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INACEP

ANNUAL EMERGENCY MEDICINE CONFERENCE

APRIL 11, 2024

downtown Indianapolis

Inside this Issue

A View from the Top

Lindsay Zimmerman MD, FACEP

Greetings from INACEP! At the time of this writing, we are entering the full swing of the legislative season. Our officers have been working hard on the concerns that you, our members, have brought to our attention. Hopefully we will be able to report good news to you in our next edition of EMpulse at the end of this short session. We engaged in robust discussions on pending bills and concerns of emergency physicians with our legislators at the legislative dinner on 2/13. I enjoyed answering questions and talking about the challenges of emergency medicine with the folks who can have a direct influence on the practice of medicine.

I look forward to continuing to serve you in my final couple of months as president, but am also happy to announce Emily Fitz, MD as the incoming president. She is a powerful force to be reckoned with, and I am delighted to see INACEP in her capable hands starting in April.

Galvanized by our success in partnership with ISMA with SEA 400 last year, we have undertaken some sizeable issues this year that have presented some challenges. We are continuing to make gains in our understanding of the scope of our state's reimbursement issues and working on feasible solutions. As we do so, I would like to thank the members of INACEP who have reached out to us and offered support and encouragement. However, more is needed for us and from us to continue our work at the level that we have come to expect of ourselves. Therefore, I am excited to announce the creation of INACEP's advocacy fund! We are still in the process of getting this up and running, but it is going to serve us well in future as we hope to expand our active role in shaping the community of emergency medicine. Please consider a donation to help us as we continue to work for you.

Lastly, I would like to end my final column with a quote from Theodore Roosevelt. So often the misattributed quote "do what you can, with what you have, where you are" is used in the emergency department. I feel this sentiment often leaves us dispirited with our lack of staff/beds/resources, therefore I propose a different reference: "It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best

Cont. on p. 2

'You Don't Have Go - But You Can't Stay Here...'

By: Eric Yazel MD, FACEP

Dr. Eric Yazel is a graduate of Indiana University with a B.S. in Biology. He has a M.A. in Clinical Physiology from Ball State University. He received his Medical Degree from the University of Louisville and also completed his residency in Emergency Medicine at UofL. He serves as Indiana's Chief EMS Medical Director.

The Indiana trauma system underwent a review by the American College of Surgeons, looking at all aspects of trauma care. As a follow-up, the State of Indiana Trauma Commission was developed, with INACEP board member Dr. Emily Fitz representing our interests. Several areas that are pertinent to Emergency Medicine were discussed in depth, but probably none more than the interfacility transfer process. I think any of us who work in a semi-rural or rural setting have experienced this- fingers crossed while calling a tertiary care center that beds are available, sometimes having to call place after place. Then when a bed is finally secured, you find that there no EMS units are available to transport the patient in a timely manner. As patient advocates, this leads to a great deal of frustration for ED providers.

So what is the fix? It's more of a challenge than you might think. From the EMS side of things, interfacility transfers can pose a logistical challenge. They are often faced with the option of leaving 911 calls under-covered or uncovered when they take a transfer out. They may have a hospital frustrated with them on one side if there is a delay, but on the other side, an elected official is holding them accountable to deliver 911 response in a timely manner. It's lose-lose for them. Especially when you consider in many locations around the state, the distance of a transfer may lead a truck to be out of their service area for 4-5 hours or more. In addition, as we see freestanding ED's increase statewide, and also see some critical access facilities eliminate their inpatient services. This adds significantly to the transfer burden often without providing any additional resources to the local EMS services.

