A Newsletter for the Members of the Arkansas Chapter - Summer 2020

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President's Message

Arkansas ACEP Members,

In a normal summer, we would be seeing average volumes with slightly lower acuity while balancing our partners vacation requests. Some of us would travel, see family, take down time.

This summer our healthcare systems in Arkansas have balanced on the edge, inched closer to the precipice, or whatever metaphor you choose. Our ICUs are full, and I find myself at 1am unable to even find a floor bed available. I imagine we are all tired of the additional layers we must don to see our patients, which adds additional time to each visit. I feel I am seeing sicker patients on average even if I do not include the COVID patients. The numbers plateau, go up, trend down, go up, repeat. With school starting, the numbers are most likely going to increase again, unless school does not start. Maddening is just the start of how to describe our personal and work lives. Working from home going forward will be much more universally used, but not for emergency physicians. While we can do telemedicine, our training is really geared toward and requires us to be fully present with patients. I have often thought how it might be nice to work from home, though I suspect our constitutions would not allow us to thrive that way.

Rural Emergency Medicine
Many of us work in rural hospitals, which have been closing. The number of Emergency physicians that work in rural hospitals has decreased to 8% and only 4% of residents that graduate work in rural areas. That spells trouble for staffing these hospitals, in addition to the fact that many are continuing to shut down. The pandemic has likely sped this process due to erratic patient volumes, the way hospitals make money mostly on elective procedures, and the increasing costs and decreasing reimbursements. Without a focus on encouraging and incentivizing work in rural areas, the availability of medical care will continue to wane for these patients.

An App for STEMIs - Pulsara
Coming to 67 hospitals soon: a phone app that will allow us to coordinate with EMS and consultants on STEMI. The Arkansas STEMI Advisory Committee is rolling out

this application to EMS providers, emergency departments, and the hospitals. If you have not heard of it, you likely will in the coming weeks. Once a patient is entered by EMS, they can send you the patient information, EKG, vital signs, and even pictures over a cloud based HIPPA compliant platform. You can use your personal phone, as no data is ever stored on it. You can review the EKG and decide whether to activate the cath lab from your phone, at which point the cardiologist will also have access to the same information. The application can also be used for stroke, trauma, and sepsis, but will initially be used just for STEMIs to test its efficacy and find the inevitable stumbling blocks. You can see a demonstration at pulsara.com, but you will likely be watching a demonstration soon either way.

ACEP COVID Field Guide
ACEP has put together information that we have on COVID in one place that is helpful if you are trying to piece it together with Google and Facebook. This guide contains recommendations for everything from triage, EMS, PPE, to treatment, financial issues, and EMTALA. I would encourage you to use the site for the information you specifically want, like return to work guidelines or how long recovery tends to take. We have so little information on this disease compared to just about every other one we treat, so I have appreciated being able to see what data exists, even though it will undoubtedly change as we learn more.

Mental Strain
I sincerely hope everyone is finding ways to take time for yourself. The uptick in mental stress has been nearly universal, and I have had colleagues from other states who have unfortunately committed suicide. Please watch out for each other and reach out if you think you or a colleague needs help. Most employers have an employee assistance program (EAP) that offers anonymous and free counseling if you need it. As many of us are independent contractors, ACEP also offers counseling or "wellness sessions" so you do not have to call it counseling.

Stay safe and take care of each other!

Medical Student Corner
Morgan Sweere Treece

It was quiet. A word I never would dare to say in the emergency department. It was an eerie feeling on a Sunday morning, like the calm before the storm. We sat, not speaking of it. The emergency department is a very superstitious place. Within the walls of that unique environment, the laws of nature do not seem to apply. Full moons and Friday the 13th bring out the crazy. Holidays and weekends are rough. And "quiet,"—well, that is just a naughty word that will surely get you into trouble. So, we sat. If we talked about it, we knew the crowds would begin to rush in. The phones, however, were not so still. People were scared. The fear was audible in their voices in a way I had never heard in my five years of working as a tech in the emergency department.

Since the first cases in Arkansas the week before, people were beginning to take heed to the national warnings. Even if they were sick with another illness or injury, they were calling because they were afraid to come to the hospital. Isn't this the place where you get Coronavirus in the first place? I had to choose my words even more carefully than usual. The hospital I work at had prepared us for these conversations. We needed to calm the people as much as possible. It is difficult to assure people when you are not sure what is going on yourself. My first pandemic, the Coronavirus, happened during my second year of medical school, when I was also employed as a tech at a local emergency department. I had heard from my school, from my work, and from practically everyone else on the planet about this

issue. I referred patients to our hospital's Infection Control team for further information.

We had "screening" shifts we could pick up as a tech. Screening was interesting. I sat at the entrance to the emergency department, evaluating every patient and visitor coming into hospital. People were nice and understanding, something which can occasionally get lost in the emergency department lobby. I think everyone was unsure of the situation, so people were more willing to comply with the rules our hospital put out to protect themselves and their family members. We were trained to screen out potential COVID cases and how to collect samples for this virus. It was unlike any other sample I had ever collected doing phlebotomy, flu, and strep swabs in the emergency department. The nasal swab went in a normal biohazard bag, like any other sample. However, it then went into a sealed canister, and then into a box. This sample could not be put in the "tube system," like all other lab samples. It had to be walked down to the lab personally. It felt like the precautions for this virus were even somewhat scary. I wondered what it would have been like to have been doing my medical training during the first outbreak of HIV or during another pandemic. I wondered what the aftermath of this would look like. I was proud to be involved in patient care. Proud to serve in the emergency room. Proud to be a healthcare worker.

As a medical student, however, I felt like a bystander. My last NBME of second year was cancelled. Match day for the fourth-year students was cancelled. There were medical students and residents in quarantine being monitored. It felt like the world was ending around me. Medical school feels a lot like being in another dimension. You feel as though your life has stopped, but the others keep living theirs around you. Schools were cancelled, people were sent home, but there I sat at my desk. Studying for my USMLE Step 1. That feeling was exacerbated at that time. I wondered how this 4-minute Sketchy video of a virus turned into all of this. I hardly knew anything about the virus. It was an enveloped virus. Positive sense RNA. Helical. That was about the extent of my knowledge. If there was going to be an outbreak of something, I thought it would at least be one of the longer Sketchy videos, for sure.

I felt determined to gain something positive from all of this, other than maybe a little bit more time to study. We, the students, can learn from this experience. We can learn how to respond, how to react, how to carry ourselves. Because that is what the public will be watching us for. Physicians know this: we are watching you. Every word you say and action you take during this moment. We are learning how to handle ourselves as young physicians. This is our first. It might be your first, too, but you are our elders, our mentors. When we are unsure in medicine (which is often), you are who we turn to for answers. And it is, in turn, us, who the public will eventually turn to. It is imperative to know how to act in a situation such as this. It is important to help people, to give them knowledge and reassurance. And it is wholly important that we never say the word "quiet" in the emergency department.

Medical Student Corner
Pulmonary Embolism with Hampton Hump in a COVID-19 Patient
Jonathan K. Williamson

Discussion

Pulmonary embolism (PE) is a life-threatening condition with numerous causes and various presentations. Symptoms of PE include shortness of breath, pleuritic chest pain, cough, or hemoptysis. There is a broad spectrum of presentation of PE, from minimal symptoms to profound shock or cardiac arrest.[1]

A massive PE is defined as one that presents with hemodynamically instability, while a low risk PE is small and stable. In the intermediate group, or a submissive

PE, patients may present with borderline blood pressure and evidence of ventricular remodeling.[1] Diagnostic evaluation for a suspected PE in a hemodynamically stable patient includes a determination of pre-test probability using Wells' Criteria, Geneva Criteria, or clinical gestalt. Patients with a low to moderate pre-test probability often undergo testing with a d-dimer. Those with either an elevated d-dimer or high pre-test should undergo diagnostic imaging with either computed tomography pulmonary angiography (CTPA), a V/Q scan, or pulmonary angiography. [1] Chest radiography is routinely obtained in patients presenting with dyspnea or chest pain; however, it has poor test characteristics for the diagnosis of PE. Therefore, its utility is typically in the diagnosis of other more common diseases rather than to diagnose or exclude PE. Rarely, a significant pulmonary artery obstruction may lead to a wedge-shaped infarct that is visible on chest radiograph, a sign known as Hampton Hump. [1] The lungs are normally protected from infarction by a dual lung blood supply from the pulmonary and bronchial arteries. As result, