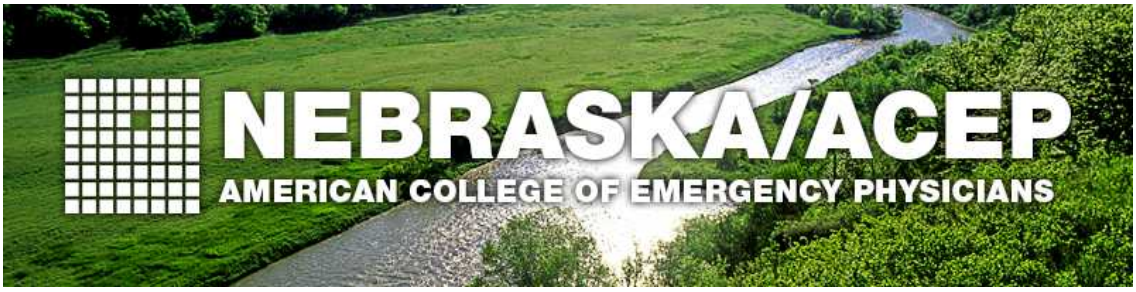
A Newsletter for the Members of the Nebraska Chapter



Renee Engler, MD, FACEP
President

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Chapter Executive
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President's Letter
Renee Engler, MD, FACEP

Dear Nebraska ACEP Members,

In conjunction with our organizations, a few of us had the opportunity to collaborate in drafting the NHA Opioid Toolkit. As part of these guidelines, there is an Emergency Department opiate-free pain option by indication. These indications include musculoskeletal pain, headache, extremity fracture or dislocation, abdominal pain, and renal colic. This tool kit also includes the Colorado ALTO Project, which is a best practice pathway for opioid-free pain control. Following is the document for your review. I urge you to adapt these pathways into your clinical practice.

The State County Attorneys are joining a class action lawsuit against pharmaceutical companies that manufacture opioids. They are analyzing data beginning in 2008. This data has validated an increase in overdoses, dependence and number of encounters.

With discussions on Capitol Hill beginning to intensify, ACEP will be a constructive partner to protect emergency patients from out of network billing. We will come to the table with specific solutions addressing the unique nature of emergency care. This proposal defers to the states if they have a comparable approach in terms of patient and provider protections but will otherwise introduce an alternative dispute resolution process for claims over a certain threshold, with interim payment in the meantime. I have the proposed resolution if you would like a copy.

We ask you to reach out to your senators in OPPOSTION of LB 528. This bill, introduced by Senator Hilkeman, is an optometric scope of practice bill. If passed, this bill would expand optometrists' scope by permitting surgery and laser treatments on patient's eyes, among other items. The bill has not been scheduled for a hearing yet.

The LB 378 repeals Nebraska's curent law that requries motorcyclists to wear a helmet. We need you to ask your senators to vote AGAINST the repeal and OPPOSE LB 378.

ACEP recently completed the development of iCAR2E. This is a tool for managing suicidal patients in the ED in collaboration with the American Foundation of for Suicide Prevention. It helps identify suicide risk, gives communication tips, risk reduction, and care beyond the ED.

The clinical policies committee has completed a draft on the critical issues in the evaluation and management of adult patients presenting to the ED with acute headache. This **draft** is open for comments until April 1st.

Finally, don't forget about the **Nebraska Chapter Annual Meeting** that is currently scheduled for April 30th at Flemings Steakhouse in Omaha. RSVP for this event, by clicking **here**.