This is an area where the Trauma Commission has prioritized as an area of improvement. In the next month, the **RAPID** team pilot will be put out for bid. Standing for **R**ural **A**ccess **P**aramedicine **I**nterfacility **T**ransfer and **D**idactics, this program will allow a state supported local service to provide interfacility transfer coverage with a regional approach, covering several counties and critical access facilities. For areas that have strong processes already, this will not infringe on their systems, but for many areas this will be some much needed relief. In addition, it will allow us to examine funding gaps in order to advocate for changes that make this a more sustainable process state-wide. The Indiana Rural Healthcare Association has a similar pilot underway as well. In addition, we are looking at ways to track bed availability state-wide. Having a real-time assessment of resources availability can facilitate the patient acceptance process and also help with overutilization and underutilization of our various trauma centers. Last but not least, there are major workforce initiatives that are in place across the state. Grants supporting instructor development, student scholarship, test prep, and educational equipment assistance have all been announced in the last few months. Improving the overall workforce can only help the interfacility transfer process.

Hopefully the pilot programs can provide some level of much needed relief for this challenging situation. And the deeper examination through the Trauma Commission will provide the springboard for long term sustainable improvements in the process. As we look to make our trauma system the best it can be, timely access to definitive care for our patients has to be a core foundation.

A View from the Top (cont.)

knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat." Together, we can do so much in this profession. We can continue to push for prevention of workplace violence. We can fight against the policies that make ED boarding an acceptable option. We can advocate for fair reimbursement for the work we do. Let us continue to strive and dare greatly.

Legislative Update

by Lou Belch, The Corydon Group

This article is being written at the halfway point of the 2024 Session of the Indiana General Assembly. The Session must adjourn by statute no later than March 14. Legislative leaders are targeting March 8th for adjournment.

The following bills passed the House and waiting for action in the Senate.

HB 1414

HB 1414, authored by Rep. Mike Karickhoff (R-Kokomo) and sponsored by, Sen. Tyler Johonson, DO (R-Leo), mandates the Budget Committee's review of contracts with managed care organizations (MCO) in the Medicaid program. It permits MCOs and Medicaid providers to establish value-based health care reimbursement agreements (VBA) in writing, allowing reimbursement rates different from established ones. The General Assembly in 2023 increased the Medicaid fee schedule to 100% of Medicare thereby negating some of the VBA agreements. This bill attempts to correct that error. It also places some protections for providers that these cannot be forced upon them.

HB 1327

Authored by Rep. Donna Schaibley (R-Carmel), HB 1327 requires changes of ownership of physician group practices be disclosed to the state department.

The following bills are dead:

SB 3

Authored by Sen. Tyler Johnson, DO (R-Leo), Sen. Ed Charbonneau (R- Valparaiso), and Sen. Chris Garten (R-Charlestown).

The bill sought to ban prior authorization. There may be attempts to amend some provisions into other bills.

SB 192
Authored by Sen. Tyler Johnson, DO (R-Leo), Sen. Vaneta Becker (R-Evansville), and Sen. Mike Bohacek (R-Michiana Shores), Senate Bill 192 addresses compensation for physicians providing emergency medical services to Medicaid participants. Under the legislation, physicians with agreements with the Office of Medicaid Policy and Planning or managed care organizations are promptly compensated based on an autopay list published by the office. The bill prohibits delays or denials in compensation unless specified in Medicaid managed care laws, administrative rules, federal regulations, or the provider agreement.

HB 1164

HB 1164, authored by Rep. Becky Cash (R-Zionsville), would require physicians and staff members of a medical facility to report suspected child abuse to the department of child services and local law enforcement within a two-hour window.

The bill failed to advance by the House 3rd reading deadline.

The INACEP board will continue to monitor the Session and act accordingly.

INACEP President Lindsay Zimmerman MD, FACEP volunteered as 'Physician of the Day" for the Indiana legislature.

Another chance to advocate for emergency physicians!

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.

Blood clots in kids on the rise - Do you know the latest pain-free treatments?

by Kyle Davis MD
Pediatric Hematologist
Indiana Hemophilia & Thrombosis Center

Cases of blood clots in kids are rising, emphasizing the need for emergency healthcare providers to learn the latest approaches to blood clot prevention and when to consult specialty hematology for co-management.

