal and allows for broad discussion on potential initiatives in the 2023 Legislative Session.

Interim Study Committee on Public Health, Behavioral Health and Human Services
The topic of the first meeting was Delta 8, Delta 9 and other THC products. The committee heard testimony from 25 individuals and organizations. As to be expected the testimony was compelling on both sides of the issue. The committee is not likely to make a recommendation.

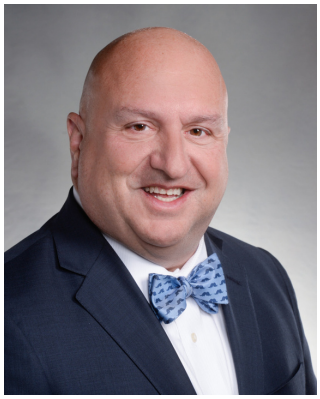
The topics of the second meeting were maternal mortality and Logansport State Hospital training issues. Multiple physicians testified on the issue of maternal mortality. It seemed the committee was taking this as information and not likely to make a recommendation. The Logansport issue was also taken as information with not much conversation regarding legislative fixes.

The third and final meeting was a joint meeting of this committee and the interim study committee on financial institutions and insurance. The topic was a study of the market concentration of health insurance, hospitals, health practitioners and pharmaceutical services.

Interim Study Committee on Financial Institutions and Insurance
The topic of the first on only individual meeting or the committee was prior authorization. The committee heard testimony from hospitals, physicians, chiropractors, physical therapists and insurance industry. The Chairman announced that he was not inclined to make a recommendation. While he said both sides make compelling arguments, he is concerned that if prior authorization is prohibited the number of retroactive denials will increase. This will cause a more significant financial problem for patients.

CONGRATULATIONS!
Tyler Johnson, DO
New Indiana State Senator

Rep. Jeff Thompson, (R-Lizton) named Ways and Means Chairman
Speaker Todd Huston has named Rep. Jeff Thompson the Chair of the Ways and Means Committee. With the retirement of Rep. Tim Brown, MD this has been the subject of much speculation this summer. Rep. Thompson has been a longtime member of the committee. His legislative areas of interest have been education policy and local government issues. He also becomes a member of the State Budget Committee.



Louis M. Belch is President at The Corydon Group where he oversees the strategy and day-to-day operations for all health care clients of the firm. Lou has been a well-known fixture at the Indiana Statehouse since he was named legislative liaison for the Indiana Health Professions Bureau (now the Professional Licensing Agency) in 1989 under Governor Evan Bayh. In 1991 Lou left state government and began lobbying for the Indiana State Medical Association, one of Indiana's most prominent health associations. Since 1997, Lou has been a contract lobbyist specializing in representing health-related clients and has one of the best track records of success of any governmental-affairs professional – having developed and maintained key relationships on both sides of the political aisle for the past three decades.

(Cont. Pg. 11)

AG Complaints & Other Licensing Considerations

Brian Park
Attorney at Law

If you practice in health care long enough, at some point you may find yourself on the receiving end of a patient complaint (known in the law as a "consumer complaint") filed with the Attorney General's Office. This article is intended to provide a broad overview of the consumer complaint process, and raise issues to consider if you ever find yourself having to respond to a consumer complaint.

As background, Indiana law allows persons to file what are known as consumer complaints against licensed professionals, filed with the Attorney General's Office. Consumer complaints can be filed for essentially any reason, and they are. Among other things, they are filed for issues such as rude service from office staff, prescription disputes, suspicion of substance abuse, adverse outcomes, billing disagreements, and everything in between.

A consumer complaint is not a formal disciplinary matter; it is just that, a complaint by a consumer/patient, leading to subsequent investigation by the Attorney General's Office. This can lead to several outcomes, including: closure of the investigation; request for additional information; a warning letter; or the filing of a disciplinary complaint against the provider's license. Where criminal, fraudulent, or other unlawful conduct are uncovered in the investigation, the matter could also be referred to the Medicaid Fraud section of the Attorney General's Office, outside state or federal agency, or even a criminal prosecutor. In short, the consequences of a consumer complaint can range from being legally benign, to extraordinarily serious.

The Attorney General's Office is required to notify the licensee of the nature of the consumer complaint, which is often done by forwarding a copy of the actual complaint filed by the complaining individual. Once notified that a consumer complaint has been filed against you, you will have a deadline to respond. This is typically 20 days, but extensions of time can be requested.