ED Opiate-Free Pain Options by Indication

Musculoskeletal Pain: Acute on chronic opiate-tolerant OR acute opiate naïve
No IV access - Intranasal Ketamine 50mg (0.5ml)
Acetaminophen 1000 mg PO/IV
Ibuprofen 600mg PO or Ketorolac 15mg IV/IM
Trigger Point injection - Lidocaine 1% 1-2ml subQ
Cyclobenzaprine 5mg PO or Diazepam 5mg PO/IV
Dexamethasone 8mg PO/IV
Ketamine 0.2mg/kg IV over 5-10 min
Lidoderm patch to most painful area, MAX 3 patches
Gabapentin 300mg PO (neuropathic component of pain)

Recurrent Primary Headache/Migraine
Acetaminophen 1000mg PO/IV
Ibuprofen 600mg PO or Ketorolac 30mg IV/IM
1 liter Normal Saline Bolus
Sumatriptan 6mg subQ
Cervical or Trapezius Trigger Point Injection with Lidocaine 1% 1-2ml IM
Metoclopramide 10mg IV
Promethazine 12.5mg IV
Magnesium 1gm IV over 60 minutes
Valproic Acid 500mg/50ml NS IV over 20 minutes
Levetriacetam 1000mg/100ml NS IV over 15 minutes
Dexamethasone 8mg IV (migraine only)
Haloperidol 2.5mg IV over 5 min
Lidocaine 1.5mg/kg in 100ml NS over 10 minutes (max 200 mg)
If tension component: - Cyclobenzaprine 5mg PO or Diazepam 5mg PO/IV

Extremity Fracture or Joint Dislocation
Consider regional anesthesia: e.g. nerve blocks: wrist, ankle, ulnar, radial, etc.
Immediate therapy: (steps 1-3 while setting up for block) - Intranasal Ketamine 50mg (0.5ml) - Acetaminophen 1000mg PO/IV
Followed by setting up for: - Ultrasound guided regional anesthesia ○ Joint dislocation and extremity fracture ▪ Lidocaine 0.5% peri-neural infiltration (Max 5mg/kg)
If unable to do ultrasound-guided regional anesthesia: - Ketamine 0.2mg/kg in 50ml NS IV over 5-10 min

Abdominal Pain
Metoclopramide 10mg IV
Diphenhydramine 25mg IV
Promethazine 25mg IV
Dicyclomine 20mg PO
Haloperidol 2.5mg IV over 5 min
Lidocaine 1.5mg/kg in 100ml NS over 10 min (Max 200mg)
Ketamine 0.2mg/kg in 50ml NS IV over 5-10 min
Sumatriptan 6mg subQ
Capsaicin 0.025% topical

Renal Colic
Acetaminophen 1000 mg PO/IV
1 liter normal saline bolus
Ketorolac 15mg IV
Lidocaine 1.5 mg/kg in 100 ml NS over 10 min (Max 200mg)
Intranasal Ketamine 50mg (0.5 ml)

Upcoming Chapter Event


SAVE
the
DATE
Tuesday
APRIL 30, 2019
6:00pm
NEBRASKA CHAPTER ANNUAL MEETING
Guest Speaker - Robert Takla, MD sponsored by Janssen Pharmaceuticals, Inc.
www.neacep.org
RSVP by April 23, 2019:
ne.chapter@acep.org

OUR GUEST SPEAKER WILL BE

Robert Takla, MD

Medical Director and Chief of Emergency Medicine
St. John Hospital and Medical Center, West Bloomfield, MI
Dr. Takla is a paid speaker for Janssen Pharmaceuticals, Inc.

DATE/TIME

Tuesday, April 30, 2019
6:00 PM

LOCATION

Fleming's Prime Steakhouse
140 Regency Parkway, Omaha, NE 68114 • (402) 393-0811

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Please note that the company prohibits the offering of gifts, gratuities, or meals to federal government employees/officials. Thank you for your cooperation.

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INDICATIONS

XARELTO® is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation (AF).

There are limited data on the relative effectiveness of XARELTO® and warfarin in reducing the risk of stroke and systemic embolism when warfarin therapy is well controlled.