Dr. Kyle Davis is a pediatric hematologist-oncologist at the Indiana Hemophilia & Thrombosis Center (IHTC) in Indianapolis and a member of the multidisciplinary, multi-institutional neonatal and pediatric comprehensive stroke program between IHTC and St. Vincent Ascension's Peyton Manning Children's Hospital (PMCH) in Indianapolis. Dr. Davis and IHTC colleagues are available to discuss clotting and stroke with any healthcare team member in search of stroke education and preparedness measures.

Rising pediatric VTE rates
Venous thromboembolism (VTE) is blood clotting in the veins, a serious medical condition that can cause disability and death. VTE in kids is rare, but cases are growing .

There was a 130% increase in pediatric VTE between 2008 and 2019 in children younger than 18 years, according to a study of the Pediatric Health Information System (PHIS). The study found 46 VTE cases per 10,000 admissions in 2008 compared to 106 VTE cases per 10,000 admissions in 2019. Seventy-eight percent of these patients had a chronic medical condition.

While 32% of all VTE admissions were younger than 12 months of age, the highest relative risk of VTE was found to be in adolescent admissions. A VTE diagnosis was reported in more than 1 out of every 100 inpatient admission in adolescents ages 15 to 17 years.

Why the rise in VTE rates in kids? The study cites the following possible reasons:

- An increase in survival of children with serious medical conditions
- An increase in VTE diagnosis in cases that previously may have gone undetected
- An increase in the use of central venous catheters
- An increase in adolescent obesity and immobility (in conjunction with oral contraceptive use)

Pediatric VTE: A medical emergency
According to the American Society of Hematology, urgent treatment for pediatric VTE is key to optimizing a child's outcomes. It is "a severe problem because of the potential for associated mortality and significant complications including PE and cerebrovascular events, as well as post-thrombotic syndrome."

Kids who experience disability caused by VTE resulting in stroke, lung or other organ damage will have more years living with functional limitations. Timely treatment can be lifesaving and make the difference in ensuring long-term functional outcomes and minimizing clot recurrence.

Providers should be aware of VTE symptoms, including:
- Lightheadedness or fainting
- Irregular or faster-than-normal heartbeat
- Chest pain or discomfort
- Difficulty breathing
- Coughing up blood
- Sudden or gradual pain in the arm or leg including swelling, tenderness and redness or warmth of the skin

These VTE symptoms should signal the need for urgent treatment.

Specialty hematology is the first call providers should make when presented with a pediatric VTE case. An example of an emergent approach to VTE care is the collaboration between the Indiana Hemophilia & Thrombosis Center (IHTC) and Ascension St. Vincent in Indianapolis. IHTC hematologists are on call to lead treatment strategies for the hospital's youngest clotting patients and are available to consult with other healthcare providers 24/7.

Direct oral anticoagulants
Two direct oral anticoagulants (DOACs), dabigatran and rivaroxaban, were approved in 2021 as the first of their kind in pediatric thrombosis prevention and management. Both were found to have a similar efficacy to injectable anticoagulants.

Previously, these oral alternatives had only before been approved for use in adults, and the only anticoagulant treatment for kids was off-label injection of enoxaparin and the less-commonly used fondaparinux.

Dabigatran
Capsule or pellet
- For use in children ages 3 months to 17 years
- Before starting, patient must receive at least 5 days of injectable or intravenous treatment for blood clots

Rivaroxban
Tablet or oral suspension
- For use in children from birth to younger than 18 years.
- Before starting, patient must receive at least 5 days of injectable or intravenous treatment for blood clots

Cont. pg. 8

Case Study: Nonketotic Hyperglycemic Hemichorea/Hemiballismus Syndrome, a Stroke/Seizure Mimic

Authors:
Alaa Kassir, MD, MBI
Chiamara Anokwute, MD
Matthew Tews, DO
Indiana University School of Medicine Emergency Medicine Residency Program

Overview:
An 80-year-old African American female known to have HTN, stage III CKD, HTN, HFpEF, and diabetes mellitus presented to the ED with involuntary abnormal movements of the right upper extremity that started 1 hour prior to presentation while she was at church. They were episodic and happened in bursts lasting 1-2 minutes. She had a tough time describing the movements, but they seemed to be nonrhythmic, involuntary, and non-purposeful. She endorsed a sensation of restlessness extending from her shoulder to her hand. She had no syncope or LOC, numbness, or weakness in any extremities. She did not have abnormal movements of her other extremities. She did endorse some word finding difficulties but no subjective change in her speech fluency. She was uncertain of the current medications she takes but chart review revealed prescriptions for semaglutide, losartan, atorvastatin, and metoprolol.

Initial Findings and Workup:

Vital Signs: BP 123/79, HR 70, RR 16, SpO2 98% on room air, T 36.8°C.
Physical Exam: Non-toxic appearing. Alert and oriented. GCS 15, AAOx3. Equal strength and sensation in all extremities. Intact finger to nose testing in bilateral upper extremities. During bedside physical examination, she had a 1-minute-long episode of non-purposeful movement of her RUE that was non-rhythmic and non-suppressible, which self-resolved. This was not present in any other extremities. No cranial nerve changes. NIH Stroke Scale of 1 for slight word finding difficulty.
EKG: NSR, non-specific T-wave abnormalities in V5 and V6.
Initial laboratory studies: WBC 5.1, HGB 9.1, PLT 200k, creatinine 1.80 (near baseline), blood glucose 594, bicarbonate 24, anion gap 7, no urine ketones on urinalysis.
Imaging: CXR was reassuring. CTA head and neck obtained with asymmetric hyperdensity seen in L lentiform nucleus, concerning for diabetic striatopathy. MRI brain w/o contrast was obtained, which confirmed the diagnosis.

Management: Upon arrival to the ED via EMS, the patient was at her reported baseline and described that this was the first time these movements had happened. We were able to witness an episode of her hemichorea at the bedside while she was in the ED, which did not involve a change in level of consciousness or speech. The immediate concern from the ED physician team was for stroke vs. seizure and neurology was consulted. She had basic labs obtained, which were remarkable for a glucose level of 594 but no signs of DKA on BMP. She received a CT Angiogram of her head/neck which showed her L diabetic striatopathy. She received insulin subcutaneously which brought her blood glucose to 229. She was admitted for glycemic control and further inpatient management. The inpatient team later learned that she had been taken off her semaglutide a few weeks ago and had a questionable medication compliance history. MRI confirmed the diagnosis seen on CT, and she also received a routine EEG which did not show seizure activity. She was discharged 4 days later after improvement of her RUE chorea, with adequate blood glucose control and resumption of her home diabetes medications but had persistent minor RLE hemiballismus even with glycemic control and diabetes education. She was discharged in stable condition and was set up to follow up with neurology as an outpatient.

Discussion:
Chorea is a hyperkinetic movement disorder typified by involuntary, swift, and erratic contractions. The triggers for acute acquired chorea to consider in the emergency department encompass vascular, metabolic, toxic, demyelination, infectious, and autoimmune causes. The most prevalent cause of acute chorea is ischemic or hemorrhagic stroke with basal ganglia involvement. Thus, it is prudent to keep stroke/seizure near the top of the differential diagnosis with this acute presentation. The second most common source of acquired chorea is metabolic; nonketotic hyperglycemia is the primary etiology in this set of sources, while others include acute intermittent porphyria, hyperthyroidism, hypoparathyroidism, hyper/hyponatremia, hypocalcemia, or renal/hepatic failure. Therein lies the value of a metabolic workup in this patient population.

A study conducted at the Mayo Clinic over a 15-year period identified only seven cases of chorea triggered by hyperglycemia, which comprised about 1% of all chorea cases at the center during this time. This suggests that it is rare, but the actual incidence may be underreported due to misdiagnosis or missed diagnosis. While the true incidence is not generally known, it is considered a rare complication of uncontrolled diabetes.

Nonketotic hyperglycemic hemichorea, also known as diabetic striatopathy, hemichorea-hemiballismus syndrome, or chorea, hyperglycemia, basal ganglia (C-H-BG) syndrome, is most common in elderly women, particularly those of Asian descent. In a meta-analysis by Oh et al, almost 91% of the patients were Asian. One theory is that postmenopausal estrogen levels decrease,

Seeking Nominations

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

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

2010 - Peter Stevenson MD, FACEP, Evansville, IN
2011 - David VanRyn MD, FACEP, Elkhart, IN
2012 - Thomas Madden MD, FACEP, Bloomington, IN
2013 - Thomas Gutwein MD, FACEP, Fort Wayne, IN
2014 - Tom Richardson MD, FACEP, Danville, IN
2015 - Randall Todd MD, FACEP, Indianapolis, IN
2016 - Chris Burke MD, FACEP, Carmel, IN
2017 - John McGoff, Indianapolis, IN
2018 - Thomas Heniff MD, FACEP, Boone Co, IN
2019 - Chris Hartman MD, FACEP, Carmel, IN
2020 - James H. Jones MD, FACEP, Zionsville, IN
2021 - N/A
2022 - Sara A. Brown, MD, FACEP, Monroeville, IN
2023 - Brian Sloan, MD, Zionsville, IN

The Indiana ACEP board is now accepting nominations for this year's consideration. The individual nominees will be evaluated in regard to their leadership, involvement and contributions to their emergency medicine group, hospital, community and state. To nominate a worthy physician, please submit a single typed page detailing the qualifications of a deserving emergency physician whom you know which includes the information included in the template below. The nominated person must be an emergency physician currently practicing in the state of Indiana and be a current member of Indiana ACEP. The person making the nomination however need not be a member of ACEP nor a physician.

All submissions are due by **March 15, 2024**

and are to be submitted electronically to cindy@inacep.org.

Nominations for the Fred Osborn Memorial Award – Excellence In Emergency Medicine must include the following information:

Name of Nominating Person_____

Name of Nominee_____

Date of Nomination_____

Nominee's Positions of Leadership_____

Nominee's Involvement / Contributions to their Group_____

Nominee's Involvement / Contributions to their Hospital_____

Nominee's Involvement / Contributions to their Community_____

Nominee's Involvement / Contributions to their State_____

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

April 11, 2024

REGISTRATION NOW OPEN

52ND ANNUAL INACEP EMERGENCY MEDICINE CONFERENCE

AGENDA

7:30-8:00 am	**Registration and Continential Breakfast**
8:15-9:15 am	**"Strengthening the Emergency Medicine Leadership Pipeline"** **Dr. Aisha Terry, ACEP President** Associate Professor, Department of Emergency Medicine, and Director, Emergency Medicine Health Policy Fellowship, George Washington University School of Medicine and Health Sciences, Washington, D.C.; Assistant Professor, Department of Health Policy, Milken Institute of Public Health, George Washington University
9:15-9:45 am	**"Anorectal Potpourri"** **Dr. Evan Fitz** Colon and Rectal Surgery, Franciscan Physician Network
9:45-10:15 am	**"Modern Management of Diverticulitis from a Surgical Perspective"** **Dr. Scott Dolejs** Colon and Rectal Surgery, Franciscan Physician Network
10:30-11:30 am	**"Teachable Tox Tidbits: A case based review of the principles and pitfalls of caring for tox patients in the ED""** **Dr. Jerry Snow** Assistant Director of the Medical Toxicology Fellowship and Director of the Toxicology rotation at Banner – University Medical Center in Phoenix. Assistant Professor of Emergency Medicine and Internal Medicine at the University of Arizona College of Medicine – Phoenix.
11:30-12:00 pm	**Resident Forum**
11:30-12:30 pm	**Lunch/INACEP Meeting/National Update**
12:30-1:30 pm	**"Why in the World Do We Keep Missing Vascular Catastrophes?"** **Dr. Joseph Martinez** Associate Professor of Emergency Medicine, Associate Dean for Medical Education and Learning Environment, University of Maryland School of Medicine
1:30-2:00 pm	**"Disaster Medicine"** **Dr. Ryan Hata** Assistant Professor of Clinical Emergency Medicine, Indiana University School of Medicine
2:00-3:00 pm	**"Ready, Aim, Block: Practical Regional Anesthesia for the ED"** **Dr. Daniel Brenner** Assistant Professor of Clinical Emergency Medicine, Indiana University School of Medicine
3:10-4:30 pm	**Rising Speaker Series** **Dr. Austin Marett – Neonatal Emergencies** **Dr. Bryce De Venecia – Buprenorphine** **Dr. Alex Weston – Fingernail Injuries** **Dr. Steve Wipprecht – Bloody Airway**

Blood Clots in Kids
(cont from page 8)

There are scenarios that point to injectables as the best choice for treatment, and they tend to be less expensive. However, even though providers tend have more experience treating with off-label injectables, clinical data continues to grow and support the use of DOACs in kids. Two pivotal trials demonstrated efficacy and safety of DOACs in children with publication of the Einstein Jr study of Rivaroxaban and the Diversity study of Dabigatran.

Comfort over cost
Imagine a child with a blood clot has just returned home from the hospital. They were prescribed an injectable anticoagulant for continued management. Each day, they must wake up before school and anticipate a needle injection. Later that evening, they face another needle before falling asleep.

If this child had instead been prescribed a DOAC, their needle anxiety and pain are no longer concerns. The child's clotting is instead treated with oral doses in either tablet, capsule, pellet or liquid form. No more needle pokes, burning or bruising.

Pediatric VTE prevention
Children's Hospitals' Solutions for Patient Safety is a network of more than 140 children's care facilities working together to "(eliminate) harm in children's hospitals," including VTE. [JL1]

Preventing VTE requires providers to identify patients' risk factors and intervene on those that can trigger VTE when possible. The more risk factors a patient has, the higher their likelihood of developing VTE.

Pediatric VTE risk factors include:

·Age
·Not moving for long periods of time (i.e., being on bed rest or hospitalized)
·Central venous catheters
·Blood clotting disorders
·Cancer
·Diabetes
·Heart conditions (i.e., congenital heart disease)
·Infection
·Kidney disease
·Spinal cold injury
·Obesity
·Surgery
·Family history

A patient's individual risk factors are considered with each hospital admission, and prophylactic anticoagulation may be recommended to prevent blood clots from forming. DOACs may be prescribed as prophylaxis for appropriate patients during, and potentially after, their hospital stay.

IEMPAC Donors

Your contributions support a sucessful INACEP legislative dinner with the House and Senate Health Committees

Daniel Elliott MD, FACEP
Jody Ghosh MD, FACEP
Peter Pang MD, FACEP
Lauren Stanley MD, FACEP

Have YOU contributed?

Case Study

Cont'd from page 5

which causes hypersensitivity of nigrostriatal dopamine receptors, making elderly women more prone to this complication. The meta-analysis by Oh et al. did conclude that men were affected much more frequently than previously reported, but the female to male ratio remains 2:1. In these cases, the chorea and ballismus usually involve unilateral limbs, which is opposite to what is expected in other metabolic etiologies of chorea. Our patient had hemichorea involving the right upper extremity that extended to the right lower limb as an inpatient, but was not present in the ED. The exact pathophysiology is not known, but some proposed theories include hyperviscosity which leads to local tissue hypoperfusion, depletion of GABA, petechial hemorrhage, acute dysfunction secondary to hyperglycemic or hyperosmolar insult, and accumulation of manganese-containing gemistocytes in the basal ganglia - which can appear as T1 hyperintense lesions. According to the meta-analysis by Oh et al, the mean serum glucose level in this condition was 481.5 mg/dL.

As suggested by the term diabetic striatopathy, the imaging abnormalities involve the striatum (putamen and caudate nucleus) of the basal ganglia contralateral to the clinically noted hemichorea. Striatal hyperdensity and T1 hyperdensity are noted on non-contrast CT brain and MRI, respectively. The findings on the CT and MRI obtained in our patient were consistent with this. However, bilateral chorea in patients with diabetic striatopathy may present with bilateral striatal abnormalities on rare occasions. One case of nonketotic hyperglycemic hemichorea with normal CT and MRI imaging has been reported and may represent a different subtype.

Blood glucose normalization is the mainstay of treatment, yet symptoms may take time to resolve. The same strategies adopted to prevent cerebral edema in hyperosmolar hyperglycemic state can be used when treating a patient with nonketotic hyperglycemic hemichorea. During treatment, it is vital to monitor the patient's mental status and serum osmolality to identify cerebral edema, a known complication. In our patient, with control of blood glucose by means of insulin infusion, her choreiform movements also improved as expected for the syndrome. However, in some cases, choreiform movements can persist for a longer period, despite hyperglycemia correction. In these cases, antipsychotics, anticonvulsants, and neuroleptics may be helpful. Repeat inpatient imaging may also be indicated. This condition has an excellent prognosis, with both symptoms and imaging abnormalities usually resolving after restoring normoglycemia. In our patient's case, her symptoms persisted for a few weeks prior to resolution.

Conclusion:
In the evaluation of a patient exhibiting chorea and elevated blood glucose levels, nonketotic hyperglycemic hemichorea should be considered. This condition is defined by a triad of nonketotic hyperglycemia, hemichorea, and contralateral basal ganglia imaging abnormality. Risk factors encompass female gender, older age, Asian descent, and suboptimal glucose management. However, it is imperative to keep stroke and seizure near the top of the differential diagnoses initially. The prognosis is generally favorable, with both symptoms and imaging abnormalities usually resolving with glucose control.

References:

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Tintinalli's emergency medicine: A comprehensive study guide (Eighth edition.). New York: McGraw-Hill Education. 2019.

Welcome New Medical Students

Mikia Davis
Claire Claire Lauterbach
Alex Piekarczyk
Ashleigh Nicole Suppinger
Maclaren Tobin
Jonathon Verde

Help WANTED

Emergency Medicine Clinical Associates (part-time) - Crown Point, IN

The University of Chicago's Department of Medicine, Section of Emergency Medicine, seeks part-time Clinical Associates at 10% effort for renewable terms of up to two years. Appointees will treat patients at the newly-built Emergency Department at Crown Point Hospital in Crown Point, Indiana. The Crown Point Hospital is a 130,000-square-foot multispecialty care center and micro-hospital, for which the ED is an 8-bed unit with an annual volume of approximately 8,000 patient encounters in year 1, with an expected growth to approximately 11,000 by year 4. This ED is a part of a new micro-hospital being built by the University of Chicago Medicine to serve the needs of the Northwest Indiana community. These positions do not require teaching or scholarly activity. Compensation is paid per shift and does not include benefits.

Prior to the start of employment, qualified applicants must: 1) have a medical doctorate or equivalent, 2) hold or be eligible for medical licensure in the State of Indiana, and 3) be Board certified or eligible in Emergency Medicine or equivalent.

To be considered, those interested must apply through The University of Chicago's Academic Recruitment job board, which uses Interfolio to accept applications: http://apply.interfolio.com/140395. Applicants must upload a CV. Review of applications will begin after February 16, 2024.

Equal Employment Opportunity Statement
All University departments and institutes are charged with building a faculty from a diversity of backgrounds and with diverse viewpoints; with cultivating an inclusive community that values freedom of expression; and with welcoming and supporting all their members.

We seek a diverse pool of applicants who wish to join an academic community that places the highest value on rigorous inquiry and encourages diverse perspectives, experiences, groups of individuals, and ideas to inform and stimulate intellectual challenge, engagement, and exchange. The University's Statements on Diversity are at https://provost.uchicago.edu/statements-diversity.

The University of Chicago is an Affirmative Action/Equal Opportunity/Disabled/Veterans Employer and does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity, national or ethnic origin, age, status as an individual with a disability, protected veteran status, genetic information, or other protected classes under the law. For additional information please see the University's Notice of Nondiscrimination.

Job seekers in need of a reasonable accommodation to complete the application process should call 773-834-3988 or email qualopportunity@uchicago.edu with their request.

ADVERTISE WITH US

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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Timothy Burrell MD, FACEP
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and

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