

# The PULSE

Osteopathic Emergency Medicine Quarterly

## Presidential Viewpoints

**Thomas A. Brabson, D.O., MBA, FACOEP-D, President**



I want to begin by wishing everyone a Happy and Healthy New Year! I also want to thank everyone for all of the support and encouragement that you have given me over this past year. I now have the opportunity to serve as president of the ACOEP for a third year due to some unfortunate circumstances that a member of our ACOEP family has experienced. Our former president-elect Anthony Jennings, D.O. continues to have improving health. He has also reaffirmed his commitment to serve the ACOEP to the best of his ability. He also suggested that our College members take just a few moments of their time to review the World Association of Sarcoidosis and Other Granulomatous Disease (WASOG) website.

With the beginning of every New Year we have the opportunity to reflect on our experiences of the prior year and set goals and objectives for the coming year. In 2010, your ACOEP had many positive experiences. Our membership has continued to grow each year. We not only

## We have achieved much...

## But have so much more to accomplish

experienced a growth in our practicing osteopathic emergency physicians, but we also had a dramatic increase in our resident and medical student members. All of our members are the life of our organization but the resident and student chapters continue to bring a continuously renewed vitality to the ACOEP that benefits us all. The great news is that we had two new emergency medicine programs and one new pediatric emergency medicine program approved in 2010 with more in line for this year.

Our executive director, Jan Wachtler, the ACOEP staff, committee chairpersons and committee members all worked very diligently last year to help us execute the strategic plan that we developed in March. The strategic plan was organized into 5 categories: Advocacy, Awareness and Marketing, Education and Knowledge, Membership, and Organizational Performance.

In the Advocacy category, we have worked very closely with the AOA on issues that would have an impact on our members. Some of these issues included; speaking out against the Medicare cuts and the SGR, letters of support to maintain the Texas Osteopathic medical school, educating the Texas Medical Board that AOBEM and ABEM are the only recognized certification Boards for emergency medicine. We have also been active participants in the AOA Strategic Planning Retreat Process. We also had the results of our emergency medicine

workforce endeavor with ACEP and many other organizations published in the Pulse and the Annals of Emergency Medicine. We will be participating in another meeting of the large group in January, 2011. We have also worked with the AOBEM to enhance our communication on issues that affect our members. The AOBEM secretary, Mark Stone, D.O. has worked very collaboratively with Jan and I and he has been to each of our membership meetings to address the membership and answer their questions on the certification and re-certification processes. We will continue to work with the AOBEM on these issues and the evolving maintenance of licensure issues.

In the Awareness and Marketing category, we have placed much emphasis on our website. We are making many positive changes that will embellish our ability to serve our members. We also plan to have the website make it easier for our members to gain value from their membership and better communicate with fellow members. We will also continue to work with the AOA to enhance the public awareness of osteopathic medicine.

Education and Knowledge has always been a major focus for the ACOEP. As I mentioned earlier, our emergency medicine residency programs continue to grow. The AOA President, Karen Nichols, D.O. has challenged each specialty society to grow

*continued on page 25*



## EMCARE CURRENTLY HAS OPPORTUNITIES AVAILABLE IN OHIO!!

Systems Medical Director to oversee both Lake Health West and Lake Health TriPoint Medical Centers  
Full-time and part-time staff physicians and mid-level practitioners  
Criteria: BC/BE EM



**Lake Health West Medical Center – Willoughby, OH**  
20 minutes east of Cleveland, OH

- 36,000 projected annual patient visits
- 180-bed hospital; 23-bed ED with a 5-bed Thru Care
- 41 hours of physician coverage with 17 hours of MLP coverage daily
- Physicians work shifts at both Lake Health facilities; West Medical Center and TriPoint Medical Center in Concord Township
- Helicopter service available; Cardiac Cath Lab on site; Radiology with a 64-slice CT and night reading services
- "A" rated malpractice insurance program with no tail obligation upon departure; CME reimbursement of 2k/year



**Lake Health TriPoint Medical Center – Concord, OH**  
30 minutes east of Cleveland and 5 miles south of Lake Erie

- 36,000 projected annual patient visits
- 119-bed hospital; 22-bed ED with a 5-bed Thru Care
- 41 hours of physician coverage with 17 hours of MLP coverage daily
- Physicians work shifts at both Lake Health facilities; West Medical Center and TriPoint Medical Center in Concord Township
- Helicopter service available; Radiology with a 64-slice CT and night reading services; 6-bed Clinical Decision Unit
- "A" rated malpractice insurance program with no tail obligation upon departure; CME reimbursement of 2k/year

**\*\* We have immediate needs! If you know of anyone at your current facility looking for some extra work, please pass along the information. Thank you!**



For more information, please call Craig Bleiler at (800) 247-8060 ext.25165 or email [Craig\\_Bleiler@emcare.com](mailto:Craig_Bleiler@emcare.com)

## VALLEY EMERGENCY MEDICINE RESIDENCY OF MODESTO



Valley Consortium for Medical Education



### NEW EM RESIDENCY PROGRAM DIRECTOR WANTED!

**N**ew Emergency Medicine Residency Program Director wanted for program at large teaching hospital in Modesto, California starting in 2012. Must meet all requirements for Program Director position as stated by the ACOEP.

Great opportunity, great salary and benefits, great location and working conditions and educational environment.

Please contact **Dr. Peter Broderick**, CEO/DIO, Valley Consortium for Medical Education, affiliated with Midwestern University OPTI.

*Surrounded by California's top destinations just miles away.*

209-576-3528 (office) | 209-404-7160 (cell)  
Email: [valleyconsortium@gmail.com](mailto:valleyconsortium@gmail.com)

**The Pulse**  
**An Osteopathic Emergency**  
**Medicine Quarterly**  
**142 E. Ontario St., Suite 1500**  
**Chicago, IL 60611-5277**

*Editorial Staff:*

Drew A. Koch, DO, FACOEP-D, *Editor*  
 Wayne Jones, DO, FACOEP, *Assist. Editor*  
 Thomas Brabson, DO, MBA, FACOEP-D  
 Anthony Jennings, DO, FACOEP  
 Janice Wachtler, *Executive Director*

*Editorial Committee:*

Drew A. Koch, DO, FACOEP-D, *Chair*  
 Wayne Jones, D.O., FACOEP, *Vice Chair*  
 David Bohorquez, DO  
 Thomas Brabson, DO, FACOEP-D  
 Joseph Dougherty, DO, FACOEP  
 Anthony Jennings, DO, FACOEP  
 William Kokx, DO, FACOEP  
 Annette Mann, DO, FACOEP  
 Brian Wiboon, DO  
 Janice Wachtler, CBA

*The PULSE* is a copyrighted quarterly publication distributed at no cost by the ACOEP to its Members, library of Colleges of Osteopathic Medicine, sponsors, exhibitors and liaison associations recognized by the national offices of the ACOEP.

*The PULSE* and ACOEP accepts no responsibility for the statements made by authors, contributors and/ or advertisers in this publication; nor do they accept responsibility for consequences or response to an advertisement. All articles and artwork remain the property of *the PULSE* and will not be returned.

Display and print advertisements are accepted by the publication through Norcom, Inc., Advertising/Production Department, PO Box 2566 Northbrook, IL 60065 · 847-948-7762 or electronically at [theteam@norcomdesign.com](mailto:theteam@norcomdesign.com). Please contact Norcom for the specific rates and print specifications for both color and black and white print ads.

Deadlines for the submission of articles and advertisements are the first day of the month preceding the date of publication, i.e., December 1; March 1, June 1, and September 1. The ACOEP and the Editorial Board of *the PULSE* reserve the right to decline advertising and articles for any issue.

©ACOEP 2009 – All rights reserved. Articles may not be reproduced without the expressed, written approval of the ACOEP and the author.

# THE PULSE

OSTEOPATHIC EMERGENCY MEDICINE QUARTERLY

## Table of Contents

Presidential Viewpoints . . . . .1  
*Thomas A. Brabson, DO, MBA, FACOEP-D*

Editorial . . . . .4  
*Drew Koch, DO, FACOEP-D*

Executive Director's Desk . . . . .5  
*Janice Wachtler, BA, CBA*

Mixing Business with Pleasure in the Sunbelt . . . . .6  
 ACOEP Welcomes 2011 with New Tech Initiatives . . . . .7  
*Erin Sernoffsky*

Scientific Assembly Breaks Records . . . . .8

ACOEP Recognizes Members . . . . .9

Guest Column . . . . .11  
*Kade Rasmussen, D.O.*

ACOEP FOEM: Foundation Focus . . . . .12

ACOEP FOEM: 2010 Research Competitions . . . . .13

ACOEP FOEM: 2010 Research Competitions Abstracts . . . . .14

ACOEP FOEM: Thanks You for Your Contributions . . . . .17

From the Pediatric Case Files . . . . .20

Are Doctors Going to Pot . . . . .23  
*Gregory Christiansen, D.O., M.Ed., FACOEP*

In My Opinion . . . . .26  
*Wayne T. Jones, D.O., FACOEP*

Changes on the ACOEP Board . . . . .26

Health Policies Studies . . . . .27

Resident Chapter Report . . . . .28  
*Sherry D. Turner, D.O., President*

Members in the News . . . . .28

At First Look . . . . .29

Ethics in Emergency Medicine . . . . .31  
*Bernard Heilicser, D.O., M.S., FACP, FACOEP*

# Editorial

**Drew Koch, D.O., FACOEP-D, Editor**



The first significant snowfall of the year is yet to arrive but winter temperatures prevail in the Northeast. The days are shorter and colder. Thanksgiving 2010 and the Holiday season have come and gone.

ACOEP celebrated its 35th year this year and capped off its celebration with the 2010 Scientific Assembly in San Francisco from October 24th – 28th 2010. This was held in conjunction (same city and same dates) as the AOA United Osteopathic Convention.

The ACOEP 2010 Scientific Assembly was the largest and in my opinion the most enjoyable ACOEP Scientific Assembly that I ever attended. I've been to 19 of the past 20 fall programs and each successive seminar surpasses the previous one in both attendance and quality of the education.

What made this conference so enjoyable and successful?

**Location** plays a huge role in determining how triumphant or disastrous a conference is. San Francisco, in my opinion, is an ideal location to hold a conference. It has a temperate climate; history; culture; ethnicity and diversity; landmarks such as cable car, fisherman's wharf, Golden Gate Bridge; beaches and parks and sports including the San Francisco Giants baseball team who won the 2010 World Series and played the first two games of the Series in San Francisco during the fall program. Many of these sites were within walking distance of Hilton San Francisco Union Square where the conference was held.

**Format** – The format of the 2010 Scientific Assembly was more conducive

and had minimal overlap among meetings, Student and Resident Chapter events, Oral Board Review, Case Competitions, Poster Presentations, Research and Awards Luncheon, Advanced Ultrasound Course and ACOEP lectures. The Oral Board Review, committee meetings, Resident Chapter events, Student Chapter events (for the majority of student events), Case Competitions and Poster Presentations were scheduled to meet before the ACOEP Lectures began. Historically, the Fellowship and Awards Ceremony and the Welcome Reception were held separately from any other College activities. This year the Fellowship and Awards Ceremony followed the Membership Meeting with the Welcome Reception following. Attendance at the Fellowship and Award Ceremony was greatly improved.

**ACOEP Lectures** – The hallmark of this excellent conference were the quality of both the speakers and their lectures. Special thanks and recognition should go to Christine Giesa, DO, FACOEP-D, Program Director; Nilesh Patel, DO; and the CME Committee for putting together these outstanding lectures and bringing the excellent speakers to the seminar.

**FOEM** – The Foundation for Osteopathic Emergency Medicine made available research activities, like the CPC, research panel presentations, the oral abstracts and resident research competition. FOEM was founded in 1998 and established as a 501(c)3 charitable organization by the American College of Osteopathic Emergency Physicians (ACOEP) as a philanthropic arm of the osteopathic emergency medicine community. Its purpose is to develop grants and awards to support research in emergency medicine conducted by or under the jurisdiction of osteopathic physicians. FOEM is the

only national organization created for the specific purpose of providing funds for research and education solely for osteopathic emergency medicine. These research activities enhanced and added additional CME credit to the conference.

**Sponsors** – There were 23 sponsors and exhibitors who supported the 2010 Scientific Assembly. In addition, some of our sponsors supported resident and student events as well as the Awards and Research Luncheon.

**ACOEP Staff** – This seminar's success was not possible without all the hard work and dedication of the ACOEP staff. Each staff member was extremely cordial, helpful, knowledgeable, and made a conscientious effort to make each member of the college feel that they were special.

**ACOEP members** – There were over 900 member participants at the Scientific Assembly. This was the largest gathering of members for a conference. In addition to the large number of participants at the conference, there are now over 4,000 members of ACOEP. The large showing of participants is a testament to the excellent Scientific Assembly that was bestowed upon us in San Francisco.

The 2010 fall Scientific Assembly played tribute to ACOEP's 35th Anniversary. It was by all accounts an excellent seminar. As the College embarks on its 36th year, it is imperative that the college continues to provide quality CME conferences at sensible locations that are reasonable priced and not cost prohibitive.

## Executive Directors Desk

Janice Wachtler, BA, CBA

# Be the Change...



The thing that I noticed throughout my life is that adults don't always listen to children. Growing up we were told that children 'should be seen and not heard;' however,

I also learned that you learn a lot from children and perhaps we should begin to hear what they are saying.

That being said, it's about time that we all start listening to our young physicians and medical students, who have been out in the hinter lands of medicine forever and made to feel, in some instances, like fodder for the cannon known as medicine. I say this because for over thirty years I've heard medical students use phrases like "medicine eats their young" and "slavery ended in 1863, but not in medicine." Perhaps it's time we, as "adults", opened our ears and minds to what they are saying. It's not that all physicians in their youth haven't felt this way, but once the establishment becomes the norm, we seem to forget about where we were only a few short years ago.

Last summer, the Student Chapter of the American College of Osteopathic Emergency Physicians conducted a survey to ascertain the feelings of current students toward issues related to residency training and osteopathic medicine. Was it a large survey; no. Did it present anything new or startling; no. But it showed that things in osteopathic medicine, while changing with the time, have not really changed since the early 1980's meaning we will continue to have dissatisfied students who feel like they are strangers in a strange land, until we acknowledge their concerns and make the changes necessary to accommodate their needs.

The facts and figures brought forth

in the survey of 202 assorted students, within local emergency medical clubs, made up of 100 (50%) OMS1, 71 (35%) OSMII, 27 (14%) OSMIII and 2 (1%) OSMIV students from 22 COMs and from 36 different states aren't any different than previous studies done with larger samples that have been conducted by other agencies.

The survey included a question on what characteristics students were looking for in their future residency training programs. Topping the list were location and program quality, at the top with 89% and 88%, respectively, responding that these were the deciding factors. Following closely behind were trauma level (69%) and department volume (58%). Other less important features were program size and academic setting, tied at 33%, followed by family atmosphere (32%) and research opportunities (13%).

Another question on the survey asked how they ranked osteopathic vs. allopathic training program; surprisingly the majority (61%) favored osteopathic programs over allopathic programs (39%) selection. When queried further those stating who preferred allopathic training did so because of the location of the program. Also, 70% of those who preferred allopathic training over osteopathic training stated that they would be interested in seeking osteopathic certification if this was available to them.

The Chapter also asked the student's perception on how they felt the AOA met their expectations, the majority was favorable, however, 27% answered in the negative, why? Listen to these paraphrased and condensed statements . . .

- AOA has done little to curb the growth of COCA accredited schools while not maintaining growth of residency positions for these graduates.
- Little communication about any kind of residency training, except family medicine

- Not enough slots to accommodate graduates
- Hard to find out information about residency training on website or from staff
- Not enough osteopathic medicine taught in schools

While we would like to put all the blame on AOA, some of it lies at ACOEP's doorstep with our inability to create sufficient slots and programs nationwide to help place student desiring emergency medicine positions. But there is plenty of blame to go around, including our own member apathy and the apathy of all the other physicians who have complained as students. These physicians, as they have moved into the position of an "adult" physician have forgotten their trials and tribulations of the past.

So where do we go from here? A first step would be to become involved with your medical school and mentors and work with these young physicians as they begin to select their special niche in medicine. Next, the ACOEP must send out a core of physician-educators to work with COMS and Emergency Medicine Chapters to develop and implement lectures and activities in emergency medicine. The third and most critical step for our members is to become the squeaky wheel and become active not only in the ACOEP Committees, Boards and Special Interest Groups, but in the osteopathic profession at the regional, state and national levels. This will provide an avenue to let your concerns and the concerns of these students to be heard in a forum that can make the changes that you want and need to be successful in your practice.

Emergency physicians can no longer afford to be the tacit voice in osteopathic

*continued on page 25*

# Mixing Business with Pleasure in the Sunbelt

It's never been a better time to be a doctor. (Or for that matter, married to a doctor, the best friend of a doctor, or the child of a doctor. An Osteopathic ER doctor, specifically!) ACOEP's Spring Seminar is on the horizon, and this is one trip where mixing business with pleasure is made easy.

There are plenty of CME hours to be had through the didactic sessions (which conclude by noon each day), Case Study Poster Competition and review course for the COLA 8 exam premiering in 2011. An optional EMT track will offer five extra hours with lectures on such topics as therapeutic hypothermia, disaster response in Haiti, pre-hospital stroke care and international EMS. The membership meeting will keep everyone abreast of the latest changes and advancements within ACOEP.

While this course is an excellent learning opportunity, it's also designed with spring break in mind!

The Marriott Harbor Beach Hotel in Fort Lauderdale sits on 16 acres of pristine, private beaches where attendees and their guests can enjoy boating, jet skiing, snorkeling and a myriad of other ocean activities. However, if salt water is not appealing, a tropical lagoon pool sprawls throughout a stunning patio. After soaking up chlorine, DO's and their families can head to the luxurious private spa overlooking the stunning Atlantic waters. For the sportier set, golf privileges at some of Florida's most celebrated courses are available for guests as well as complimentary access to a state of the art fitness center.

Those traveling with children can take advantage of the Surf Club for Kids which includes everything from a custom built surf simulator to underwater cameras and formatting programs to create unique souvenirs. The hotel is also conveniently located close to activities such as the Museum of Science and Discovery to the Riverwalk Arts and Entertainment District just four miles away.

As the sun sets in the west on Tuesday, April 26th, conference attendees and their families are invited to a private, ocean-front reception. This is the perfect opportunity to relax with old and new friends and mingle with the families and friends of fellow DO's.

In Fort Lauderdale, the cuisine can be summarized in two words: fresh and marine. The Harbor Beach boasts three incredible restaurants, each with a unique flavor and oceanfront view. From the sophisticated 3030 Ocean to the fun and laid back Sea Level Restaurant and Ocean Bar, there is something for every palate.

Who said medical conferences can't also be a vacation for the whole family? The ACOEP staff looks forward to working to make this a professionally rewarding conference that is educational and relevant. We're leaving the fun and sunny part up to Florida!

## Side Bar 1

*Dates to Remember*

## Welcome Reception

Tuesday, April 26, 2010

5:00-6:30pm

Enjoy a glass of wine, delicious appetizers, old friends and sand between your toes at the annual Welcome Reception. Friends and family are welcome!

## FOEM Case Study Poster Competition

Wednesday, April 27

1:00-4:00pm

Student and residents take center stage as they present and defend cases that they have seen in their practice. First place winner receives \$500!

## COLA 8 Review

Thursday, April 28

Review for the newly released COLA 8 exam. Attendees will be briefed on the articles addressed in the new test and have the opportunity to take the exam at the

conclusion of the course. The fee for the course is \$200 and includes refreshments as well as 5 hours of 1A CME credit.

## EMS Track

Friday, April 29

New this year!

An optional EMS track will be offered this year and includes discussion on topics such as therapeutic hypothermia, disaster response in Haiti, pre-hospital stroke care and international EMS. The cost for this track is \$50 and provides attendees with 5 additional hours of 1A CME credit.

## Side Bar 2

*Speaker Feature!*

ACOEP is thrilled to welcome back Dr. Ken Butler. Dr. Butler is Associate Professor of the Division of Emergency Medicine at the University of Maryland School of Medicine in Baltimore, Maryland as well as the Associate Residency Director for the Division of Emergency Medicine Residency Program at the University of Maryland School of Medicine. Dr. Butler most recently spoke at ACOEP's Scientific Assembly in San Francisco and was described by one happy attendee as "a clear expert!"

## Side Bar 3

Need help with planning your visit? Try these valuable resources to get the most out of the sunshine state!

Marriott Harbor Beach Hotel  
[www.marriottharborbeach.com](http://www.marriottharborbeach.com)

The Greater Fort Lauderdale Convention and Visitor's Bureau  
[www.sunny.org](http://www.sunny.org)

Official Source for Travel in the Sunshine State  
[www.visitflorida.com](http://www.visitflorida.com)

The Everglades  
[www.evergladesgateway.com](http://www.evergladesgateway.com)

# ACOEP Welcomes 2011 with New Tech Initiatives

Nowhere is the advent of a new year more noticeable than in the Emergency Room with its steady stream of the over indulgent. However ACOEP is making its own preparations to keep up with the coming year and to stay ahead of the ever changing e-curve. Once the flow of the inebriated slows down to its normal pace, take to your computer or smart phone to see ACOEP's exciting new 2011 technological initiatives!

The most noticeable of these enterprises will be the unveiling of ACOEP's newly redesigned website! Along with sporting a sleek new look, the site boasts easier navigation, up-to-date information regarding conferences, membership news, and increased interactivity. Brian Thommen, Director of Information Technology, has made the site a one-stop hub to view member benefits, keep up with committee news, job postings, competition notifications and sponsorship information. Registering for conferences or updating dues information will be easier than ever on a site that links seamlessly with the database. ACOEP.org will also host links to papers and information from leaders in the Osteopathic Emergency field. Says Thommen, "the new site is designed with our members needs in mind and we are thrilled to get it off the ground. It's user-friendly and a great tool to stay informed without having to waste time searching the web. It's created so that all the information is at your fingertips."

Student and Resident Chapter sites will also undergo a facelift. Student Resident members will now be able to

visit their website to view information that will aid them in their study and as they establish new practices. This will be the place to buy ACOEP apparel in support of the Student Chapter (it's never too early to start next year's holiday shopping), view the Fast Tracks Newsletter, and read up on the New Student Survival Guide as well as view abstracts and material on the student lecture series beginning with the Spring Seminar.

Along with the new website, ACOEP is proud to announce the launch of AVECtra Social, a personalized networking site designed specifically for ACOEP. Working in conjunction with our database, members will be able to log in and view a private, tailored page that will offer, among many other things, the ability to collaborate outside of meetings, build individualized profiles, share committee information and documents on everything from didactic sessions at the latest conference, to competition information, to national news pertinent to all physicians.

As the world becomes more connected, so too does ACOEP, and the need to stay linked to fellow DO's has never been greater. Networking should not stop at the end of a meeting and it does not need to mean hours spent online looking at different pages or arduous evenings wading through the latest Hollywood news. ACOEP is making it easy to be in touch with the launch of a new Facebook® page and Twitter® feed.

On Facebook® you can connect with other members, hospitals and programs. While you are there, check

out pictures of recent events, registration deadlines. Facebook will announce competition winners, recognize members for achievements in the field and provide an excellent platform to stay connected to fellow DO's. Visit ACOEP's page to see information on food and entertainment in the cities that host each conference (Vegas, baby!). Facebook is a useful means in sparking conversations and sharing information with physicians and program chairs across the country.

Not just for celebrity gossip, ACOEP's Twitter feed will keep you abreast of news from the College as well fellow associations such as the AOA and ACEP. The benefit of Twitter is that you chose the news you wish to receive and get pertinent, concise information without having to sift through articles and e-mails. It is an excellent place to receive alerts on deadlines and to keep abreast of Board appointments, committee decisions, staffing changes or national news such as the ongoing health care debate in Congress. Twitter will be a great way for the College to disseminate information quickly to a broad base of users, and not just the latest on Lindsay Lohan's rehab status!

As surely as New Year's Eve means a busy night and crazy stories for ER docs, ACOEP will keep its members connected. The new website and social media outlets are just the tip of the iceberg in efforts to make life easier for ACOEP members and to support vital practices in ED's across the country.

# Scientific Assembly Breaks Records

2010 was a remarkable year in many ways. Oil spewed forth in the Gulf. Earthquakes rocked Haiti, floods ravaged Pakistan. The TSA got rather friendly in security lines. The world came together in South Africa for the World Cup, and then again to protest the officiating at the World Cup. The Health Care Reform Debate spread like wildfire through town hall meetings across this great nation. And most importantly, ACOEP broke attendance records at the annual Scientific Assembly in October!

Under the direction of Co-Chairs, Christine Giesa, DO, FACOEP-Dist., first-time Chair Nilesch Patel DO, FACOEP, the 2010 Scientific Assembly hosted 921 attendees this year, including, 555 attending physicians, 143 residents and 209 students. This marks a 31% increase in attendance from 2009's conference in Boston. With 39 possible CME hours, nine committee meetings, the election of new board members, and 25 didactic sessions ranging on every topic from cutting edge management in CVA to controversies in trauma resuscitation, the 2010 Scientific Assembly was packed with activities and opportunities for professional development.

"Overall this was the best slate of speakers," said one happy attendee. "I really appreciated the emphasis on current trends, research and practice guidelines and staying away from just another review course."

For the first time, Scientific Assembly also included the Oral Board Review Course. Under the direction of new Chair, Christopher Colbert, DO, this course also boasted record-breaking participation. 51 attendees prepared for their Oral Boards and the conference continues to grow in popularity as it moves back to Chicago before the March exams.

While the didactic sessions proved valuable and informative, it was not all work on the west coast. The San Francisco Hilton Union Square, which played host to this year's convention, is centrally located near San Francisco's historic

Chinatown, bustling Fisherman's Wharf and not far from the colorful Haight-Ashbury neighborhood. Attendees and their families took extra time to visit wine country, tour Alcatraz and enjoy the famous San Francisco sour dough bread and Ghirardelli's chocolate.

ACOEP's conference also provided ample time to reminisce with old friends and network with new contacts while enjoying cocktails at the Welcome Reception. The 2010 reception took place in the breathtaking Cityscape on the 38th floor of the Hilton. The ballroom walls are completely made of glass and provide an dramatic 365 degree view of San Francisco and the Bay. It is no wonder that one physician noted, "even the food was a distraction!"

The bar has been set high for the 2011 Scientific Assembly, which moves to America's playground: Las Vegas. The



ACOEP staff is already hard at work preparing to outdo themselves again. The conference will take place at the new and luxurious Encore hotel in Las Vegas. An all-star lineup of speakers and events, surrounded by beautiful art work, a state of the art casino, lush grounds and all the show stopping activities that Sin City has to offer. No matter the news stories that dominate the cable networks and magazines throughout the next 12 months, ACOEP is determined to have another story worthy of the headline, "Scientific

Assembly Breaks Records for the Second Year in a Row!"

## SIDE BAR

Congratulations to our new Board Members!

Otto Sabando and David Leavy will each serve a three-year term

Anita Eisenhart, re-elected through 2013  
Sherry Turner, Resident Chapter President  
Andrew Little, Student Chapter President

## Meet the Chairs!

Although this is his first year as the conference chair, the 2010 Scientific Assembly is hardly Nilesch Patel's first involvement with ACOEP. A 2003 graduate from Philadelphia College of Osteopathic Medicine and a 2007 resident with Lehigh Valley, Patel is currently working at St. Joseph's Regional Medical Center in Paterson, NJ. He is a Robert Donaghy Teaching Fellow through EMRA and in 2009 he was awarded as Faculty of the Year by the resident's at St. Joseph's. Patel has participated as a lecturer with the Scientific Assembly, Spring Seminar and Intense Review, as well as being a member of various committees and has served as an examiner for the biannual Oral Board Review Course.

Christine Giesa, has been involved with ACOEP for many years in a myriad of roles. She has served as the long-time Chair of the CME committee as well as chair of the Spring Seminar in addition to Scientific Assembly. She is also an Assistant Professor of Emergency Medicine at the Philadelphia College of Osteopathic Medicine as well as an Adjunct Clinical Instructor of Emergency Medicine at Jefferson Medical College. She has also served as the Assistant Director of the Delaware County Memorial Hospital Emergency Department as well as an attending physician at both Delaware County Memorial Hospital and the Albert Einstein Medical Center.

# ACOEP Recognizes Members at 2010 Scientific Assembly

The American College of Osteopathic Emergency Physicians happily recognized its members for the contributions that they make to the College, profession of emergency medicine and humanity at its Fellowship and Awards Ceremony at the Scientific Assembly in San Francisco on October 25th.

Special recognition was given to **Peter Ajluni, D.O.**, former AOA President as he was made an Honorary Member of the ACOEP for his work with us to obtain our new office space a few years ago. Dr. Ajluni joins us as the fourth Honorary Member in our 35 year history.

Special recognition was also given to **Levente Batizy, D.O., FACOEP**, who was honored for his many years of service to the profession as founding Program Director at South Pointe Hospital in Brentwood Hospital and long-time member of the College as the recipient of the **Bruce D. Horton, D.O., FACOEP Lifetime Achievement Award**. The Horton award is given to emergency physicians who have given back to the profession through word and during their professional lifetime.

Also recognized for his passion for education and service to the educational community was **John C. Prestosh, D.O., FACOEP** of Bethlehem, Pennsylvania. Dr. Prestosh received the **Benjamin A. Field, D.O., FACOEP Mentor of the Year Award** for his service to the profession as Program Director at St. Luke's Hospital in Bethlehem, PA and for work with the Resident In-Service Examination (RISE) Committee as a member and now chair. Dr. Prestosh has worked for the past five years to upgrade the examination and make it a quality examination that helps to prepare our young physicians for their certification examinations and the programs to make better assessment of the residents' progression through training.

**Drew A. Koch, D.O., FACOEP-D** was recognized for his contributions to the field of emergency medical services in the Ithaca, New York area. Dr. Koch received

the **Robert D. Aranosian, D.O., FACOEP Excellence in EMS Award**. Upon moving to the Ithaca, NY area, Dr. Koch was thrust into the EMS area and placed in charge of their emergency medical service area where he worked to revamp the system to make it serve its constituents better.

The award of the title of **Distinguished Fellow** is based on the further accomplishment of physicians already holding the honorary title of Fellow in the ACOEP. These physicians have been a Fellow of the College for a minimum of 10 years and have gained recognition for their involvement on committees, boards, or other activities in the ACOEP, AOBEM or AOA; prior or current involvement in professional organizations on an international, national, state or local level that concern emergency medicine, EMS/disaster management, pediatric emergency medicine or medical toxicology; involvement in significant ongoing research contributions to the specialty of emergency medicine or any of the above subspecialty areas of emergency medicine; development of a clinical training program as the program director, (initial or continuing position); service to the profession that has achieved national, state, or regional recognition, and recognition or awards for excellence in emergency medicine (or its subspecialty areas) from local, state, and national organizations. Honored in 2010 were: **Steven E. Aks, D.O.** (Chicago, IL); **Thomas A. Brabson, D.O., MBA** (Media, PA); **William Fraser, D.O.** (Columbus, OH); **Christine F. Giesa, D.O.** (Collegeville, PA); **Douglas M. Hill, D.O.** (Morrison, CO); **Mary J. Hughes, D.O.** (DeWitt, MI); **Joseph C. Hummel, D.O.** (Sewell, NJ); **Alan R. Janssen, D.O.** (Fenton, MI); **B. Bryan Jordan, D.O.** (Rochester, NY); **Drew A. Koch, D.O.** (Ithaca, NY); **Joseph J. Kuchinski, D.O.** (Mountain Lakes, NJ); **Mark S. Rosenberg, D.O.** (Denville, NJ); **Bryan D. Staffin, D.O.** (Buchanan, MI); **Louis C. Steininger, D.O.** (Tucson, AZ); **Robert**

**E. Suter, D.O., MHA** (Dallas, TX); **David A. Wald, D.O.** (Wynnewood, PA), and **Douglas P. Webster, D.O.** (Solvang, CA).

The award of Fellow of the American College of Osteopathic Emergency Physicians is presented to members of the College who have met specific achievements in the careers. The physician presented with this award has met strenuous requirements that indicate his or her commitment to medicine and emergency medicine. These include board certification in emergency medicine; commitment to emergency medicine as evidenced through membership in the ACOEP; service to the osteopathic emergency medicine community; evidence of continued education; involvement in medical education on the pre and postdoctoral levels; publication of scientific articles; achieved of advanced degrees beyond a medical degree; active direction or emergency medical services on a national, community or local level, and service to the Foundation or above and beyond that expected of a young physician. Honored in 2010 were: **Paul J. Adams, D.O.** (Fort Lauderdale, FL); **Michael Applewhite, D.O.** (Temple, TX); **Robert K. Bazuro, D.O.** (Sandy Hook, CT); **Todd A. Bell, D.O.** (Lima, OH); **Marc M. Bonin, D.O.** (Greenfield Twp., PA); **Nikolai Butki, D.O.** (Clarkston, MI); **Michele P. Butler, D.O.** (Lake Havasu, AZ); **Victoria A. Camba, D.O.** (Fort Lauderdale, FL); **Stephanie L. Davis, D.O.** (Kansas City, MO); **Elaine Diaz, D.O.** (Miami, FL); **John J. Fosbinder, D.O.** (Bakersfield, VA); **Michele M. Fowler, D.O.** (Tulsa, OK); **Richard C. Giovannini, D.O.** (Utica, MI); **Michael L. Kelley, D.O.** (Hudson, OH); **Kyle Kennedy, D.O.** (Joplin, MO); **Judith M. Knoll, D.O.** (Erie, PA); **Cindy Y. Kuo, D.O.** (Colton, CA); **Michael A. LoGuidice, Sr., D.O.** (New Port Richie, FL); **Daniel Lombardi, D.O.** (Mahopac, NY); **Tariq Noohani, D.O.** (Tampa, FL); **Brian Panik, D.O.** (Kamuela, HI); **Joseph J. Peters, D.O.** (Peoria, IL); **Katherine J. Pitus, D.O.** (West Bloomfield, MI);

**Frederic A. Rawlins, II, D.O.** (Radford, VA) ; **Brian Risavi, D.O.** (Erie, PA); **Martha J. Shadel, D.O.** (Harrison Township, MI); **Afar Shamoon, D.O.** (Rochester, NY); **Kellee R. Shea, D.O.** (Park City, UT); **Cynthia Shen, D.O.** (Queenstown, MD); **Greg Sorkin, D.O.** (West Orange, NJ); **Ali Tariq, D.O.** (Troy, MI); **Harrison Tong, D.O.** (Clarkston, MI); **Susan S. Watson, D.O.** (Gunnison, CO); **Amber Weigler, D.O.** (Garden City, MI); **James B. Williams, D.O.** (Oklahoma City, OK), and **Shelly Zimmerman, D.O.** (Edmond, OK).

We welcome all of our members to our pride in recognizing the contributions of all of these physicians and direct you to our website to view the photographs from this ceremony and other activities at the Assembly.

If you are interested in becoming a Fellow, Distinguished Fellow or nominating a physician you may know for any of the awards described above, please visit our website [www.acoep.org](http://www.acoep.org) to learn more.

# MICHIGAN STATE UNIVERSITY

Michigan State University College of Osteopathic Medicine, is seeking an experienced emergency medicine physician. This opportunity is an exciting mix of patient care, academic teaching, clinical research and curricular development. Current faculty members in the department include a mix of primary and specialty care physicians, and all are involved in residency training, bedside teaching, course development, small group medical student education, and lectures to pre- and post-doctoral trainees. Many are also involved in research activities. Comfort with information technology is essential. Curricular development skills with demonstration of implementation and evaluation of efforts will receive the highest priority. Competitive salary and rank are commensurate with experience and qualifications. Candidates must possess an accredited DO degree and be AOBEM or ABEM certified or eligible. Successful candidates will have proven clinical and teaching experience; graduating residents will be considered if they possess outstanding interpersonal and teaching skills. Candidates should submit a cover letter and CV to: **Mary Hughes, DO, FACOEP, FACEP, MSU-COM Department of Internal Medicine, B-305 West Fee Hall, East Lansing, MI 48824. Phone: (517)353-3211 or email [hughesm@msu.edu](mailto:hughesm@msu.edu).**

MSU does not discriminate on the basis of race, color, religion, national origin, gender, age, disability, or status as a Vietnam-era veteran in its hiring and employment practices.

MSU IS AN AFFIRMATIVE ACTION, EQUAL OPPORTUNITY EMPLOYER.

We scream

for ice cream.



**And baseball games. Walks in the park and ballet recitals.** We're Emergency Medicine Physicians and we're champions for life. If you're dedicated to delivering the best in emergency medicine, and living life to its fullest, consider a career with EMP. We're a democratic group that's owned and operated by emergency medicine physicians that understand life is precious—and so is living it. Visit [emp.com](http://emp.com) to discover how you can create your own schedule your entire first year.

**EMP**  
Emergency Medicine Physicians

[EMP.com](http://EMP.com)   
Opportunities across the USA.

# Affect of Healthcare Reform on Access to Care

Guest Columnist

*Kade Rasmussen, D.O.*

*ACOEP-RC Board Member*

This year has been one of great excitement and trepidation in the healthcare community with the passing of the Affordable Care Act of 2010. This bill will increase the number insured individuals by roughly 32 million Americans, but at what cost. Prior to the passage of this reform, there was already a projected shortage of primary care physicians. According to the Council on Graduate Medical Education estimates that among 24,378 medical students who were matched to residency training positions in 2010, between 3891 and 4385 plan careers as primary care physicians. Thus, only 16 to 18% of medical students who obtained positions through the National Resident Matching Program in 2010 are likely to practice primary care<sup>1</sup>. The American College of Internist reported that of the new residents going into Internal medicine, only 22% were going to stay primary care which is down from 56% in 1998. With this additional 32 million soon to be insured Americans, the need for primary care physicians will be even greater.

How does this shortage affect us as Emergency Department Physicians? Massachusetts has provided the model of the things to come. In a recent Newsweek article<sup>2</sup>, they reviewed the affects of the Massachusetts health care law. It did show a decrease in the number of uninsured individuals from 12.5% in 2006 to 4.8% in 2009. Sharon Long of the Urban Institute was quoted as saying in relation to Emergency Room visits in Massachusetts since the passing of their health care law, "about a third of the non-elderly go at least once a year, and half their visits involve "non-emergency conditions." The New England Journal of Medicine in 2009<sup>3</sup> reported, "40% of family doctors (up from 30% in 2007) and 56% of internists (up from 49%) said they were not accepting

new patients." So despite the fact that there has been a decrease in the number of uninsured, there remains a large number of ED visits. Michael Tanner<sup>4</sup> of the CATO Institute commented on the cost of the Massachusetts healthcare bill, "Health care costs continue to rise much faster than the national average. Since 2006, total state health care spending has increased by 28 percent. Insurance premiums have increased by 8–10 percent per year, nearly double the national average."

What is to be done about this shortage? Common sense would warrant increasing the number of physicians. The Balance Budget Act of 1997 froze the number of residency spots. Since that time, only 1000 spots have been added. Congress recently rejected a proposal to increase the spots by 15%. They choose instead to redistribute about a 1000 spots from hospitals that did not fill during the match. Interestingly, most of these spots came from primary care fields. With the increasing debt medical students have coming out of medical school compared to what the annual salary of a primary care physician is, it is no wonder that more students steer away from primary care. The one good thing that this new bill has done is increased repayments to primary care physicians but has done nothing for non primary care specialties. Health and Human Services does not consider emergency medicine primary care, thus these new incentives found in the Affordable Care Act are of no use to the ED.

The affects of the new health care law remain to be seen, and probably won't be seen for many years to come. Most of these uninsured will not actually become insured until 2014. If the trend continues and we round the estimated number of new graduates from medical school going into primary care to 4000 a year

for 4 years equaling roughly 16000 new physicians, but only two of these classes will be graduated at the time the bill takes full affect. That means the two graduated classes will be responsible for roughly 4000 patients each. That is of course not taking into account the current primary care physicians or the continued aging population. The likely outcome will be the increased use of mid level providers. This will lessen the blow of this new influx of patients, but it will not lessen the amount of patients in the ED. The ED will play an even higher role in the general health care system. The need for residency trained ED physicians will be even more important than ever before.

---

1. Council on Graduate Medical Education. 20th Report on advancing primary care. (Not yet released by HHS but approved by the council.) Washington, DC: Health Services and Resources Administration, Department of Health and Human Services, 2010.

2. <http://www.newsweek.com/2010/07/19/massachusetts-offers-preview-of-obamacare.html>

3. Iglehart JK, Reform and the Health Care Workforce — Current Capacity, Future Demand, N Engl J Med 2009; 361:e38

4. Tanner M, Massachusetts Miracle or Massachusetts Miserable What the Failure of the "Massachusetts Model" Tells Us about Health Care Reform, CATO Institute Briefing Papers, No. 112, 6/9/2009

**Juan Acosta, D.O., MS, FACOEP, President, FOEM**

## Foundation Focus



2010 was such an exciting year for the Foundation for Osteopathic Emergency Medicine (FOEM). We were able to provide a David A. Kuchinski Memorial Research

Grant to James Turner, D.O., FACOEP and his team at Charleston Area Medical Center for research being done on “Posttraumatic Stress Disorder, Work Stress, and Burnout among Healthcare Professionals.” We look forward to seeing their progress in 2011.

FOEM also had the pleasure of hosting five extremely successful research competitions that capped off with an elegant Awards Luncheon in San Francisco where the **2010 FOEM/EMP Research Paper Competition** winners presented their research to the crowd. At the end of a very nice meal, the awards for the various competitions were presented to the winners by members of the FOEM Board.



Also, for the first year ever, FOEM held a raffle in conjunction with the ACOEP Scientific Assembly that boasted prizes such as an Apple iPad, hotel certificates, and a laptop computer. The FOEM booth

raffle was a success, raising thousands of dollars to go towards research in osteopathic emergency medicine. Thank you to all that participated in this fun event, stop by the FOEM booth at the 2011 Spring Seminar to find out about future fundraising initiatives.

As mentioned in the October issue of *The Pulse*, the FOEM Board was lucky enough to acquire some talented new members this year. It did not take long to notice their positive impact, and I would like to take a moment to briefly introduce these new Board members to you.



William Lynch, Jr. is the owner of National Hotel Services (NHS), an extremely successful provider of site selection, meeting planning, and consulting. Being one of the non-physician members of the FOEM Board, Mr. Lynch is charged with the Events Planning responsibilities of FOEM. He will undoubtedly prove to be a benefit to the Foundation, as will surely be seen in future FOEM luncheons, galas, and receptions.



Robert Suter, D.O., MHA, FACEP, FIFEM is an already prominent figure within the ACOEP community and has been a founding member of both the ACOEP Student and Resident Chapters, and a member of numerous other boards and committees. He has served as President of ACEP in 2004-2005 and has a very long history of service to emergency medicine on a state, national, and international level. Dr. Suter’s impressive research background, vast philanthropic experience, and scholastic aptitude will be an enormous benefit to the Foundation.

Douglas P. Webster, D.O., FACEP, FACOEP-dist is currently Executive Vice President of EmCare, and has previously



served as Regional Chief Executive Officer of EmCare’s Midwest Region. He is a board certified and residency trained physician that has a long and impressive history within the emergency medicine community. He is the author of numerous publications in science and medicine, and a board member of several charitable organizations. Dr. Webster’s strong research and statistical background, business savvy, and philanthropic experience will definitely be a huge asset to FOEM.



Stephanie Whitmer is the Executive Secretary of the FOEM Board, and has been eagerly devoting her time to develop and perfect the daily operations at the FOEM office. Any and all FOEM related inquiries, from grant applications to competition information, should be directed towards Stephanie as she is always happy to help.

Nike Whitcomb, CFRE is not on the FOEM Board, but has been successfully providing fundraising consultation to the Foundation since July, 2010. She is the principal of the fundraising consultant firm Nike B. Whitcomb & Associates, Inc. and has 40 years of experience in management, marketing, public relations and fund raising in both the public and private sectors. Her personal expertise will help the Foundation grow revenue that will directly benefit the osteopathic emergency medicine community.

It is an incredible honor to have these people on the Board, and we are all excited to put our talents to use. For full bios of the entire FOEM Board, please visit [www.foem.org](http://www.foem.org).

# 2010 FOEM Research Competitions

It was another exciting year at the **2010 FOEM Research Competitions** as we had the pleasure of watching our students, residents, and faculty compete against one another for recognition and of course, cash prizes. Year after year, the quality of research and presentation skills has improved, and we look forward to many more successful years to come. We hope everyone enjoyed participating in and observing these fun and educational events and we would like to thank all the generous donors, sponsors, judges, and participants that made the **2010 FOEM Research Competitions** possible. We could not do it without you!

## 2010 FOEM Case Study Poster Competition

1st Place: **Marianna Karounos, D.O.** from St. Joseph's Regional Medical Center for her poster titled, *Gastroesophageal Intussusception: Now you See It, Now You Don't*

2nd Place: **Alexandre Pierrot, D.O.** from St. Barnabas Hospital for his poster titled, *Rapidly Expanding Non-Traumatic Pericardial Effusion with Tamponade*

3rd Place: **James Rodriguez, D.O.** from *Botsford Hospital* for his poster titled, *Isoniazid Toxicity*

## 2010 FOEM and EMP Research Paper Competition

1st Place: **Julie Lata, D.O.** from Mount Clemens Regional Medical Center for her paper titled, *A Prospective Evaluation of Emergency Ultrasound Using Hydrophrosis Index versus the Graded Renal Pelvis Dilatation for the Evaluation of Ureteral*

## Obstruction and Ureteral Lithiasis

2nd Place: **Anthony Catapano, D.O.** from St. Joseph's Regional Medical Center for his paper titled, *The Utilization of Computed Tomography in Diagnosing Renal Colic Due to Uretero-nephrolithiasis; Is it Necessary in all Cases?*

3rd Place: **Lionel Lee, D.O.** from Arrowhead Regional Medical Center for his paper titled, *Fournier's Gangrene and Increasing Methicillin-resistant Staph Aureus Association between 2002 - 2008*



Lionel Lee, D.O. presents his research at the 2010 FOEM/EMP Research Awards Luncheon

## 2010 FOEM and Schumacher Group Clinical Pathological Case (CPC) Competition

Resident 1st Place: **Brian McGrath, D.O.** from St. Barnabas Hospital

Resident 2nd Place: **Irene Dmitruk, D.O.** from Northwestern University/CCOM

Resident 3rd Place: **Julie Sanicola-Johnson, D.O.** from St. Joseph's Regional Medical Center

Faculty 1st Place: **Otto Sabando, D.O., FACOEP** from St. Joseph's Regional Medical Center

Faculty 2nd Place: **Mary Hughes, D.O., FACOEP** from Edward W. Sparrow Hospital

Faculty 3rd Place: **James Turner, D.O., FACOEP** from Charleston Area Medical Center

## 2010 FOEM and MedExcel Poster Competition

1st Place: **Shannon Weinstein, D.O.** from Good Samaritan Medical Center for her poster titled, *Is the Use of Multiple Medications an Independent Predictor of Length of Stay and Probability of Admission?*



Shannon Weinstein, D.O. receives her 1st Place Award

2nd Place: **Marianna Karounos, D.O.** from St. Joseph's Regional Medical Center for her poster titled, *Placing a Physician on Triage: The Effects of an Urban ED.*

3rd Place: **Alaina Hunt, D.O.** from Hamot Medical Center for her poster titled, *Cervical Collars in the Pre-hospital Setting: How well do they fit?*

**2010 FOEM and EmCare Oral Abstract Competition**

1st Place: **Diana Kontonotas, D.O.** from Good Samaritan Medical Center for her presentation titled, *EM Residents Use Bedside Ultrasound to Diagnose Appendicitis and Avoid the Radiation of CT Scans - The Effect of Feedback.*



*Diana Kontonotas, D.O. receives her 1st Place Award*

2nd Place: **Michael DeVarona, D.O.** from Mount Sinai Medical Center for his presentation titled, *Does Rib Raising Increase Peak Flow in Healthy Volunteers?*

3rd Place: **Josh Uptigrove, D.O.** from Edward W. Sparrow Hospital for his presentation titled, *The Impact of Teleradiology on Emergency Department Care.*

Congratulations to all our winners! The 2010 FOEM Case Poster Competition will take place on Wednesday, April 27, 2011 from 1 – 4 PM in conjunction with the ACOEP Spring Seminar in Ft. Lauderdale, FL. **The deadline for submitting 2011 FOEM Case Poster Competition applications is January 31, 2011.** If you are interested in participating in the 2011 FOEM Research Competitions, need more information, or would like to advertise in the widely distributed FOEM competition booklet please contact Stephanie Whitmer at [swhitmer@foem.org](mailto:swhitmer@foem.org)

# 2010 FOEM Research Competitions Abstracts

**FOEM and EMP  
 2010 Research Paper Competition**

**First Place**

*A Prospective Evaluation of Emergency Ultrasound Using Hydronephrosis Index versus the Graded Renal Pelvis Dilatation for the Evaluation of Ureteral Obstruction and Ureteral Lithiasis*

Julie Lata, D.O.  
 Mount Clemens Regional Medical Center



*Julie Lata, D.O., proudly accepts her award.*

**ABSTRACT**

**Study Objective:** Ureteral colic is a common etiology for patients presenting to the emergency department with severe flank or abdominal pain. CT scan is a typical imaging diagnostic modality of choice. The goal of this study was to use bedside emergency renal ultrasound using the Hydronephrosis Index as a sensitive and specific indicator of ureteral obstruction and offer a safe and efficient alternative to helical CT scanning for the workup of patients with renal colic.

**Methods:** We conducted a prospective single blinded randomized clinical trial at a single teaching suburban ED with an annual volume of 58,000. Patients were included if they were over the age of 18 presenting with clinical signs and symptoms of renal colic including severe sudden onset unilateral flank pain. Patients were excluded if pregnant, unstable vital signs, abdominal trauma or signs of an acute surgical abdomen, known current history or diagnosis within two weeks of ureteral Lithiasis, suspected ectopic pregnancy, or those with known congenital or pathologic urogenital diseases. Patient received IV hydration, antiemetics, pain medication, and was randomly assigned to an ultrasound imaging study. Renal images were taken from both the symptomatic and asymptomatic sides of the patient. Record was made of the HI on both kidneys, and the difference in numerical measurement was tabulated and recorded. Patients in the graded hydronephrosis group had record made of the degree hydronephrosis present and whether there was a change in the hydronephrosis grade. All study patients underwent CT scanning using a radiology renal stone protocol and final interpretations were made by attending staff radiologists.

**Results:** During the 6 month study, a total of 39 patients with symptoms suggestive for renal colic were enrolled. Of these, 16 were studied using the HI and 19 were studied using hydronephrosis grading. Investigators noted a measurable significant difference in the Hydronephrosis Index in patients with positive CT scans with a mean difference between the symptomatic and asymptomatic side of  $-8.93 \pm 4.71$ , [CI

0.95], ( $p=.001$ ). The Hydronephrosis Index sensitivity of 85.7% and a specificity of 100%. The graded hydronephrosis group had sensitivity for detection of the disease at 90.9% and a specificity at 87.5%.

**Conclusion:** Our study suggests that in symptomatic low risk patients presenting with renal colic a bedside ultrasound can be utilized with the Hydronephrosis Index method and have a good sensitivity and high specificity for diagnosing patients with renal lithiasis.

### Second Place

*The Utilization of Computed Tomography in Diagnosing Renal Colic Due to Ureteronephrolithiasis; Is it Necessary in all Cases?*

Anthony Catapano, D.O.

St. Joseph's Regional Medical Center



Anthony Catapano, D.O., accepts his 2nd Place Award at the 2010 FOEM/EMP Research and Awards Luncheon

### ABSTRACT

**Objective:** The goal of this study is to evaluate the necessity of CT in young, otherwise healthy patients in whom the diagnosis of ureteronephrolithiasis is strongly suspected and who symptomatically respond well to pharmacologic interventions in the ED.

**Subjects and Methods:** A one year retrospective study was initiated at a

single center urban emergency department to identify patients who have a high likelihood of uretero-nephrolithiasis, and who may forego abdominal CT imaging in the emergency department based on clinical and laboratory presentation. Data was collected from patients who presented between July 1, 2007 and June 30, 2008. The study was conducted using patients 18-35 years of age who complained of flank pain, back pain radiating to the groin, hematuria and/or similar complaints correlating with suspicion for ureteronephrolithiasis/renal colic. Patients who met these criteria were required to undergo CT imaging.

**Results:** A total of 152 patients met the initial criteria for this study, as being diagnosed with ureteronephrolithiasis. Nine of these patients were excluded from this study, as they did not have a CT performed. Two others were excluded as they had renal insufficiency. Most patients responded well to pharmacological treatment, and were discharged home with outpatient follow-up. A total of only 7 out of 141 patients (5%) were admitted to the hospital. The reasons for admission included intractable vomiting (3), urinoma (1), large stone (> 7mm) with moderate hydronephrosis (2), and colostomy with possible abscess (1).

**Conclusion:** There has been an overuse of CT scan to diagnose ureteronephrolithiasis in otherwise young, healthy patients. CT scan in these individuals exposes patients to unnecessary radiation, longer stays in the emergency department, crowding of emergency departments, increased expense and does not change overall outcomes. Moreover, these patients are likely to present again with recurrent episodes of ureteronephrolithiasis, further exposing them to repeat CTs and repeat doses of radiation. If imaging is necessary, the use of alternative imaging modalities such as low dose radiation CT scanning or ultrasound might limit radiation exposure

in the emergency department. Patients could then follow up with urology in an outpatient setting.

### Third Place

*Fournier's Gangrene and Increasing Methicillin-resistant Staph Aureus Association between 2002 - 2008*

Lionel Lee, D.O.

Arrowhead Regional Medical Center

### ABSTRACT

**Study Objective:** The incidence of Methicillin-resistant Staph aureus (MRSA) appears to be increasing but the relationship with Fournier's gangrene has yet to be established. Emergency department (ED) clinicians are often the first-line providers when evaluating and treating patients with Fournier's gangrene. In this study, we present our findings to investigate the relationship with cases of confirmed MRSA and Fournier's gangrene.

**Methods:** A retrospective chart review of 19 consecutive patients with Fournier's gangrene between 2002-2008. Charts were reviewed for patient demographics, comorbidities, Charlson Comorbidity Index (CCI), cultures, Fournier Gangrene Severity Index Score (FGSIS), and outcome. Diagnosis was confirmed by clinical and pathological findings.

**Results:** A total of 19 male patients ages ranging from 26 years to 65 years. Nearly all patients (94%) had polymicrobial cultures with four or more organisms. Staph epidermidis was the most common isolate (44%) and MRSA was present in nearly 20%. Of interest, there is an increasing trend of MRSA scrotal infections with 30% due to MRSA since 2006-08. No cultures were positive for MRSA before 2006. Diabetes was the most common comorbidity (42%), followed by obesity (26%). There CCI was similar in both those with and without MRSA infections,

respectively (1.0 vs 1.3, p=0.58). The FGSIS range was 1-16 and the mean FGSIS was similar with MRSA and those without, respectively (4.0 vs 5.36, p=0.51). No mortalities were recorded within 30 days surgical debridement. Six patients had repeat debridements, three patients had diverting colostomies completed, and none of the MRSA positive patients had repeat debridements or diverting colostomies. The average length of hospital stay was 22.6 days.

**Conclusion:** In this case series there appears to be an emerging association of MRSA and Fournier's gangrene. Therefore, this should support further consideration by ED providers in the use of MRSA covering antibiotics.

**FOEM 2010 Case Poster Competition**

\*Because the Spring 2010 Case Poster Competition winning abstract was not available to be published in the July 2010 issue of the Pulse, it is being published in this issue.

**First Place**

*Gastroesophageal Intussusception: Now you see it, now you don't.*

Marianna Karounos

N. Boulos

St. Joseph's Regional Medical Center

**Case Report:** A 43 year old male with a past medical history of GERD, hiatal hernia, and achalasia, and past surgical history of cholecystectomy, presented to the emergency department (ED) with a chief complaint of epigastric pain and bilious vomiting for one day.

Review of patient's social history was negative for tobacco, alcohol, or drug use. Review of family history was negative for any gastrointestinal or cardiac disease.

Review of Systems was significant for epigastric pain, nausea, and vomiting and negative for fever or diarrhea.

History of present illness was significant for crampy, non-radiating epigastric pain, nausea and bilious vomiting that began approximately 10 hours prior to arrival in the ED. Physical exam revealed mild tenderness to palpation in the epigastric area, no masses palpated. Rectal exam was guaiac negative. The remainder of the physical exam was benign. Two hours after arrival to ED pt had an episode of hematemesis. Placement of a 16F nasogastric tube was attempted but resistance was met at approximately 45 cm and remainder of tube was unable to be passed into the stomach and thus the procedure was unsuccessful. Labs were significant for an elevated WBC at 20.4 with 83 neutrophils and 8 bands. Amylase, lipase, and LFT's were all within normal limits. The patient was eventually taken for a CT scan of the abdomen and pelvis with PO and IV contrast which showed severe thickening of the distal esophagus with intussusception of the stomach into the distal esophagus. The patient was admitted and a Gastroenterology consult was obtained from the ED. Further studies included barium swallow which showed severe achalasia and repeat CT scans showing no evidence of intussusception as it had resolved spontaneously. After in-house workup and treatment, the patient was discharged home with outpatient GI follow-up.

**Introduction:** Gastroesophageal intussusception is a rare disorder with a very common presentation, making it difficult to diagnose and thus increasing the morbidity and mortality associated with it.

**Discussion:** Gastroesophageal intussusception is a rare disorder with an incidence of only 1.4% based on radiographic diagnosis. The first adult human case was described in 1903 with the first pediatric case only being reported in 2004. It presents with the very common ED

complaint of epigastric pain and vomiting, which initially points to a very wide differential diagnosis. Risk factors include hiatal hernia, achalasia, increased intra-abdominal pressure caused by vomiting, and gastric lymphoma. It may initially be asymptomatic but as it progresses it can cause dysphagia, abdominal pain, hematemesis, and obstruction. CT scan of the abdomen and pelvis may show the intussusception or the appearance of a tumor or mass. It usually resolves spontaneously, but severe persistent cases require endoscopic reduction or even laparotomy with manual reduction. If unrecognized or untreated and spontaneous resolution does not occur, obstruction and even ischemic necrosis of the esophageal segment can result. It is important to recognize that patients with these risk factors or previous gastroesophageal surgery such as a myotomy, are at high risk for this disorder and that their initial presentation may appear as benign gastrointestinal problem. Further and careful investigation of these patients is essential and must be conducted promptly starting with a CT scan of the abdomen and pelvis in the ED in order to identify the disorder early and obtain a gastroenterology consultation for immediate intervention if required.

**FOEM and MedExcel  
 2010 Research Poster Competition**

**First Place**

*Is the Use of Multiple Medications an Independent Predictor of Length of Stay and Probability of Admission?*

Shannon Weinstein, D.O.

Good Samaritan Medical Center

**ABSTRACT**

**Objectives:** Currently it is required that all patients presenting to the Emergency Department (ED) be asked to provide their

*continued on page 19*

## FOEM Thanks You for Your 2010 Contributions

\*Contribution data taken from donations received between 1/1/2010 and 12/7/2010. Donations received after 12/7/2010 will be displayed in the April 2011 issue of *The Pulse*. Although we strive for accuracy, if there are any errors in our records, please contact me at [swhitmer@foem.org](mailto:swhitmer@foem.org) and I will be quick to remedy the problem. Thank you.

### \$7,500 and Above

EmCare  
 Emergency Medicine Physicians (EMP)  
 Schumacher Group

### \$2,500 - \$7,499

Joseph Kuchinski, D.O., FACOEP-Dist  
 Robert E. Suter, D.O., MHA,  
 FACOEP-Dist  
 James Turner, D.O., FACOEP & Sherry  
 Turner, D.O.

### \$1,000 - \$2,499

Juan Acosta, D.O., M.S., FACOEP  
 Anita W. Eisenhart, D.O., FACOEP  
 Mark A. Foppe, D.O., FACOEP  
 William Lynch, Jr.  
 MedExcel, USA  
 Janice Wachtler, BA, CBA  
 Douglas P. Webster, D.O., FACOEP-Dist  
 Gary Willyerd, D.O., FACOEP-Dist,  
 FAODME

### \$500 - \$999

ACOEP  
 Peter A. Bell, D.O., MBA, HPF, FACOEP-  
 Dist  
 Thomas Brabson, D.O., MBA, FACOEP-  
 Dist  
 John Everett, D.O.  
 Peter J. Kaplan  
 Beth Longnecker, D.O., FACOEP  
 Steven Parrillo, D.O., FACOEP-Dist  
 John C. Prestosh, D.O., FACOEP  
 Duane Siberski, D.O., FACOEP  
 Bruce Whitman, D.O., FACOEP

### \$250 - \$499

Anthony Affatato, D.O., FACOEP  
 Gregory Christiansen, D.O., FACOEP  
 Stephen G. Kaiser, D.O., FACOEP  
 Judith Knoll, D.O., FACOEP  
 Drew A. Koch, D.O., FACOEP  
 James Morosco, D.O.

### \$100 - \$249

Jamie Adamski, D.O.  
 Gaiti Bakhsh, D.O., FACOEP  
 Gregory Boris, D.O.  
 Dale Carrison, D.O., FACOEP  
 Kenneth Doroski, D.O., FACOEP  
 Nate Drexler, D.O.  
 Mark Edwin, D.O.  
 Clifford Fields, D.O., FACOEP  
 Calixto Garcia, D.O.  
 Christine Giesa, D.O., FACOEP-Dist  
 William Gluckman, D.O.  
 Patricia Guntern, D.O.  
 Valerie Hart, D.O., FACOEP  
 Ira Brady Husky, D.O., FACOEP  
 Alan R. Janssen, D.O., FACOEP-Dist  
 Julie Johns, D.O., FACOEP  
 Helene Labonte, D.O.  
 Robert McJennet, D.O.  
 Mark A. Mithcell, D.O., FACOEP  
 Nilesh Patel, D.O.  
 Jon-Pierre Pazevic, D.O., FACOEP  
 Christopher Posey, D.O., FACOEP  
 Stephen Pulley, D.O., FACOEP  
 Otto Sabando, D.O., FACOEP  
 Victor J. Scali, D.O., FACOEP-Dist  
 Jane Sennett, D.O., FACOEP  
 Michael E Sheehy, D.O., FACOEP  
 Robert M. Sidwa, D.O.  
 Murry Sturkie, D.O., FACOEP  
 John A. Tyrell, D.O.  
 James S. Walker, D.O.

Susan Watson, D.O.  
 John D. Weilbacker, D.O., FACOEP  
 Stephanie Whitmer  
 Anthony D. Wilko, D.O., FACOEP

### Under \$100

Fahim Shan Ahmed, D.O., M.S., FACOEP,  
 FACEP  
 Steven Aks, D.O., FACOEP-Dist  
 Michael Allswede, D.O.  
 Sean Al-Salman, D.O., MSHcA  
 Leonardo Altamirano, D.O., FACOEP  
 Adam Ankrum, D.O.  
 Eric Applebaum, D.O.  
 Amy Arnold, D.O.  
 Sarah Arzt, D.O.  
 Dale Askins, D.O., FACOEP  
 Larry Bachle, D.O., FACOEP  
 R. Scott Baeder, D.O.  
 Fred Jr. Bailor, D.O., FACOEP  
 Michael L. Baker, D.O.  
 William Barone, D.O.  
 Gary Batten, D.O.  
 Robert Bazuro, D.O., FACOEP  
 Gary Beasley, D.O., FACOEP  
 S. Addison Beeson, D.O.  
 Joseph Gregory Beirne, D.O., FACOEP,  
 FACEP  
 Donna Bell, D.O.  
 Sheldon Bender,  
 David Berg, D.O.  
 Craig Black, D.O.  
 Brad Blaker, D.O., FACOEP  
 Janice Blau, D.O.  
 Brian Blaustein, D.O., FACOEP  
 Daniel Bommlje, D.O.  
 Charles Boothby, D.O.  
 Thomas Borgstedte, D.O.  
 Wallace Broadbent, D.O.  
 Billy Bryan, D.O., FACOEP  
 Kyland Burden, D.O.

Russell E. Burkett, D.O.  
 Jeffrey Butler, D.O., FACOEP  
 George Sarkis Caleel, D.O.  
 Arthur Calise, D.O., FACOEP  
 Brett A. Call, D.O.  
 Carla Cameron, D.O.  
 Nicholas Cardinal, D.O.  
 Terry L. Carr, D.O.  
 Melissa Carter, D.O.  
 Thomas E. Carter, D.O.  
 Jason Everett Cheatham, D.O., FACEP  
 Mark E. Cichon, D.O., FACOEP-Dist  
 Kevin Clark, D.O.  
 Ryan Coates, D.O.  
 Jeffrey Cohan, D.O.  
 Andrew Cohen, D.O.  
 Brian Collins, D.O., FACOEP  
 Michael S. Cone, D.O.  
 Elizabeth Cook, D.O.  
 Jeffrey R. Cotner, D.O.  
 Jeffrey Couturier, D.O., FACOEP  
 Kevin Cranmer, D.O.  
 Eric Csernyik, D.O., FACOEP  
 John Current, D.O.  
 Melissa Cusumano, D.O.  
 Mario D'Alessandro, D.O., FACOEP  
 Stephanie L. Davis, D.O.  
 Phillippe De Kerillis, D.O.  
 John Deagle, D.O.  
 Glenn DeLong, D.O., FACOEP  
 Louis DeMicco, D.O.  
 Stephen DeWitt, D.O., FACOEP  
 William DiCindio, D.O., FACOEP  
 David Didur, D.O.  
 Freya Dittrich, D.O.  
 Anamika Doma, D.O.  
 Jean Emmanuel Dorce, D.O.  
 Joseph Dougherty, D.O., FACOEP  
 Paul Dubiel, D.O., FACOEP  
 Stephen P. Dubos, D.O.  
 Kevin Durell, D.O., FACOEP  
 Michael C. Eastman, D.O.  
 Jeffrey Evans, D.O.  
 Robert Faber, D.O.  
 Kathleen Faccio, D.O., FACOEP  
 Andrew Felsted, D.O.  
 Michael Ferraro, D.O.  
 Michael Filart, D.O.  
 Donald Findlay, D.O.  
 Jerry Fitzgerald, D.O.

Patrick Flaherty, D.O.  
 James J. Flowers, D.O., FACOEP  
 William S. Folley, D.O.  
 Matthew Font, D.O., FACOEP  
 C.H. Fowlkes, D.O.  
 Gregory R. Frailey, D.O., FACOEP  
 Kevin Franks, D.O.  
 J. Gregory Frappier, D.O., FACOEP  
 William R. Fraser, D.O., FACOEP-Dist  
 Joan M. Gable, D.O., FACOEP  
 Steven Gable, D.O.  
 Raul Garcia-Rodriguez, D.O., FACOEP  
 Tressa Gardner, D.O., FACOEP  
 Michelle Gebhart, D.O.  
 Timothy Genetta, D.O.  
 Mary Gessner, D.O.  
 Tara Gleeson, D.O., FACOEP  
 Bernadette Gniadecki, D.O.  
 Sodi Goldstein, D.O.  
 Greg Gray, D.O.  
 Brian Greenberg, D.O.  
 Jeffrey Greenlee, D.O., FACOEP  
 Raymond Griffith, D.O., FACOEP  
 David Grinbergs, D.O.  
 Kyle Groom, D.O.  
 Joseph Guarnaccia, D.O., FACOEP  
 Anthony Guarracino, D.O., FACOEP  
 Regina Hammock, D.O.  
 John Havlick, D.O.  
 Bernard Heilicser, D.O., FACOEP  
 David Hess, D.O.  
 Ralph Hess, D.O.  
 Gregory Higbee, D.O.  
 Douglas Hill, D.O., FACOEP  
 Edwin M. Hinton, IV, D.O.  
 Bradford Hoffman, D.O., FACOEP  
 Dorene Hojnicky, D.O.  
 Susan Horling, D.O.  
 Evan Houck, D.O.  
 Darrin Houston, D.O.  
 Randall Howell, D.O., FACOEP  
 Donald G. Hudson, D.O.  
 Anwer Hussain, D.O., FACOEP  
 Ali Jamehdor, D.O.  
 Raymond James, D.O.  
 Michael Jarzabek, D.O.  
 Tabitha Jeffers, D.O.  
 Gregory Jones, D.O.  
 Risty T. Kalivas, D.O., FACOEP  
 Scott Kanagy, D.O.

Jonathon Karol, D.O., FACOEP  
 Jessica Kasirsky, D.O.  
 Elizabeth Kassapidis, D.O.  
 Dmitry Katkovsky, D.O.  
 Sophie Kay, D.O.  
 Gloria Kayfan, D.O.  
 Kenneth Keller, D.O.  
 Sara Kelly, D.O.  
 Thomas C. Kickham, D.O.  
 Wendy Anne Kissinger, D.O.  
 Thomas E. Klie, D.O.  
 William Kokx, D.O., FACOEP  
 Joseph Kovacic, D.O.  
 Michael Kovalick, D.O.  
 David Kraus, D.O., FACOEP  
 Jay Kugler, D.O.  
 Christ Kyriakedes, D.O., FACOEP  
 Sheera Lall, D.O.  
 Catherine Langston, D.O., FACOEP  
 Gary LaPolla, D.O., FACOEP  
 Richard Lartey, D.O.  
 Ronald Joe Leckie, D.O.  
 Shi-Wen Lee, D.O.  
 James Leonard, D.O.  
 Francis L. Levin, D.O.  
 Robert Linkenheimer, D.O., FACOEP  
 Kevin Loeb, D.O., FACOEP  
 Michael LoGuidice, D.O., FACOEP  
 Carrie Loterno, D.O.  
 Lisa Henning Low, D.O.  
 Freda Lozanoff, D.O., FACOEP  
 Sean Ludlow, D.O.  
 Mary-Lyn Magarelli, D.O., FACOEP  
 Mary E. Malcom, D.O., FACOEP  
 David T. Malicke, D.O., FACOEP  
 Gerald Maloney, D.O., FACOEP  
 Michelino Mancini, D.O.  
 Thomas Marchiando, D.O., FACOEP  
 Christopher Martella, D.O., FACOEP  
 Bruce A. Marts, D.O.  
 Mihaela E. Matei, D.O.  
 Robert Mathews, D.O.  
 Michelle M. Maureau, D.O.  
 Ronald McAdam, D.O.  
 Maureen McClarville, D.O.  
 James McClay, D.O.  
 James W. McCorry, D.O., FACOEP  
 James McMullen, D.O.  
 Michael Mendola, D.O.  
 Bryan Menges, D.O.

Andrew Mersky, D.O.  
 Midstate Medical ,  
 Scott T. Miekley, D.O., FACOEP  
 Julie Mills, D.O.  
 Anna Milman, D.O.  
 Eric Mohr, D.O.  
 Jeffrey Moldovan, D.O.  
 Gary Moorman, D.O., FACOEP-Dist  
 Andrew E. Morrison, D.O.  
 Robert A. Mott, D.O.  
 Robert D. Mullins, D.O.  
 Michelle Naegele, D.O.  
 Samuel Namey, D.O.  
 Kevin P. Neenan, D.O.  
 Joe A. Nelson, D.O., FACOEP  
 Matthew Nerland, D.O.  
 Dzung-Young Nguyen, D.O.  
 Matthew Nickerson, D.O.  
 David J. Niles, D.O.  
 Daniel E. Oberdick, Sr., D.O., FACOEP  
 Julia Ann O'Brien, D.O.  
 Price Paul Omondi, D.O., FACOEP  
 Robert Ormanoski, D.O., FACOEP  
 William E. Osborn, D.O.  
 Diane M. Paratore, D.O., FACOEP  
 Neelesh Parikh, D.O.  
 Malsuk Park, D.O., FACOEP  
 Ernest Patti, D.O., FACOEP  
 Arthur Pecora, D.O.  
 Scott Plasner, D.O.  
 James D. Polk, D.O., MS, CPE, FACOEP  
 Valerie A. Pollard, D.O.  
 J.A. Poplawski, D.O.  
 Sean Quinn, D.O.  
 Carol Rahter, D.O.  
 Narasinga Rao, D.O., FACOEP  
 Jody Rein, D.O.  
 Craig Reynolds, D.O., FACOEP  
 Vincent Rimanelli, D.O.  
 Alexander Riss, D.O.  
 Samuel Robles, D.O., FACOEP  
 Alexander Rodi, D.O.  
 Chadwick Ross, D.O.  
 Timothy Rossi, D.O.  
 David P. Ruby, D.O.  
 Brandon Russell, D.O.  
 Fred E. Sabol, D.O., FACOEP  
 Cary Schneider, D.O., FACOEP  
 Marie Schreiber, D.O.  
 Michael Schreiber, D.O.

John Scranton, D.O., FACOEP  
 Donald Sefcik, D.O., FACOEP  
 Shane Serfling, D.O.  
 Regina Sexton, D.O.  
 Troy Shaffer, D.O.  
 Ashwin Shetty, D.O., FACOEP  
 Merlin L. Shriner, D.O., FACOEP  
 Purabi Mehta Simon, D.O.  
 Steven A. Smith, D.O., FACOEP  
 J. Keith Speed, D.O.  
 Theodore Spevack, D.O., FACOEP-Dist  
 John Stepanek, D.O.  
 Douglas D. Stern, D.O.  
 Ronald Sterrenberg, D.O.  
 Jennifer Stevenson, D.O.  
 John F. Sullivan, Jr., D.O., FACOEP  
 Matthew Swayze, D.O.  
 Edith Szabo, D.O.  
 Ben Tapper, D.O.  
 Laurie Taylor, D.O.  
 Marcus Teng, D.O., FACOEP  
 James Thomas, D.O.  
 Timothy Thompson, D.O., FACOEP  
 Harrison Tong, D.O.  
 Jeffrey Trager, D.O.  
 Craig Steven Turner, D.O.  
 Erwina Ungos, D.O.  
 Sazanne Vass, D.O.  
 Sanford Vieder, D.O., FACOEP  
 Darrel Vlachos, D.O.  
 Peter Wachtel, D.O., FACOEP  
 Brett D. Wagner, D.O.  
 Lisa M. Ward, D.O.  
 John Palmer Weddle, D.O.  
 Fred G. Wenger, D.O., FACOEP  
 Thomas Westenberger, D.O.  
 Jeffrey Wheeler, D.O.  
 Erik White, D.O.  
 Kenneth Scott Whitlow, D.O.  
 Stacy J. Williams, D.O., FACOEP  
 Jennifer B. Wilson, D.O.  
 Warren Wisnoff, D.O.  
 Maury Witkoff, D.O., FACOEP  
 William Wixom, D.O., FACOEP  
 Michael Yangouyian, D.O., FACOEP  
 Michael E. Zielinski, D.O.

*Competition Abstracts  
 continued from page 16*

current medications and that this list be updated or reconciled when the patient is discharged. Since this information is now readily available, we sought to determine whether there is an association between the number of medications provided to the ED staff and the length of stay (LOS) in the ED and probability of hospital admission.

**Methods:** We conducted a retrospective cohort study (chart review) of all ED patients seen in the adult ED over a 12 month period. The primary outcome measurements were the length of stay (LOS) and probability of admission as a function of the number of medications recorded at arrival. Other variables such as age, sex, and triage category were also measured.

**Results:** Of the 16,382 charts reviewed, 25.7% of patients were admitted and the average LOS was 311.5 minutes. There was a high correlation with the length of stay and the number of medications recorded. The probability of admission increased Odds Ratio (OR) for each additional medication provided at arrival. The length of stay increased for each additional medication provided to the ED staff. We have found statistical significance with regards to both increased admission probability and increased length of stay. The data is being validated by a statistician currently.

**Conclusions:**

The number of medications a patient provided at arrival is a predictor of length of stay and probability of admission, and may be useful in constructing models of ED throughput.

## From the Pediatric Case Files...

Andrew Wilkis, MD

David Q Bell, PhD, MD

Anita W Eisenhart, DO, FACOEP, FACEP

Arizona Children's Center Pediatric Emergency Department at

Maricopa Meical Center

Phoenix, Arizona

# An 11 Year Old Girl in Septic Shock

Many children with previously undiagnosed leukemia will present to an Emergency Department (ED) in various stages of sepsis, or complications from improper marrow function. The most common form of pediatric leukemia (with the greatest survival rate) is Acute Lymphocytic Leukemia (ALL). We present a case of a previously healthy pre-menarcheal 11 year old girl in septic shock, ultimately diagnosed with **Biphenotypic Acute Leukemia (BAL)**. We hope to stimulate great discussion and thought based on some immediate management decisions.

### Our Case

This 11 year old girl was transferred via medical helicopter from a community hospital ED to our tertiary care children's ED. She was previously healthy, except for a bout of pharyngitis one week earlier, treated with cephalexin. She never made a full recovery from that illness. Mother describes subjective weight loss over this last week and vomiting one day prior to presentation.

She presented to the community hospital with tachycardia, tachypnea, hypotension, high fever, dehydration, confusion, and scattered petechiae. Laboratory examination at this hospital was significant for the following; WBC  $7.1 \times 10^3$ , HGB 5.7 gm/dL, and platelets of  $7 \times 10^9/L$ .

Resuscitation efforts included 3 liters of normal saline for intravascular volume expansion (with a fourth liter by helicopter transport team), placement of a femoral triple lumen catheter, and empiric antibiotic coverage with 2 gram of IV ceftriaxone. She also received 1 gram of rectal acetaminophen. She had a Foley catheter placed with 200 mL of concentrated urine out (after almost four liters of IV fluids).

After stabilization as described above, the child was transferred to our children's

hospital ED via helicopter without complication.