XARELTO® is indicated for the treatment of deep vein thrombosis (DVT). XARELTO® is indicated for the treatment of pulmonary embolism (PE). XARELTO® is indicated for the reduction in the risk of recurrence of DVT and/or PE in patients at continued risk for recurrent DVT and/or PE after completion of initial treatment lasting at least 6 months.

XARELTO® is indicated for the prophylaxis of DVT, which may lead to PE in patients undergoing knee or hip replacement surgery.

XARELTO® is indicated, in combination with aspirin, to reduce the risk of major cardiovascular events (cardiovascular [CV] death, myocardial infarction [MI], and stroke) in patients with chronic coronary artery disease (CAD) or peripheral artery disease (PAD).

IMPORTANT SAFETY INFORMATION

WARNING: (A) PREMATURE DISCONTINUATION OF XARELTO® INCREASES THE RISK OF THROMBOTIC EVENTS, (B) SPINAL/EPIDURAL HEMATOMA

A. Premature discontinuation of XARELTO® increases the risk of thrombotic events
Premature discontinuation of any oral anticoagulant, including XARELTO®, increases the risk of thrombotic events. If anticoagulation with XARELTO® is discontinued for a reason other than pathological bleeding or completion of a course of therapy, consider coverage with another anticoagulant.

B. Spinal/epidural hematoma
Epidural or spinal hematomas have occurred in patients treated with XARELTO® who are receiving neuraxial anesthesia or undergoing spinal puncture. These hematomas may result in long-term or permanent paralysis. Consider these risks when scheduling patients for spinal procedures. Factors that can increase the risk of developing epidural or spinal hematomas in these patients include:

- **Use of indwelling epidural catheters**
- **Concomitant use of other drugs that affect hemostasis, such as non-steroidal anti-inflammatory drugs (NSAIDs), platelet inhibitors, other anticoagulants, *see* Drug Interactions**
- **A history of traumatic or repeated epidural or spinal punctures**
- **A history of spinal deformity or spinal surgery**
- **Optimal timing between the administration of XARELTO® and neuraxial procedures is not known**

Monitor patients frequently for signs and symptoms of neurological impairment. If neurological compromise is noted, urgent treatment is necessary.
Consider the benefits and risks before neuraxial intervention in patients anticoagulated or to be anticoagulated for thromboprophylaxis.

Please see Important Safety Information continued on next page.
Please see accompanying full Prescribing Information, including Boxed WARNINGS, or visit www.XARELTOhcp.com.

Janssen Pharmaceuticals, Inc.

janssen
Johnson & Johnson

Adriana's Corner

Member of the Year!

Often, I hear a positive story about how one of you went above and beyond to help a patient, fellow colleague or the chapter. I feel recognition is deserved for your outstanding service to emergency medicine. Do you agree?

For this reason, we are looking for a **Chapter Member of the Year**!

When you hear about a fellow colleague, member of the chapter, who deserves recognition for demonstrating outstanding service through commitment, passion, professionalism and dedication to any aspect of emergency medicine, let me know. Send me an **email** with details about why recognition is deserved. I will make sure recognition is given!

A well-deserved recognition will be given via the chapter e-newsletter, the chapter website and/or announced at any upcoming chapter event. He/she will be the **Nebraska Chapter Member of the Year** and will have his/her name, photo and bio placed on the chapter website for the entire year.

As always, please feel free to contact **me** if you have any questions about the chapter and/or your membership with National ACEP or the Nebraska Chapter.

Welcome New Chapter Members

Jared Baster - Medical Student
Alissa Marie Dixon Bates - Medical Student
Jonathan Bauman - Medical Student

NEWS FROM ACEP

American College of Emergency Physicians
ADVANCING EMERGENCY CARE

Bedside Tools

ACEP has a number of web-based tools for you to use at the bedside. From sepsis, to acute pain to agitation in the elderly - we've got you covered!

- **ADEPT** - Confusion and Agitation in the Elderly ED Patient
- **ICAR2E** - A tool for managing suicidal patients in the ED
- **DART** - A tool to guide the early recognition and treatment of sepsis and septic shock
- **MAP** - Managing Acute Pain in the ED
- **BEAM** - Bariatric Examination, Assessment, and Management in the Emergency Department. For the patient with potential complications after bariatric surgery

Unscheduled Procedural Sedation: A Multidisciplinary Consensus Practice Guideline

The new ACEP policy statement, Unscheduled Procedural Sedation: A Multidisciplinary Consensus Practice Guideline, was approved by the Board in September 2018 and has been endorsed by several other organizations. **Read the final version of the policy here**.

Social Media Policy

Make sure you're protecting yourself. ACEP has a new social media policy to help keep you and your patients safe. **Read the policy here**.

New Policy Statements, PREP and Information Paper

During their January 2019 meeting, the ACEP Board of Directors approved the following new or revised policy statements/PREP/information paper:

New Policy Statements:
Autonomous Self-Driving Vehicles
Reporting of Vaccine Related Adverse Events

Revised Policy Statements:
Advertising and Publicity of Emergency Medical Care
Economic Credentialing
Emergency Physician Stewardship of Finite Resources
Medical Services Coding
Patient Information Systems
Providing Telephone Advice from the ED

Revised Policy Resource and Education Paper (PREP):
Military Emergency Medical Services

New Information Paper:
Suicide Contagion in Adolescents: The Role of the Emergency Department

Articles of Interest in *Annals of Emergency Medicine* - Winter 2019

Sam Shahid, MBBS, MPH
Practice Management Manager, ACEP

ACEP would like to provide you with very brief synopses of the latest articles in ***Annals of Emergency Medicine***. Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population.

Shih HM, Chen YC, Chen CY, Huang FW, Chang SS, Yu SH, Wu SY, Chen WK. **Derivation and Validation of SWAP Score for Very Early Prediction of Neurological Outcome in Patients with Out-of-Hospital Cardiac Arrest.**
The aim of this study was to establish a simple and useful assessment tool for rapidly estimating the prognosis of patients with out-of-hospital cardiac arrest (OHCA) after their arrival at an emergency department (ED). A total of 852 patients admitted from January 1, 2015 to June 30, 2017 were prospectively registered and enrolled into the derivation cohort. Multivariate logistic regression on this cohort identified four independent factors associated with unfavorable outcomes: initial nonshockable rhythm, no witness of collapse, age >60 years, and pH ≤7.00. The shockable rhythm–witness–age–pH (SWAP) score was developed and one point was assigned to each predictor. For a SWAP score of 4, the specificity was 97.14% for unfavorable outcomes in the derivation cohort. The study concluded that the SWAP score is a simple and useful predictive model that may provide information for the very early estimation of prognosis for patients with OHCA.

Chinn E, Friedman BW, Naeem F, Irizarry E, Afrifa F, Zias E, Jones MP, Pearlman S, Chertoff A, Wollowitz A, Gallagher EJ. **Randomized Trial of Intravenous Lidocaine versus Hydromorphone for Acute Abdominal Pain in the Emergency Department.**
This randomized, double blind clinical trial compared the efficacy and safety of intravenous lidocaine to that of hydromorphone for the treatment of acute abdominal pain in two emergency department (ED) in the Bronx, NY. Adults weighing 60-120 kg were randomized to receive 120 mg of IV lidocaine or 1 mg of IV hydromorphone. 30 minutes after administration of the first dose of study drug, participants were asked if they needed a second dose of the investigational medication to which they were randomized. The primary outcome was improvement in 0-10 pain scores between baseline and 90 minutes. Out of the 154 patients enrolled, 77 received lidocaine and 77 received hydromorphone and by 90 minutes, patients randomized to lidocaine improved by a mean of 3.8 points on the 0-10 scale, while those randomized to hydromorphone improved by a mean of 5.0 points. The study concluded that IV hydromorphone was superior to IV lidocaine, both for general abdominal pain and a subset with nephrolithiasis.