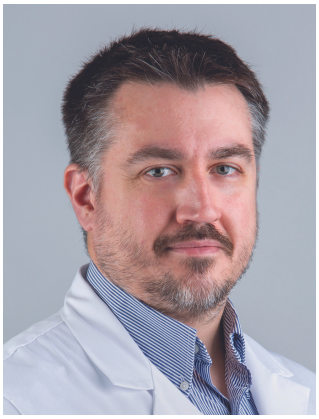
How you respond to a consumer complaint will largely depend on the circumstances. A practitioner does not have to respond, and there may be occasions where not responding or offering minimal response is warranted, such as if the licensee is facing related and pending criminal charges. But failing to respond also means the Attorney General's Office will make its investigative determination without hearing the practitioner's side of the story, which could be construed as non-cooperative, and also potentially increase the likelihood the matter could be escalated beyond the investigation stage. In short, there is no one-size-fits-all approach to responding to a consumer complaint.

In order for a consumer complaint to escalate to the level of a disciplinary action, the Attorney General's Office must have reasonable basis to believe there has been a violation of what is known as the Health Professions Standards of Practice, Indiana Code § 25-1-9 et seq. Commonly charged violations include: criminal convictions bearing on the practitioner's ability to practice competently, or are deemed harmful to the public; being unfit to practice due to professional incompetence, failure to keep abreast of current theory, or drug/ alcohol abuse; violating any statute or rule governing the profession; discipline in another state; diversion; engaging in sexual contact, or soliciting sexual contact with a patient; among other things. If the Attorney General's Office believes a violation has occurred, they can file a disciplinary complaint against your license. A disciplinary complaint is a civil proceeding, meaning there are no criminal penalties, but analogies can be drawn to criminal law. Also note, while a disciplinary complaint is a civil proceeding, separate criminal charges could still be filed based on the same set of facts. Thus, in some instances practitioners are faced with the difficult circumstance of having to defend themselves of both criminal and disciplinary matters.

Brian Park is a member/partner of SKO, a regional firm with over 150 lawyers. He concentrates his practice on representing hospitals, physicians, nurses and other health care providers in all manners of litigation and general legal advisement. Prior to joining SKO, Brian was legal counsel to the Indiana Board of Medical Examiners and Indiana Veterinary Board, among other State agencies.

(Cont. Pg. 11)

Sickle Cell Disease in Indiana's Emergency Departments



A Q & A with Brandon Hardesty, MD - Indiana Hemophilia & Thrombosis Center

Sickle cell disease (SCD) is a genetic blood disorder in which red blood cells take on an abnormal shape, block small blood vessels and don't last as long as normal red blood cells. Complications from SCD can be life-threatening.

Emergency providers are among the most resilient and nimble in the healthcare community. SCD patients have come to rely on the expertise of emergency healthcare staff for some of their most difficult healthcare emergencies.

In the Emergency setting, there are several acute complications providers might encounter among SCD patients. Learning common acute presentations while also learning to balance preconceived notions of patients who present to the ER in pain crises can mean all the difference in helping lessen future complications that can have life-altering consequences.

Question: How common is SCD in the state of Indiana?
Dr. Hardesty: Nearly 1,700 Indiana residents live with SCD. Of these, 87 percent are Black or African American, and 83 percent are non-Hispanic. In 2019, 1 in every 1,608 live births was a sickle cell birth in Indiana. 1 in every 446 live births in the Black or African American population was a sickle cell birth.

Question: Are there areas of Indiana with more SCD among residents than others?
Dr. Hardesty: Yes. According to 2020 figures, while individuals living with SCD reside all over the state, the majority reside in Marion and Lake counties (63 percent). Allen County is home to 5.8% of Indiana's SCD population.

Question: What is the life expectancy for someone with SCD?
Dr. Hardesty: SCD was once considered a childhood disease. In fact, in the 1970s, the average life expectancy for Hoosiers living with SCD was less than 20 years. Today, 95 percent of Americans living with SCD live to age 18 years, according to the Centers for Disease Control (CDC). Unfortunately, the life expectancy for adults has not significantly improved over the last few decades. Persons with severe forms of sickle cell disease have a median survival into their 50s, while individuals with less severe disease typically live into their 60s. There is a mortality spike in the 20s around the time pediatric patients are transitioning to adult medicine. Some of this is thought to be due to a lack of adult hematologists with expertise in caring for SCD, but other factors contribute as well. Continued advocacy and support of Indiana SCD care, resources and programs is critical. Young sickle cell patients are living longer, but continued access to care and treatment adherence are important keys to increasing their life expectancy.

Question: Where do Indiana SCD patients go for care?
Dr. Hardesty: There are only five SCD care clinics in the state—located in Marion, Allen and St. Joseph counties, and one outreach clinic in Lake County. The remaining patients are seen by local emergency departments and hematologists if they are lucky.

Question: Why is sickle cell disease commonly seen in the ER?
Dr. Hardesty: It goes without saying that emergency providers play a very important role in the care of sickle cell patients. Vasco-occlusive crisis (VOC) is sudden, acute pain, and the most common complication in this population. Due to the often-severe nature of VOC in the chest, back and/or extremities, emergency care is necessary.

Question: What is the most common cause of SCD-related hospitalization?
Dr. Hardesty: As mentioned, VOC is the most common complication in SCD patients. ER providers should treat pain while undergoing workup, and consider evaluation for other causes of pain, such as PE, acute chest syndrome or other entities. VOC can occur in the presence of other complications; it is typically sudden and commonly experienced in extremities, chest and back. Adult patients with more than 3 hospitalizations for VOC in a year are at an increased risk of early death. Treat with opioids using individual protocols. NSAIDs can also be used.

(Cont. Pg. 6)

Sickle Cell Disease (Cont.)

(Cont. from Page 5)

Question: What is the most common cause of SCD-related death?
Dr. Hardesty: Acute chest syndrome (pneumonia) is the most common cause of SCD-related death and is the second leading reason for hospitalization in children and adults with SCD. An SCD patient might present with a cough and shortness of breath. Necessary treatment for these patients includes antibiotics that cover pneumococcus and atypical bacteria, as well as blood transfusions and supplemental oxygen.

Question: What are other presentations of SCD complications in the ER?
Dr. Hardesty: In addition to VOC and acute chest syndrome, the below are presentations of SCD complications that ER providers might also encounter:
* Fever (must be treated with antibiotics to cover pneumococcus due to functional asplenia)
* Renal complications
* Anemia
* Hemorrhagic Stroke
* Ischemic stroke
* Multisystem organ failure
* Priapism

Question: What is the most common misconception about SCD patients that can impact their care?
Dr. Hardesty: Pain is invisible, and every SCD patient's pain crisis is different. When an SCD patient visits the ER for VOC, they are often anxious about whether healthcare staff will believe their level of pain and need for prescription pain treatment. Opioids should be used to treat VOC pain, but there is a very real concern in the healthcare community regarding opioid treatment. A common fallacy is that there is a high rate of opioid misuse within the SCD community when—in fact—there is a low rate of opiate use disorder among this population.

Between 1999-2013, an astounding 174,959 non-SCD patients died due to opioid prescription pain relievers (OPR) compared to just 95 SCD patients. Less than 1% of deaths among SCD patients due to all causes was due to OPR in the same period. (https://academic.coup.com/painmedicine/article/17/10/1793/2270349)

Question: What can ER providers do to help improve the care of SCD patients?
Dr. Hardesty: Some ways ER providers can help continue to improve SCD outcomes:

* Truly listen to patients; they have been dealing with their SCD-related pain for decades and know their bodies well. Parents of adolescents and young adult patients can be instrumental in understanding complications, as these patients are still learning.

* Encouragement in trying times can go a long way. Positive comments can help just as much as negative comments can hurt (i.e., "You don't look sick").

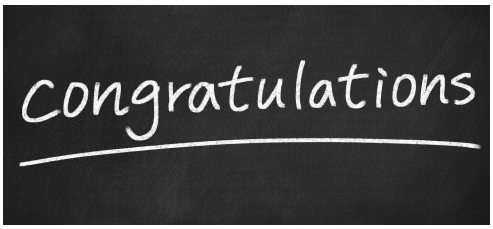
* Be understanding when an SCD patient says they don't feel well. Some patients have reported healthcare staff not be-lieving they are sick due to eating, when eating helps stave off opiate-related nausea. Many patients will use their phones as a way to distract them from the severe pain they are experiencing.

* Treat each SCD patient as a unique case. SCD patients are often fighting an uphill battle of disease-related complications, in addition to racial stereotypes. Providers should be aware of their own unconscious biases that may come from their last poor interaction. Each case should be treated as a new and different patient.

* Encourage ongoing and timely outpatient follow-up visits.

Dr. Brandon Hardesty is an adult hematologist-oncologist with the Indiana Hemophilia & Thrombosis Center (IHTC) in Indianapolis, specializing in hemophilia and sickle cell disease. Dr. Hardesty is also a member of an SCD advocacy group that visits the Indiana statehouse annually to speak with legislators about pressing concerns related to Indiana sickle cell care.

MEMBER SPOTLIGHT



Newly Elected ACEP Board of Directors 2022-23 Officers

John T. Finnell, MD, FACEP, FACMI - Vice President

James L. Shoemaker, Jr., MD, FACEP Secretary/Treasurer

2022 ACEP National Emergency Medicine Faculty Teaching Award

Joseph Turner, MD, FACEP
Indiana Chapter

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INACEP proudly recognizes the following physicians in earning the prestigious FACEP credential

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Geoffrey Hays, MD, FACEP
Jonathan Kirschner, MD, FACEP
Scott E. Ludwig, MD, FACEP
Adam Engel Nevel, MD, MBA, FACEP
Daniel Nathan Seitz, MD, FACEP
Haig Setrakian, MD FACEP
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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.

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*Display ads must be high resolution PDFs.

Make sure your graphics and fonts are embedded and all images are 300 dpi.

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The 2022 Ad Deadlines are:
Feb. 3, May 2, Aug. 1 and Oct. 31 (approximately).

Mail: Indiana ACEP
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Indianapolis, IN 46217
Email: cindy@inacep.org

Case Study: Pediatric GI Bleed

By Daniel Epperson, M.D. and Sandra Schwab, M.D

Overview
A 7-month-old female with a history of recurrent ear infections and a family history of Von Willebrand disease presented to the emergency department with dark tarry stools. Family reported symptoms started approximately 24 hours prior to arrival prompting them to go to a local emergency department. At that time, she had a normal exam and normal abdominal x-ray but positive fecal occult blood test. She was discharged home with a pantoprazole prescription and urgent outpatient pediatric gastroenterology referral. At her primary care follow up the next morning the patient appeared pale and point-of-care hemoglobin was 8.4 mg/dl. Due to ongoing symptoms and significant anemia, the patient was sent to the pediatric tertiary care hospital for further evaluation. In the emergency department the family reported a total of 3 episodes of melanotic stools, decreased appetite, and increased sleepiness. The parents denied abdominal discomfort, constipation, vomiting, hematemesis, easy bruising or bleeding, sick contacts, or fevers. She did have an ear infection treated with penicillin 2 months prior but no other recent illness. Parents denied recent travel, ill contacts or exposures to farm animals or reptiles.

Findings and Work Up
Vital Signs: Temp=36.4 o C, HR=173, RR=34, BP=122/68, SpO2=100%

Physical Exam Findings
Pale but well appearing female who was smiling and interactive, in no acute distress. The oral mucosa was moist. Cardiac exam was significant for tachycardia but without cardiac murmurs or gallops. She had normal peripheral perfusion. She had no increased work of breathing with clear and equal lung sounds. Her abdomen was soft, non-tender, non-distended with normal bowel sounds. There were no masses or hepatospleno-megaly. A large amount of dark black tarry stool was in the diaper with blood-tinged/ maroon colored stool around the buttocks and perianal region. There was no skin breakdown, anal fissure, or hemorrhoids. The patient's skin was pale No rashes, bruising or petechiae were present.

Initial Work Up
Shortly after the patient arrived an IV was placed. A weight appropriate dose of pantoprazole was given due to concern for GI bleed of unknown etiology. Repeat complete blood count in the emergency department demonstrated a hemoglobin of 7.8 gm/dl and a white blood cell count of 15k. Platelet count, PT/INR, and renal function were within normal limits. A type and screen was sent to the blood bank. Rapid stool studies were negative for pathogens and a stool culture was sent. Emergent transabdominal ultrasound was performed with no abnormalities found. Pediatric general surgery and gastro-enterology were consulted.

Management
The patient's family was updated with the labs, radiologic findings, and the medical teams concern for GI bleed possibly due to a Meckel's diverticulum. The case was discussed with the on-call surgeon and gastroenterology specialist. The patient was admitted for a nuclear medicine Meckel's scan and serial abdominal exams as well as monitoring for hemodynamic instability. The findings of the Meckel's scan were consistent with ectopic gastric mucosa in the right central abdomen, consistent with a Meckel's diverticulum. Diagnostic laparo-scopy was performed and confirmed a Meckel's diverticulum with surrounding inflammation. The area was resected (diverticulectomy). The patient tolerated the procedure well without complication. Post-operatively she tolerated a normal diet, had no significant pain, and no additional melanotic stools. She was discharged the next day in good condition. No other follow up information was available.

Discussion
Pediatric GI bleeding is a somewhat uncommon presentation to the emergency department. Upper GI (UGI) bleeding accounts for approximately 1 to 2 per 10,000 visits per year, and lower GI (LGI) bleeding is slightly more common at 30 per 10,000 visits per year in the ED. There are many causes of UGI and LGI bleeding in children, and the causes vary by age group. The emergency provider's differential diagnosis should be guided by the child's age and appearance (sick vs not sick).

(Cont. Pg. 9)

Case Study (Cont.)

Common causes of GI bleeding that can present at any age include fissures, infectious gastroenteritis/colitis, polyps, and vascular malformations.

In the neonate (0-30 days), GI bleed should be considered serious until proven otherwise! In a sick appearing neonate, worrisome and life-threatening diagnoses include necrotizing enterocolitis, malrotation with volvulus, and coagulopathy (Vit K deficiency, inherited). In the well appearing neonate the differential includes anal fissures, swallowed maternal blood, and allergic proctocolitis.

In the well appearing infant/young child (1-5 years) consider fissures, infectious colitis, gastritis, benign polyps, swallowed blood from epistaxis/food or food coloring/medications (cefdinir). In the unwell infant (tachycardic, pale, dehydrated, etc.) the provider must consider **intussusception**, cryptic **liver disease, esophageal** bleeding/ hemorrhagic gastritis, vascular malformation, hemolytic uremic syndrome, and Meckel's diverticulum. **Patients with intussusception or Meckel's diverticulum may initially appear well but then decompensate due to rapid blood loss or gut ischemia.** Finally, in the older child/ adolescent (5-18 years) that is well appearing consider esophageal irritation/ gastritis and peptic ulcers. Ill-appearing patients include those with liver disease (varices), severe gastritis, vascular malformation, or inflammatory bowel disease.

This case exemplifies the unwell appearing infant/young child with GI bleeding who ultimately was diagnosed with a Meckel's diverticulum. Meckel's diverticulum is the **most common congenital malformation of the GI tract**, and one of the most common causes of GI bleeding in the toddler. It is caused by ulceration of the small bowel due to acid secretion by ectopic gastric mucosa within the diverticulum. These patients (as with the patient in this case) often present with painless LGI bleeding. If the diverticulum is inflamed, it can cause abdominal pain and tenderness.

The diagnostic study of choice is a technetium-99m scan (Meckel's scan), but definitive diagnosis is via laparoscopy with tissue biopsy. The features of a Meckel's diverticulum are easily (or not so easily) remembered by the "Rule of Twos": presents by **age 2**, affects **2%** of the **population**, **2 inches** in length, **2 types** of mucosae, within **2 feet** of the ileocecal valve.

Disposition is critical for the pediatric patient with a suspected GI bleed. For the well appearing child with nor-mal vital signs, minimal/mild bleeding and a reassuring exam, diagnostic work up including stool studies and routine labs can be obtained in the ED and an urgent pediatric gastroenterology clinic follow up is often suf-ficient. In the unwell appearing child regardless of age: resuscitate! Proton pump inhibitors may be beneficial in some conditions such as hemorrhagic gastritis or Meckel's diveticulum. Consider blood transfusion (start with 10ml/kg of packed red blood cells) if the child is unstable or has severe symptoms from anemia. Labs to order include complete blood count, coagulation studies, type and screen, and stool testing/cultures. Imaging may be helpful in some cases (abdominal x-ray or ultrasound, CT scan) but do not delay in consulting your pediatric surgeon, gastroenterologist, and intensivist. These cases often require urgent endoscopy or laparoscopic surgery and pediatric intensive care unit admission.

Conclusion

For the pediatric patient with a GI bleed: Think worst first! Serious causes can be difficult to distinguish at first, so stay vigilant! Bloody stools with abnormal vitals or exam findings are concerning! Remember the age-based differential and consult your specialist team early if your patient has concerning features or findings.