On presentation to our facility the patient was tachycardic, febrile, and toxic appearing. Her heart rate was 158 bpm, respiratory rate was 40 bpm, her blood pressure was 105/60, her temperature was  $39.1^{\circ}C$  and her oxygen saturation on 100% non-rebreather was 96%.

She was alert and oriented only to herself and confused. She had dried blood on her lips, nares, and posterior oropharynx with very dry mucous membranes. Her neck was supple without lymphadenopathy. Her chest was clear with shallow tachypneic effort. No cardiac murmur was appreciated, no rubs, gallops, or ectopy. Her abdomen was soft, non-tender, no mass, no organomegaly. She had scattered petechiae throughout her body. She was Tanner I. Her cranial nerves were grossly non-focal. She was moving all four extremities equally and purposefully.

Given her confusion, septic shock clinical appearance and expected stormy clinical course, the child was rapidly intubated with Ketamine and vecuronium both for airway protection and to optimize oxygenation and perfusion. Subsequent sedation was achieved with lorazepam. Gastric decompression revealed coffee ground material.

After the airway was secured, a lumbar puncture was performed and vancomycin added to the antibiotic coverage. Resuscitation continued with irradiated, CMV-negative packed red blood cells.

After the initial resuscitation efforts at our facility, the patient's vital signs normalized. A repeat CBC (after nearly 4 liters of normal saline) showed a WBC  $20.6 \times 10^3$ , HGB 4.3 gm/dL, and platelets  $3 \times 10^9/L$ . Manual differential showed 98 blasts, 1 seg and 1 lymphocyte.

After consultation with a pediatric oncologist, the child was transferred to the pediatric oncology center without immedi-

ate complication.



Post-intubation CXR

BAL is a rare form of leukemia, 5% of all acute leukemias. Histologically, when leukemic cells co-express several myeloid and lymphoid antigens in the same cells, the diagnosis of biphenotypic acute leukemia is made. Chen, et al went on to describe prognosis for children with BAL as "poor". A four-year survival rate of 0 has been reported. A two-year survival rate as high as 60% has also been reported. These are all relatively small studies as this disease process is somewhat rare.

Treatment for children with BAL is not straight-forward as clear guidelines are absent in the literature. Approaches have been established to treat the AML or the ALL portions individually. Attempts to treat both with aggressive induction regimens have led to early treatment-related mortality.

### Discussion Point 1 Transfer Issues

This child was transferred from a community hospital ED with no pediatric admission ability to a tertiary care children's hospital that is void of pediatric oncology. After further stabilization in the

ED, she was transferred to another pediatric tertiary care center with a pediatric oncology service.

This community hospital has a functional agreement with the children's hospital (2nd facility) to take all of their pediatric admissions. In this case, the accepting attending physician at the children's hospital suggested to the physician assistant (PA) from the community hospital that this child likely has some form of cancer and would benefit from a transfer directly to pediatric oncology center. The community hospital responded with, "The helicopter is already on the way here and my charge nurse said you take all our transfers."

It was the decision of the physician at the children's hospital to accept the transfer for further stabilization. It was the perception of the accepting physician that the sending treatment team would not have been comfortable or able to affect a different transfer in a timely manner and, in the best interest of the child; she was transferred to the children's hospital.

In 1995 the Emergency Medical Labor and Treatment Act (EMTALA) was enacted to protect patients and hospitals from inappropriate transfers, or dumping. The rules are clear, and extensive, and the punishments feared. That being said, no violation occurred in this case. The child was stabilized at the community hospital, and they had an accepting physician at the children's hospital (which was a higher level of pediatric critical care than the community hospital).

The question arose; should the physician at the children's hospital have accepted this child, knowing she would likely need to be transferred again for definitive care. After some internal discussion, the children's hospital supported their physician's decision to accept transfer. Only the accepting physician communicated with the sending PA. Therefore only that physician could evaluate the risks posed to the child and the abilities of the sending team to efficiently and safely transfer the child to another facility.

The fortunate reality was that the child was further stabilized at the children's hospital before being sent to the pediatric oncology center without any immediate harm. Additionally, definitive oncology care was not initiated until hospital day two at the pediatric oncology center. It was at that time a bone marrow aspirate was

obtained. Prior to that, further stabilization measures were performed. And a bone marrow aspirate is almost never indicated at the midnight hour when these transfers were being executed.

### ***Discussion Point 2*** **Safety of Lumbar Puncture**

At the children's hospital, the decision was made to obtain spinal fluid before adding broader antibiotic coverage. The CBC from the community hospital revealed a platelet count of  $7 \times 10^9/L$ . The child received three liters of intravenous fluids before and during transfer. A CBC at the children's hospital was pending, but would later reveal a platelet count of  $3 \times 10^9/L$ . A lumbar puncture (LP) was performed.

Many textbooks list extreme thrombocytopenia as a contraindication or a relative contraindication to performing LP's. Nelson's Textbook of Pediatrics lists a platelet count  $< 20 \times 10^9/L$  as a contraindication for LP's due to risk of bleeding in the subarachnoid or subdural space. Roberts suggests platelet infusion prior to LP in a patient with thrombocytopenia.

A landmark, albeit retrospective, study from St. Jude's Children's Research Hospital showed no ill effects from LP's performed on thrombocytopenic children with ALL. Of the 5223 LP's evaluated in the study, 29 were performed on children with platelet counts  $< 10 \times 10^9/L$ , and there were no bleeding complications in that small sample.

Our patient had no immediate or subacute complications as a direct result of this emergent LP. While caution should always be observed when performing procedures in the face of thrombocytopenia, there are some retrospective data to suggest that a carefully thought out risk/benefit ratio may influence the emergency physician's decision making.

### ***Discussion Point 3*** **Blood Transfusion**

Life-saving stabilization techniques and procedures were performed at the children's hospital without specific consents. Under consultation with the Intensivist and the Oncologist at the pediatric oncology center, it was decided to initiate a transfusion of packed red blood cells, irradiated and CMV-negative. After the blood was spiked

and transfusion begun, the bedside nurse suggested we obtain consent from mother for transfusion.

The mother was at the bedside, where she could plainly see global petechia, epistaxis, and oozing blood from the mouth. After she told the resident she and her daughter (our patient) were Jehovah's Witnesses, she signed consent for blood transfusion.

This case is further complicated by the fact that the child was a Jehovah's Witness (JW). JW's first issued a ban against blood transfusion in 1945. Since that time, their stance has developed to distinguish between whole blood, which is proscribed, and certain blood products such as albumin and clotting factors which are acceptable.

The legal and philosophical support for JW's refusal of blood products is based largely upon an argument of autonomy. Autonomy is the concept that an inherent component of being human is the ability and ultimately the right to make choices for oneself.

Autonomy is considered to be good for three reasons. First, it allows us to make ethical judgments regarding both individuals and actions. We can only be ethically praised for good choices and condemned for evil choices if such choices are actually made independently and without coercion. Second, valuing and promoting autonomy is arguably more likely to lead to greater overall satisfaction. Individuals tend to have a better and more intimate understanding of what their specific values and goals are and what they wish to accomplish than any outsider could have.

Third, autonomy is also valued not as the means to an end of greater happiness, but as an end in itself. This line of thought argues that the ability to knowingly shape both the world and one's character is distinctly human in nature and ought to be nourished.

Based on the principle of autonomy, if a person understands the implications of a decision, and that decision is made in a well-reasoned manner without coercion, it ought to be respected as an independent decision by a moral being which deliberately shapes and determines both the world and that specific individual. It is under this premise that JW's argue that they have the right to refuse blood products.

This case, however, is not so cut and dried. Most importantly, the patient in

question is a minor rather than a full-fledged consenting adult. Furthermore, the patient is encountered in the emergency department rather than in the more controlled setting of an inpatient ward or outpatient setting. Lastly, the fact that the patient is in extremis makes issues of consent and capacity much more difficult to ascertain.

Although adult JWs have the right to refuse blood products, the courts have established that children and adolescents do not have this right. Additionally, a JW parent cannot refuse a blood transfusion for their under-age child. While the principle of autonomy is used to support the right of an adult JW to refuse life-saving care, in the case of children, it suggests that they and their parents cannot refuse such care.

First, the principle of autonomy is based upon the assumption that the individual in question understands the risks of refusing treatment. This is obviously not the case with children, although it becomes less certain with adolescents in their early teen years. As a society, we have agreed to limit the decisions that children can make to those which tend to have less long-term and possibly substantially negative consequences.

Second, autonomy is often viewed as a future good rather than simply something to be valued at a specific moment in time. In this drive to preserve the function of future autonomous choice, the argument is made that current decisions which significantly restrict future autonomy are irrational and hence prima facie not autonomous (fully informed) decisions, as well as defeating the principle of autonomy as being a worthwhile good in itself rather than any specific means to an end.

Children have not yet developed a sufficient sense of self and an understanding of the world to fully utilize their autonomy at this time. The principle of autonomy would thus suggest that any significant and potentially devastating or life-ending choices be postponed until they have had the time and capacity to evaluate and set forth their own values and life-goals.

The setting of this case in the ED also makes it more difficult. In the ED, one is dealing with insufficient information, lack of time, and the instability of the patient. Although the ED was informed that the patient was a JW, she had been flown

in from another hospital and her family was not there to clarify their beliefs and wishes. In fact, in this case the patient was intubated before the mother arrived at the hospital.

While most JWs do not wish to receive blood transfusions, there is certainly a minority that is willing to undergo this process. Even if the family was immediately at bedside, it would have been difficult to thoroughly explain the gravity of the patient's situation, evaluate her predicted course if not transfused/stabilized, give options in terms of patient care and stabilization, and attempt to ascertain the family's own beliefs, all while ensuring that the patient does not further deteriorate.

In a setting such as this, life-saving treatment and supportive care should be the priority and the default option of the physician.

Finally, the patient's current capacity to refuse treatment is itself questionable based upon her extremis. She is altered, tachycardic and febrile. The chance that she can thoroughly understand the risk and benefits of refusing such life-saving treatment would be very much in question at this point.

This is not unique to our patient. Many of the patients who are being treated in the ED are confused, altered, in severe pain, and otherwise unable to give true informed consent. In such cases, we tend to judge the patient's decisions against our recommendations as doctors or against the standard of what a reasonable person would choose. It is only when patients make decisions against the standard of reasonable practice that we question their competence. Again, in such cases, the principle of autonomy suggests that it is best to provide the immediate life-saving treatment until the patient's understanding and mental competence can be further and more closely evaluated.

### **Hospital Course**

After a very tumultuous two month hospital course, fraught with several bouts of sepsis, septic emboli, hundreds of transfusions and procedures, this child succumbed to her primary disease, BAL.

### **Conclusions**

Emergency physicians face critical deci-

sion making scenarios daily. We weigh risk/benefit ratios with scientific data, social pressures, family wishes, local political climates, and intuition on a regular basis.

We have presented here an unfortunate case of a child in septic shock from an unusual diagnosis, BAL. Several issues regarding her care were discussed without necessarily straight-forward answers, but rather, our interpretations of the scenario presented to us. We would like to suggest that the readers of *The Pulse* use this case as a springboard for departmental discussions. Preemptively working through some of these details may make decision-making easier when a similar case presents to your ED.

---

<sup>i</sup>Robert Chen, John Ryder, William Robinson, Han Myint, **Biphenotypic Acute Leukemia** *Clinical Leukemia*, Vol. 2, No. 3, 193-197, 2008

<sup>ii</sup>Killick S, Matutes E, Powles R, et al. Outcome of biphenotypic acute leukemia. *Haematologica* 1999; 84:699-706

<sup>iii</sup>The Emergency Medical Labor and Treatment Act (EMTALA). Pub L No. 99-272, Title IX, [S]1395dd (1995), at [S] 1395dd9a

<sup>iv</sup>**Kliegman: Nelson Textbook of Pediatrics, 18th ed.**; Chapter 591

<sup>v</sup>**Roberts: Clinical Procedures in Emergency Medicine, 5th ed.** Chapter 61 viScott C. Howard; Amar Gajjar; Raul C. Ribeiro; et al. **Safety of Lumbar Puncture for Children With Acute Lymphoblastic Leukemia and Thrombocytopenia** *JAMA*. 2000;284:2222-2224

<sup>vii</sup>Woolley, S. 2005. **Children of Jehovah's Witnesses and adolescent Jehovah's Witnesses: what are their rights?** *Arch Dis Child*. 90:715-719.

<sup>viii</sup>Muramota, O. 1998 **Bioethics of the refusal of blood by Jehovah's Witnesses: Part 1. Should bioethical deliberation consider dissident's views?** *J Med Ethics*. 24:223-230.

<sup>ix</sup>Woolley, S. 2005. **Jehovah's Witness in the emergency department: what are their rights?** *Emerg Med J*. 22: 869-871.

<sup>x</sup>Effa-Heap, G. 2009 **Blood transfusion: implications of treating a Jehovah's Witness patient.** *British Journal of Nursing*. 18:3, 174-176.

## Are Doctor's Going to Pot?

Life is not without its paradoxes and irony. Chris Rock credits these facts of life as his source for his comedy. He remarks on life's circumstances and challenges his audience to consider the paradox of our opinions. In the comedy forum, he is quoted as saying, "You know the world is going crazy when the best rapper is a white guy, the best golfer is a black guy, the tallest guy in the NBA is Chinese, the Swiss hold the America's Cup, France is accusing the U.S. of arrogance, Germany doesn't want to go to war, and the three most powerful men in America are named 'Bush', 'Dick', and 'Colon'. Need I say more?" His contrasting style in the 'real world' setting is not unlike working a shift in the emergency department. As emergency physicians we relish the comedic paradox we see enter through our doors every day. When we gather at conference we tell the latest stories and end the comments by saying, "You can't make this stuff up."

During one of our ED nights at the 'round table' there was a discussion of the stuff you can't make up. The 'cases' center around crazy stories about people who do things they may not want to do, but can't help themselves ...when they are intoxicated. Such was the case of a brilliant researcher who grew a garden of marijuana out of his home. He was apparently sanctioned by the federal government to do research on illicit drugs. In his brilliance he decided to play a game apparently common among illicit pharmaceutical research circles. The game was called 'how high can you get before you die?' This unfortunate genius tragically died from the ironically stupid act of overdosing on illicit drugs. His sad story was not in isolation as many of us at the round table could relate similar absurdities. Why would well educated and intelligent people abuse illicit substances and then come to the ED to reverse the effects of those substances they chose to ingest. Did they not know the consequences and risks of these substances? Did some medical expert say they were safe to smoke, inject, imbibe or vaporize?

Oh, the wizard of irony must have said the magic words. A champion for emergency medicine provides fodder for life's contradictions, so much for advocating for patient safety. The San Jose Mercury News (I think Mercury is still a poison) quoted former ACEP president Dr. Larry Bedard as saying he supported legalizing marijuana because it would "make our communities safer and more just." Really? If the drug is so safe and just, then why are these admitted pot abusers in my ED suffering from a variety of illnesses. The other night a 37 year old academician who was a self admitted 'pot head' complained to me that he couldn't breathe. He was disappointed in having to quit smoking pot 8 years ago because it made him cough too much. I did my part and made the diagnosis of COPD. I was concerned because his lung disease was so advanced I asked him was he smoking anything else. With a smile he said he no longer smokes anything, he now eats brownies. My other intellectual marijuana users have other needs requiring emergency medicine expertise including treatment for midnight strolls on their ATV down a cliff, and paranoid psychotic breaks requiring restraints in a padded room. All in all, I am not sure what is meant by marijuana advocates who use the term "just" to describe the legalization of unfettered marijuana use. I took it to mean the crazy things these people do are now 'justified' if pot is legalized.