Ballard DW, Kuppermann N, Vinson DR, Tham E, Hoffman JM, Swietlik M, Davies SJD, Alessandrini EA, Tzimenatos L, Bajaj L, Mark DG, Offerman SR, Uli K. Chettipally UK, Paterno

MD, Schaeffer MH, Richards R, Casper TC, Goldberg HS, Grundmeier RW and Dayan PS, for the Pediatric Emergency Care Applied Research Network (PECARN), Clinical Research on Emergency Services and Treatment (CREST) Network, and Partners HealthCare. **Implementation of a Clinical Decision Support System for Children with Minor Blunt Head Trauma at Non-negligible Risk for Traumatic Brain Injuries.**
This study utilized a secondary analysis of a non-randomized clinical trial with concurrent controls conducted at 5 pediatric and 8 general EDs between 11/2011 and 6/2014, enrolling patients <18 years-old with minor blunt head trauma. After a baseline period, intervention sites received electronic clinical decision support (CDS) providing patient-level ciTBI risk estimates and management recommendations. The following primary outcomes in patients with 1 intermediate PECARN risk factor were compared pre- and post-CDS: (1) ED computed tomography (CT) proportion adjusting for age, time trend, and site and (2) prevalence of ciTBI. The results showed that providing specific risks of ciTBI via electronic CDS was associated with a modest and safe decrease in ED CT use in children at non-negligible risk of ciTBI. **Full text available here**.

Akhlaghi N, Payandemehr P, Yaseri M, Akhlaghi AA Abdolrazaghnejad A. **Premedication with Midazolam or Haloperidol to Prevent Recovery Agitation in Adults Undergoing Procedural Sedation with Ketamine: A Randomized Double-Blind Clinical Trial**
This study evaluated the effect of midazolam and haloperidol premedication for reducing ketamine-induced recovery agitation in adult patients undergoing procedural sedation. They randomized emergency department patients older than 18 years who needed procedural sedation to receive one of the following three interventions in double-blind fashion 5 minutes prior to receiving ketamine 1 mg/kg IV: distilled water IV, midazolam 0.05 mg/kg IV, or haloperidol 5 mg IV. The main study outcomes were recovery agitation as assessed by the maximum observed Pittsburgh Agitation Scale (PAS), and by the Richmond Agitation-Sedation Scale (RASS) at 5, 15, and 30 minutes after ketamine administration. For the 185 patients undergoing adult procedural sedation, premedication with either midazolam 0.05 mg/kg or haloperidol 5 mg IV was shown to significantly reduce ketamine-induced recovery agitation while simultaneously delaying recovery.
Full text available here.

Remick K, Gausche-Hill M, Joseph MM, Brown K, Snow SK, Wright JL, AAP Committee on Pediatric Emergency Medicine and Section on Surgery, ACEP Pediatric Emergency Medicine Committee, ENA Pediatric Committee. **Pediatric Readiness in the Emergency Department**
The American Academy of Pediatrics (AAP), the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) published updated joint guidelines, “Pediatric Readiness in the Emergency Department,” that recommend ways health care providers can make sure every injured or critically ill child receives the best care possible. The joint policy statement, published in the November 2018, represents a revision of the 2009 policy statement and highlights recent advances in pediatric emergency care that may be incorporated into all emergency departments that care for children. The statement emphasizes the importance of evidence-based guidelines and includes additional recommendations for

quality improvement plans focusing on children and disaster preparedness. **Link to *Annals* publication**.

See Your Impact

You serve your community. ACEP is honored to serve you. Since 1968, ACEP has united and amplified the collective voice of emergency physicians across the world. We know you face challenges, and it's our mission to protect your interests and make it easier for you to provide the highest quality care for your patients. As an ACEP member, you are a direct contributor to important initiatives that propel the profession forward. Our **2018 Annual Report** illustrates how your support makes an incredible impact on emergency medicine.

embrs

Emergency Medicine Basic Research Skills

Are you interested in increasing and improving research in emergency medicine?

Emergency Medicine Basic Research Skills (EMBRS) is a 9-day, 2-session program where participants learn how to identify clinical research opportunities and become familiar with clinical research and outcomes. Participants are also eligible to receive an EMF/EMBRS grant based on their research grant application. This course targets: Junior faculty with limited research experience; Physicians in academic and community centers who are interested in

research basics; Physicians who have as part of their duties involvement in research, including mentoring young researchers; Fellows in non-research fellowships.

Click here to learn more and to put your name on the interest list. The next course will take place Dec. 2-7th, 2019 (session 1) and April 14-16, 2020 (session 2).

MOC Made Easy

The **New ACEP MOC Center** is the "easy button" for MOC! It's a One-Stop-Shop to keep it all together and on track for all things MOC. See what you have to do to stay certified AND what resources ACEP has to help you do it.

ABEM has made (at least) three big changes in the way they present MOC information to diplomates - 1) they launched a new website, 2) they changed the names and order of the MOC components, and 3) they changed the language they use to describe them (no more "Part" anything). ABEM also announced an alternative to the ConCert Exam, which they'll pilot in 2020 and launch in 2021.

NEWS FROM THE AMERICAN BOARD OF EMERGENCY MEDICINE FEBRUARY 2019

American Board of Emergency Medicine

Letter Available to Request Becoming ED Designated Trainer for Lab Procedures

ABEM can provide a letter of support to ABEM-certified physicians to request that their hospital laboratory director apply for a waiver for ED point-of-care (POC) testing. If the waiver is granted, a designated trainer, who may be an emergency physician, can provide annual competency testing to other ED personnel for POC testing procedures, such as hemoccult or urine pregnancy testing, etc. Waivers to allow POC testing by ED personnel help reduce the burden that emergency physicians face by having to undergo annual training by a laboratory representative as well as expedite patient throughput.

The letter and additional information about the waiver are available from physicians' Personal Page on the ABEM portal. To download the letter:

- Sign in to the **ABEM portal**
- On the left navigation, click "Print Verification of ABEM Status"

- Under letter type, click “POCT”
- Click “Continue to Next Step”

The letter is available to physicians participating in the ABEM MOC Program.

This is the most recent letter resulting from the continuing efforts of the Coalition to Oppose Medical Merit Badges (COMMB) and is signed by each representative of the Coalition. The rationale for the letter is that physicians participating in MOC have the knowledge, skills, and abilities to provide such training. Also available is a general letter stating that ABEM certification supersedes the need to complete “merit badge” requirements. That letter explains that ABEM’s MOC Program is a rigorous form of continuous professional development that contains content critical to the practice of Emergency Medicine, including procedural sedation, cardiovascular care, airway management, trauma care, stroke management, and pediatric acute care.

Certification, therefore, supersedes the need for certifications sometimes required for medical staff privileges or disease-specific care center designations.

ConCert Fast Facts

- The ConCert Exam is available twice per year-in the spring and the fall
- You can register and take the ConCert Exam during any examination administration in the last five years of your certification
- You do not have to complete all other MOC requirements to register early for the ConCert Exam
- Completing your MOC requirements early does **NOT** reset your certification expiration date (it will be good for the entire ten-year period)
- If you complete your requirements early, your new certificate will be sent toward the end of the final year of your current certification
- 60 *AMA PRA Category 1™ Credits* are available at no charge for passing the ConCert Exam and completing all other MOC requirements (go to **www.abem.org**, and click on “Stay Certified,” and “CME Credit Available for ABEM Activities” for more information)

If you have any questions about the ConCert Exam or other MOC requirements, please contact ABEM at 517.332.4800, ext. 383, or **moc@abem.org**.

Nebraska Chapter
c/o National ACEP
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Irving, Texas 75063-2524