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NEW ACEP MEMBERS

Erik Frost, DO, FACEP
Joseph Emmerson Krug, MD
Kristin C. Lipanot, MD
Pamela Soriano, MD
Matthew R. Steiner, MD
Carol L. Weesner, MD
Lindsay M. Yoder, DO

ACEP Candidates

Residents
Alaa Kassir, MD
Emily M. Lyons, MD
Kylie J. Miller, MD
Kristen M. Mylcraine, MD
Anthony R. Ragusa, MD
Jessica A. Reyes, MD
Emily Schaefer, MD
Harsh Shah, MD
Jackson Townsend, MD

ACEP Candidates (cont.)

Med Students
Sarah Caldwell
Gabriel Coleman
Jacob D. Covert
Mary Kathryn Flanagan, OMS-I, M.S.
Kamna Gupta
Karson A. Kamman
Kristopher Karanovich
Breanna Nowak
Minal B. Patel
Erika Marie Robertson, EMT-P
Marcy J. Simpson
Aish Thamba
John Verhey
Allison Young

Legislative Update (Cont.)

(Cont. from Page 3)

Election Results
Congratulations to Tyler Johnson, DO, past president of INACEP, on his election to the Indiana State Senate representing District 14 in Northeast Indiana. Sen. Johnson is the only physician in the Senate. At the time of writing this update, he has not yet received his committee assignments. The House will have 2 physicians, Dr. Brad Barrett, a retired surgeon from Richmond is the Chair of the House Public Health Committee. Dr. Rita Fleming, a retired OB/GYN from Jeffersonville is a member of the House Public Health Committee.

At the end of the day, from a majority standpoint very little changed. In the House of Representatives, the Republicans held a 71-29 majority before the election, after they hold a 70-30 majority. In the Senate, the Republicans held a 39-11 majority, after they hold a 40-10. Both remain supermajorities meaning the Democrats do not need to be present to transact business.

The 2023 session is a long session meaning the State Budget will be written for the next biennium. Other topics that will be discussed include the rising cost of health care, workforce and potentially some access to contraceptives issues. There is always and issue the emerges during the session that was not anticipated.

INACEP will cause a bill to be introduced the bill will require hospitals to have a physician on site who has as their primary responsibility the emergency department at all times the department is open. We are awaiting committee assignments to select the author. The bill is being drafted by the legislative services agency.

Please look for updates from INACEP during the legislative session.

Here's an easy way to contribute $100 now to IEMPAC
Your voice and your contribution are important

AG Complaints (Cont.)

(Cont. from Page 4)

A disciplinary complaint is filed by the Attorney General's Office on behalf of the State of Indiana, similar to how a prosecutor files criminal charges on behalf of the State. A disciplinary complaint will allege various charges/violations of the Health Professions Standards of Practice, just as a criminal charge will include various counts alleging a criminal law violation. One of the key differences is there are no penal consequences (i.e. jail or prison) in a civil disciplinary proceeding. Nonetheless, if the Attorney General's Office is able to prove its charges, sanctions can include: written reprimand; monetary penalty up to $1,000 for each violation; probation; suspension; and license revocation. The "jury" who decides your case will be the professional board of your licensed profession.

In serious cases, the Attorney General's Office can seek expedited discipline through what is known as a summary suspension. This remedy is available where the Attorney General's Office believes a practitioner presents a "clear and immediate danger to the public health and safety" if allowed to continue to practice, to be decided by the applicable professional licensing board. Oftentimes practitioners are provided very little notice of a summary suspension action, which can carry the significant consequence of an immediate suspension of one's license. Given the potential consequences, if you receive a consumer complaint or notice of summary suspension, you should immediately notify your employer and/or applicable insurance carrier, who in turn, may be able to provide you with legal counsel. An attorney experienced in disciplinary matters will help guide you through the difficult and stressful disciplinary process, will understand the legal "discovery" tools to obtain information that could be relevant for your defense, be able to advise on applicable defenses that can be raised, and if necessary, help negotiate favorable settlement. In short, a lawyer familiar with the disciplinary process will help place you in the best position to protect your license.

Disclaimer: This article includes general educational information, and should not be relied upon as legal advice for a given circumstance. Different circumstances may warrant different considerations. This article is not intended to create an attorney client relationship with the reader, and if the reader has any questions they should consult an attorney.

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

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