So, this whole issue brings me to the prestigious 2010 AOA House of Delegates meeting where I was minding my own business when resolution 429 was presented to the floor for a vote. It sounded something like this - We the people of the osteopathic societies call upon the AOA to provide guidelines and policies on the safe use of (medical) marijuana, otherwise affectionately known as blunts, Mary Janes, dime bags, locoweed, wacky tabacky, skunk, ganja, etc, etc, etc. Well we all know what happens when someone minds his or her own business - we see the consequences of it in our EDs every day. Thank goodness we were only talking

about medical marijuana instead of the 'just' kind of marijuana. What was even better is the fact of having the U.S. Surgeon General present at the meeting. She was now poised to hear how the AOA would deal with the fuming debate of cannabis consumption; for medicinal purposes of course. After all, President Obama had already gone green and announced he would not enforce federal marijuana laws in enlightened jurisdictions.

The House of Delegates vote was halted for discussion on the merits of purple haze in the treatment of disease. (If you're interested, the debate could be seen in its entirety on Hemp T.V., but I must warn you its like watching grass grow). The delegate from California reported their institution was studying Cannabis Sativa & they have "great results." I was not sure how to take or interpret that comment. Another distinguished delegate said 420 is now the law in more than 14 states - the AOA cannot possibly get in the way of the law. For those less cultured in the after school parties, 4:20 pm is the designated after school weed smoking time. It is akin to recess. Additionally, April 20th (4/20 for those too stoned to muddle through this) is the unofficial national weed day. I was now fully immersed in the irony and will of the House of Delegates who sought to have the AOA take the high road on drug abuse. The debate raged on regarding the federally banned substance and I thought to myself, will heroin, mushrooms, whippets, LSD, GHB and any other mind altering substance be far behind the next debate on the floor. Are these professionals who took the Hippocratic Oath to serve their patients and first do no harm really debating marijuana use as safe and effective therapy? What are they smoking? - Rhetorical... I know.

Well, there are always two sides to any debate. Keeping an open mind, I did a review to see what each side had to say about marijuana and particularly medical marijuana. On one side are the cannabis ban-ners. They can cite literature which identifies more than 160 harmful

substances found in marijuana. Studies show the constituents of marijuana negatively affect the hippocampus and amygdala. These findings explain the impaired memory, learning deficits and negative emotional effects documented with cannabis use. Memory impairment was found to last up to 4 weeks after cessation of pot smoking in one study. Logical thinking and calculation skills were observed to be impaired in execution of complex activities such as driving. One study found 1/3 of reckless driver citations tested positive for cannabis. Another study found 11% of all crashes were associated with cannabis use. There were documented cumulative and deteriorative effects on emotional factors when tested in teenagers. Most disturbingly were the longitudinal studies which demonstrated persistent negative effect and poorer outcomes in comparison to control groups. Growth hormone and sex hormone production were also impaired. Pregnant mothers who use cannabis had children with impaired nervous system development, inattention and inferior problem solving ability in comparison to non-exposed children. Cancer, COPD and pneumonia rates were synergistically elevated in smokers of cannabis and tobacco. The National Survey on Drug Use and Health (NSDUH) reported that 4.2 million people were dependent on marijuana. The National Institute on Drug Abuse (NIDA) says 50% of the population has used marijuana at least once. However, only 1 in 7 10th graders use marijuana which is a declining number. From the emergency medicine perspective, the effects of cannabis have a clear deleterious effect on our patient population. They come to the ED suffering the ill effects of cannabis abuse and seek help in treating these effects. Given this unequivocally evidence, the general or recreational use of cannabis can only be condemned. An endorsement by professionals charged with advocating for good health would be contrary to the oath we pledged to uphold.

On the other side of the debate are the cannabis banners gleefully touting the beneficial effects of pot smoking. Most proponents will cite the beneficial effects in treating nausea, vomiting and weight loss. Conditions with these prominent features appear to have the most benefit. Compassionate use in AIDS patients and

cancer suffers are the most frequently cited populations. Other conditions of reported benefit include glaucoma, multiple sclerosis, Alzheimer's disease, arthritis, dystonia, seizures, PMS and the list goes on. The psychological and neurologic affects of pot smoking are reported to benefit chronic pain sufferers. Cannabis use creates a euphoric state and thereby relaxes patients with pain. Synthetic substances related to marijuana show promise in stimulating brain cell growth which is being looked at in the treatment of depression, anxiety and Alzheimer's disease. The substance THC has been shown to inhibit tumor growth in lung and breast cancer. Brain cancer patients using THC had decreased tumor size without shrinking brain cells. There may be some neuro-protective and anti-inflammatory effects of cannabis which may help neural spastic disease such as MS. The complexity of cannabis has made it difficult for researchers to precisely identify its utility in medical therapies. More research is required to understand how the more than 400 chemical components interact to offer benefit in disease states.

I can only imagine how such a debate would rage if the same logic were applied to cigarette smoking. Of course cigarettes are deadly and cause cancer. The smoke is even worse so federal regulators need to have laws passed to reflect that fact. No one should smoke cigarettes near someone else without a 25 mph head wind. In some localities you can't smoke in your own home let alone on an air plane or restaurant. Despite all of these requirements, the National Debate on smoking has neglected one important, unintended consequence - the banning of medical tobacco has deprived all those suffers who need it most - depressed obese people. Some say we have an obesity epidemic precisely because government banned cigarettes. Other research suggest people who don't smoke are also just plain angry. There are just too many angry obese people who no longer smoke and now we have a national epidemic. Their condition had led to suffering from disease like chronic fatigue syndrome and brain tumors (cell phones don't cause brain tumors based on latest research). Obviously regulators need to revisit the issue state by state to give people a right and a choice to determine for themselves the benefits of smoking. We then have to sue anyone who prescribed or dispensed medical marijuana for the

medical costs incurred by society attributed to pot smoking. Additionally, a second class action suit is required to fund all the tobacco farmers who lost money growing tobacco instead of marijuana. The money raised from the law suits then need to be immediately used for shovel-ready projects and community organizers. Community organizers are key players in the process because they can educate the public about the benefits of organic medical tobacco grown here in the U.S.A. and add jobs to the U.S. economy!

Seriously, in drilling down to the issues, the first concern centers on the wisdom of a professional organization to use its clout on an issue influenced more by politics than by good medical science. Drug therapies require rigorous testing of indications and contraindications to frame the context of their utility and thus limit the unwanted side effects. Getting high by smoking marijuana does not appear to hold weight as a therapy. Certainly, there appears to be merit by the scientific community in seeking utility of some the properties contained in marijuana. A position on this issue requires a sound policy based on sound evidence to protect patients and avoid unnecessary negative publicity to the organization. The AOA would benefit in observing what other entities have faced in advocating the position described as 'medical marijuana'. The real problem is the science in advocating for medical marijuana is not convincing so proponents have turned to public forums as a tactic to persuade the debate. Sound science does not need interpretation or explanation of its merits. If questions remain or utility has to be proposed, then it is obvious that more research is necessary before a position can be staked out. Because advocates have not been able to persuade the medical community as a whole based on current science, recreational users subsequently have blurred the lines on identifying 'indications'. In Livingston County, Michigan, the rush to accept personal use of medical marijuana has led to public health and safety concerns according to the Livingston Daily. Here in lies the danger. Problems with their 2008 law have prompted the county to revisit the issue and add more penalties and restrictions to combat the negative effects of marijuana

*continued on page 31*

medicine; we are, after all the second largest specialty group within the AOA and we train over 1,000 residents annually.

What I am urging is that each and every member of the ACOEP, make it their mission to get involved, be the voice of your fellow emergency physicians and step up to the plate. You can do so in many ways; through involvement with the state osteopathic medical society, ACOEP or FOEM, and staying informed.

As Mahatma Gandhi said, "... be the change you want to see in the world."

## CALL FOR ORAL BOARD EXAMINERS!

### Looking for an opportunity for scholarly activity?

ACOEP will present an **Oral Board Review Course** on March 17th and 18th and is currently looking for examiners to serve as faculty for the program.

Attendees participate in simulated sessions, with an examiner presenting cases developed to mimic the Part II Oral Board Exam.

Examiners will receive hotel accommodations as well as a \$150 stipend and travel reimbursement. Each examiner is also eligible for 11 hours of 1A CME credit and will need to be present the entire day of the 18th.

If you are interested in participating as an examiner, please contact Erin Sernoffsky at 312.445.5709, or via email at [ErinSernoffsky@ACOEP.org](mailto:ErinSernoffsky@ACOEP.org)

### *Presidential Viewpoints, continued from page 1*

their programs this year, especially in areas of the country that don't currently have a program. The CME Committee and the respective program chairpersons have continued to deliver excellent courses. Each of our CME courses exceeded our projected participant expectations and the feedback from the participants was that the educational content was first class. Our goal this year will be to develop a Speakers Bureau. We will also create leadership development tools for our membership. The ACOEP Board also worked with the FOEM Board to help with their re-organization. This year we will work collaboratively to enhance their financial vitality so they can continue to foster conducting research by osteopathic emergency medicine physicians and residents.

Membership is always a major area of focus for the ACOEP Board and staff. Our membership goals evolve around assuring that each member experiences the value in maintaining their membership. The greatest value comes when a member is an active participant in the College. We will continue to add tangible member benefits of discounts on outside vendor purchases but more importantly it is the intangible benefits from interacting with fellow College members. Incorporating the

ideas and needs of the young physicians will also continue to be a priority.

Organizational performance is the area where we hold the ACOEP leadership and staff accountable. We have remained a financially strong organization despite our country's economic turmoil due to our conservative investment strategies. We have secured a very good financial advisory team and discuss the College's finances many times a year with them. We have also maintained a dedicated office staff that works very well together and supports each other. They have all demonstrated their commitment to help advance our strategic objectives. Our group of committee chairpersons have developed committees that function well to help guide the Board. They are always inviting new members to join their committees so please take advantage of their invitations. Anyone who is interested in serving on a committee is encouraged to send your preference in writing to my attention at the ACOEP office. Our College's strength lies not only in the numbers but in the input and synergy from the members.

As we move forward into 2011, we still have some of the same major battles to fight. We will continue advocating for our patients to get them the access to the medical care they need. Repeal of the SGR and fair payment for all emergency medical services still requires much effort. We will constantly reiterate our position

on the need for Tort reform and a more efficient legal system to handle alleged malpractice cases so they are not seen as a potential financial jackpot that comes with an unexpected or bad outcome. As the new healthcare reform process takes shape, the ACOEP will work with the AOA and our fellow emergency medicine organizations to help assure that our valuable input is provided and heard by the national policy makers.

Our College is fortunate to have a member that has been elected to Congress. Joe Heck, D.O. will begin his first term in the House of Representatives in January, 2011. Although he is elected to represent his constituents in the 3rd District of Nevada, I'm sure Congressman Heck will be there advocating for all healthcare providers and their patients. I have offered Congressman Heck the support of the ACOEP anytime he will call upon us for assistance. We wish Joe all the best as he helps guide our great nation.

In closing, I again want to thank all of the ACOEP members that contribute to making our College great. We have many unsung heroes of emergency medicine in our College who deserve to be recognized for their untiring desire to help others in need. We hope to all have a healthy new year because we have so much more to get done.

Thank you.

## In My Opinion

Wayne T. Jones, D.O., FACOEP

# Battle of the Sub-Personalities

Earl was a rough character and well known to the ED. We could always expect to see him after the bars closed. He was known for his distasteful humor and nurses typically would not enter the room alone. The triage sheet said “depression.” I took a deep breath in the hall before entering the room.

“Hi Earl, I’m Doc Jones,” I said extending my hand, “what’s going on tonight?”

“You got crooked teeth,” he answered. Actually, I was expecting that answer.

“Now Earl, be nice, it’s been a long day.” I thought I would defend myself without insulting him.

Earl leaned forward and clenched his fists. It was typical Earl. He remained quiet, staring into my eyes. Then he stood up. Instantly he delivered his hymnal of sarcastic insults.

“Earl, would you like some coffee?” I could hear my wife encouraging redirection of the conversation. Again, I was met with insults. I postured myself and raised my voice. This was my dad in me. He always raised his voice when confronted. “Sit down!” I roared. Oh God, that was a terrible reply for a professional.

Earl sat on the edge of his seat. I borrowed a play from my old college professor and sat back softening my appearance. “Earl, I’m only here to help.”

Ok, that was my mom. Earl really had me going. It was Thanksgiving; Earl was here for company. He just was not able to express himself. I should have realized. This was a classic mix of sub-personalities battling it out.

Sub-personalities have been discussed since the early 70’s. Unlike split personalities, we recognize the “person” we are emulating. The theory is that somewhere within ourselves lives that unique person that is “us.” But, that “US” is made up of multiple other “selves”.

We accumulate these other selves by experiencing our environment and using these personalities helps us cope. Just like in the story above, I understand who I am emulating. Many times, under the proper stress, that individual springs from me before I can control my response.

Other times it may be more like the devil and the angel, sitting on either shoulder, arguing a decision (such as, “Should I give him Haldol or not?”).

I think mankind has always known this, but the science behind it is yet evolving. We tend to use those acquired “persons” who have left lasting emotions and approaches imbedded within us.

When I interview job applicants, I always ask the same question... it goes something like this; Picture someone who has greatly influenced you in your life. Now I want you to tell me about

this person. What are their strengths and weaknesses? How do they respond in stressful situations? The applicant, in telling about this person, will actually tell me how they would react, because they are that person. Some realize what I am asking, while others do not. The applicants who do not realize that they are actually exposing themselves may have limited insight into their sub-personalities. This lack of insight may prove to be a difficult employee to manage.

Just recently, patient safety organizations have questioned whether the presence of sub-personalities lends themselves to less than desirable outcomes. Do we interact appropriately with patients (understanding our own sub-personality)? Can patients receive and appropriately apply treatment recommendations (using their own sub-personality)?

Sub-personalities play a critical role in not only how patients interpret new information but also the quality of their medical decision-making. Patients have similar struggles with these “selves”. While recent stressful encounters place us at risk, patients have an equally hard time entering an environment that is new or previously identified as adverse. The challenge is for both the patient and practitioner to recognize these influences and to effectively work through them.

---

## Changes on the ACOEP Board

At the Membership Meeting of October 25, 2010, the members present cast ballots to elect new members to the Board of Directors of the College. Re-elected to a third term on the Board was Anita Eisenhart, D.O., FACOEP from Cave Creek, Arizona and David L. Levy, D.O., FACOEP of Northport, NY and Otto Sabando, D.O., FACOEP of West Orange, NJ were also elected to first year terms on the Board. Terms for these

newly elected Board Members will be from October 2010 to October 2013.

Two members of the Board, Dr. Douglas M. Hill (Morrison, CO) and Dr. Anthony W. Jennings (Lake St. Louis, MO) left the Board at the end of their terms in October and were honored for their service to the College at the Fellowship and Awards Committee.

If you are interested in running for positions on the Board in the fall 2011,

members should contact the Nominations Committee, in care of the ACOEP Executive Director, with a letter of interest, current CV and photo. In return you will receive a form via email to complete and the choice of dates and times for an interview by the Nominations Committee. All interested parties will be vetted by the Committee during the months of February, March and April and the ballot will be announced in May.

**Amber Vogt, DO**

**Charles J Fasano, DO, MHA**

## Health Policies Studies

The Governmental Affairs Committee of the ACOEP held its annual meeting in San Francisco in October 2010. A major topic of discussion was the continued funding of an ACOEP resident member for the TIPS program. The committee recommended that college continue to fund resident participation in the program. The resident will be expected to be an active member of the Governmental Affairs committee and to present annual updates to the membership in addition to writing an article for Pulse. Below is an interview between myself and Amber Vogt, DO, the current ACOEP TIPS scholarship recipient.

### **1. Tell me about yourself, education, residency etc**

I grew up in a small town in the middle of Missouri. When I graduated, I attended the University of Missouri-Rolla where I played collegiate basketball and majored in Biological Sciences. After college, I worked in a public school in special education and EMS until I attended medical school at Kirksville College of Osteopathic Medicine. I completed my 3rd and 4th year of medical training in Detroit in the Henry Ford health system. I graduated from KCOM in 2007 and am currently in my last year of training in Emergency Medicine at Midwestern University in Chicago.

### **2. Tell me about TIPS, background etc**

TIPS stands for Training in Policy Studies. This is a year long program that helps osteopathic resident physicians become familiar with health care issues at both the state and federal level. The program is offered by the New York College of Osteopathic Medicine/New York Institute of Technology in association with the AOA. Generally, there are 10 TIPS positions that you can generally start applying for in May. These positions are open to individuals

who will be a OGME-2 or higher at the beginning of the next academic year. A complete application with a personal statement is required along with three recommendations. Applicants are generally chosen on prior leadership experience as well as a strong level of commitment.

### **3. How did you find out about the program? and the ACOEP scholarship**

I found out about this program through my residency director. In addition, there were previous residents from my program that participated in this program. These people can be great references and mentors on how to apply, what this process entails and what is involved in TIPS. My associate program director alerted me as to the ACOEP scholarship which she received when she did the program.

### **4. What is the time commitment you have made to TIPS?**

Participants attend four concentrated 3 day seminars throughout the year. In addition, participants are expected to devote approximately 20 hours per month to reading, research, and completing written assignments. These written assignments will culminate in a health policy issue paper. A strong commitment is needed to apply to this program. You are traveling fairly often, have reports and presentations to do, and must still balance the life of a resident.

### **5. Are there any specific projects that you are working on?**

My current project focuses on health care bill HR 5710, the National All Schedules Prescription Electronic Reporting Reauthorization Act of 2010. This is an amendment to an earlier bill that sought to establish increased monitoring of prescriptions by fostering the establishment of grants to states to administer state-wide regulatory systems. The bill was introduced on 7/1/10 and was passed by the house on

9/23/10. This bill helps states to develop programs for prescription monitoring that can eventually help develop a nationwide prescription drug monitoring system.

### **6. Any further thoughts?**

This program is invaluable in teaching health policy. Since many of us get limited information on this in medical school and residency, I would recommend anyone interested to consider this program. Generally, emergency medicine residents make up a significant portion of the group. With the recent sweeping change in the health care system, you can gain a better understanding and be on the forefront in getting legislation passed that will benefit our profession. If you have any questions, don't hesitate to contact me at [amberjvogt@gmail.com](mailto:amberjvogt@gmail.com).

**Are you  
interested in  
Fellowship or  
Distinguished  
Fellowship?**

**Check out the ACOEP  
website or contact  
the Member Services  
Department for  
applications.**

***Applications are due  
on March 1st annually***

# Resident Chapter Report

## *Sherry D. Turner, D.O., President*

I would like to take this opportunity to introduce myself; I am Sherry Turner, DO, the newly elected President of the ACOEP Resident Chapter. I was elected to this position on October 24, 2010 in San Francisco. I graduated from NOVA-SECOM in 2007. I am a PGY4 and serve as the Chief Resident at Charleston Area Medical Center in Charleston, West Virginia. I also serve as the Treasurer for the Foundation Osteopathic Emergency Medicine. I recently completed the Training in Healthcare Policies Fellowship thru NYCOM. I appreciate the opportunity to lead the resident chapter's progress to become more active in the College and to fully represent the interests of the residents as I serve as the Resident Representative on the Board of Directors of the ACOEP.

The Resident Chapter's Annual Membership Meeting was attended by 36 resident programs and approximately 170 residents. Elections were held and the new officers include Justin Arnold, D.O., from Lehigh Valley Medical Center as President-Elect and Megan Mc Grew, D.O., of MWU/CCOM as Secretary/Treasurer. Eight at large Board Members were elected; Robert Anderson, DO, John Casey, DO, Fredrick Davis, DO, Carly Drahus, DO, Kim Irvin, DO, Kade

Rasmussen, DO, Doni Marie Rivas, DO, and Christopher Tana, DO.

Tim Cheslock will now serve as the Past President and Jeremy Selley will leave the Board. We appreciate all the time and input from Jeremy. He and Tim have been instrumental in the growth of the chapter. During Dr. Selley's terms we achieved our voting seat on the Board of Directors of the ACOEP.

The Jeopardy competition continues to provide a great time and camaraderie for all the teams who combined to win the day. The first place team was a combination of Amber Williams from Oklahoma State and Matt Grounds, Tiffini Battiste, Michelle Parlett, and Jason Kent from Freeman Health System. Second place was combined team, Nathan Lowien, and Link Wilson from Southern Ohio, Beth Placzek from Sparrow, and Greg Wheeler from St. Luke's. Third was the team from Mount Sinai including Dan Padron, Alex Scumpia, Jeremy White, and Michael DeVarona.

The bylaws revisions were accepted. Later in the week the ACOEP Board approved them. This will now change the structure of the executive board providing and additional position as the Secretary/treasurer positions will separate. The President Elect will become a vice president

position which will be a one year position. The elections at the fall meeting will then be for the Vice President, Secretary, Treasurer and 8 Board Members. After next fall the elections for all officers will take place. This will allow for a larger number of individuals to become active and participate in the Chapter activities and leadership.

We have realigned the resident chapter to be more consistent with the ACOEP structure. We have committees for Membership, Communication, Finance, Research, Undergraduate Medical Education, Continued Medical Education, Emergency Medical Services, and the Election Committee. If anyone has an interest in participating on a committee level for the resident chapter please email me at sherryturnerdo@hotmail.com.

It is an exciting time for the resident chapter as we begin to prepare for the next convention. The Foundation will be having a case poster competition at the Spring conference in Fort Lauderdale, April 26-30, 2011. The deadline for submission is January 1, 2011. Be sure to get your submissions in to participate and come to Florida to have some fun!

---

## *Members in the News*

### **Joe Heck, D.O., FACOEP Elected to US House**

A strange thing happened in the November 2010 elections ... osteopathic emergency medicine; the U.S. House of Representatives got a voice in government with the election of Joe Heck, D.O., FACOEP (R-NV). Dr. Heck, a long time member of the ACOEP and 1988 graduate of the Philadelphia College of Osteopathic Medicine was elected from the 3rd District of Nevada to this office. Dr. Heck is the second osteopathic physician to be elected

since 1911 when Ira Walton Drew, D.O. was elected from Pennsylvania. Dr. Heck will take his place in Congress in January when new members of Congress are sworn in.

Dr. Heck is the president and medical director of Specialized Medical Operations, Inc. of Henderson, Nevada, which provides medical training, consultation and operational support to law enforcement,

EMS and military special operations. Dr. Heck is also a member of the U.S. Army Reserve where he is a colonel.

Our best wishes go out to Dr. Heck as he enters the Congress at a time of health care reform, a subject close to his heart and that of all his colleagues.

# At First Look

## Case 1:

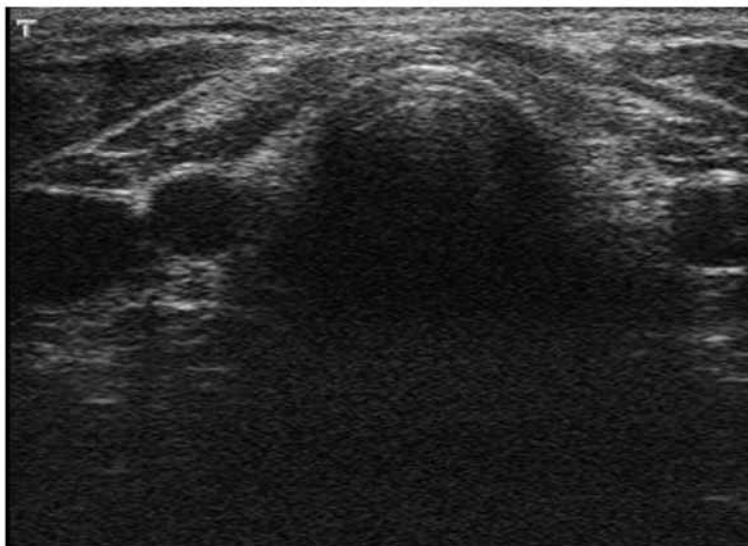
**Presentation:** 36 y/o WF arrives to the ER with CP, anxiety, disoriented and confused accompanied by her new boyfriend.

**Vitals:** BP: 210/130 HR: 170 RR: 30 and shallow O2Sa: 99 % RA Temp: 102.2

**Hx:** The boyfriend stated she had a seizure prior to making it into the ER and was unable to find any of her medications or a list.

**PE:** Multiple transverse scarring on bilateral wrists and a single scar at the base of her anterior neck were noted. You are made aware she has a history of thyroid problems so you perform the US above while awaiting your lab results.

**Question:** Can you describe the image above and do you know what is going on with the patient?



## Case 2:

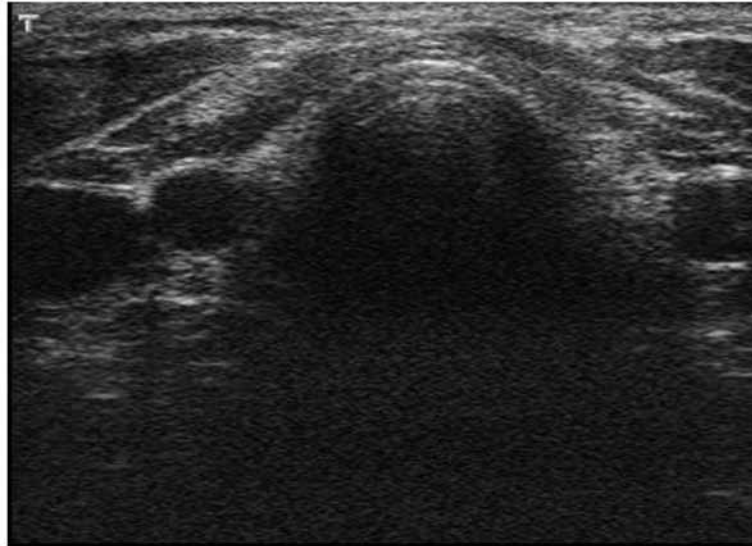
An afebrile 84 year old female presents with a lower left abdominal abscess which the patient states, "It has been there for the previous 2 days. Upon reviewing her medical history you learn she was hospitalized for a case of acute diverticulitis two months prior. You order an abdominal CT scan as above. What do you see in the CT?"



# So What Have You Been Looking At?

## Case 1 Answer:

This is a young female presents similar to a severe thyroid storm. Take note of the previous suicide attempt by cutting her wrists during the physical exam. The scar at the base of her neck was from a Thyroidectomy with post ablation using I-131. This patient had taken an overdose of Synthroid® and her last pill was taken at an unknown time. She was treated with gastric lavage followed by activated charcoal for GI cleansing, acetaminophen to control fever, and beta-blockers to control heart rate. The patient was admitted to Critical Care Unit once stabilized and was treated for symptom based issues that arose.



## Case 2 Answer:

This patient suffered from a micro-perforation of a sigmoid diverticulum leading to a connected necrotizing abdominal abscess. She was later taken to surgery for abscess drainage and bowel resection.



*Case 1 Courtesy of Jeremy Wachenschwanz OMS III, OU-COM Class 2012*

*Case 2 Courtesy of Andy Little OMS III, OU-COM Class 2012*

## Emergency Department Ethics

**Bernard Heilicser, D.O., MS, FACEP, FACOEP**

# What Would You Do?

In this issue of *The Pulse* we will review the case submitted by Fire Chief Pat Gericke, Matteson Fire Department, Illinois. This was presented in October, 2010.

This situation involved a patient who had been triaged in an emergency department and was sitting in the waiting room. He was tired of waiting to be medically treated, so he called 911 from the waiting room and requested to be transported to another hospital. His complaint was for "not feeling well".

This presented an interesting situation. What is the responsibility of EMS versus the responsibility of the ED and hospital?

If a patient is in the ED, they are the responsibility of the hospital (they are in your house). Certainly, if the patient has decision-making capacity, they can choose to leave at any time (prior to triage, prior to treatment, or against medical advice). The hospital cannot hold them. However, if the

hospital believes that patient lacks decision-making capacity or would be in jeopardy (and not understood the consequences), then they can actually restrain the patient.

Obviously, it is not a good public relations event to have an ambulance show up at the ED to take the patient elsewhere. Consequently, any attempt to mitigate the situation would be to everyone's advantage.

But, what if the situation cannot be defused? It would appear rather abusive on the part of the patient to request this EMS service. EMS is an emergency service provider, not a transfer service. Theoretically, EMS should transport to the closest hospital; you are already there! If the EMS provider does customarily transport to other hospitals on patient request, then it would be difficult to deny this patient (he could just as easily walk down the block and make the call).

What happened?

The hospital deemed this patient unable to make medical decisions and prevented EMS involvement.

Hopefully, this will be an extremely rare occurrence. It would certainly be best if the situation could be resolved without a request for EMS. That said we have experienced the scenario at our hospital where a patient got tired of being in the waiting room and observed ambulance patients being brought directly into the ED. They then walked to the corner and called EMS to take them to our ED, thereby gaining direct access. Often, these patients still wind up in triage, anyway. Not a bad idea if we ever need to scam the system.

If you have any cases in your practice that you would like to present or be reviewed in *The Pulse*, please fax them to 708-915-2743. Thank you.

---

### *Are Doctors Going to Pot?* *continued from page 24*

bars, clubs and other dispensaries. Brighton is a great place to visit but I am not sure why Livingston County officials consider a bar or club a suitable place for medical marijuana distribution. It is not sound policy. The second concern deals with the merits of medical marijuana, which in the opinion of many in the medical community, is still considered controversial. For example, the compound prescribed as Marinol has been around a long time and has mixed reviews on its efficacy. Patients prefer smoking pot to using Marinol. If the goal of medical marijuana advocates is to accept marijuana for compassionate care in terminal conditions, then marijuana should be framed in the same context as Oxycontin and Percocet to meet that expectation. Medical marijuana used in other indications appears to have more anecdotal evidence than sound science. If medical marijuana is to gain acceptance, then it needs to meet the rigor of scientific

scrutiny demonstrating the desired effect and avoiding complications. This is the reason why it is still illegal on the federal level. Additionally, it must show efficacy over currently available therapies which have been well described. Otherwise the debate will be based on political argument and suspicion will mar its use for those who could potentially benefit.

In the end, the House of Delegates decided to table the issue which was probably to correct decision. This issue requires more thought, debate and research to answer questions arising from the debates. The first priority in any policy would be to protect patients from harm especially unnecessary harm. Glaring issues still remain untested if public advocacy or policy neglects patient protection. Would the AOA want to be caught in an advocacy position if, for example, pot producers in California were sued for liability in causing lung disease or addiction as has incurred in the cases against cigarette manufacturing

companies. Taking it a step further, who will incur the cost for inducing cancer in pot smokers who were more susceptible to cancer because they have AIDS? Ironically, the treatment would suddenly have to be outlawed for being a dangerous pharmaceutical and the debate on the House of Delegates Floor would appear foolish. Would a national organization then have to adjust policy to support physicians on a legal stage who prescribed the medical marijuana? So it is easy to see that a simple yes or no on the medical marijuana issue is not so simple. Expect this issue to follow the trade winds in places like California and ironically Arizona. Confusion reigns in places like California, where they are trying to ban cigarettes and soda for being too dangerous for the public yet advocate for automated pot dispensaries in the guise of improving medical access. I look forward to having Chris Rock make sense of the 2 cents of thought given to this issue. Maybe he can help decide if physicians are going to pot?



The American College of  
Osteopathic Emergency Physicians  
142 E. Ontario Street  
Suite 1500  
Chicago, Illinois 60611

Presorted  
Standard  
U.S. Postage  
**PAID**  
Chicago, IL  
Permit No. 2177



The American College of  
Osteopathic Emergency Physicians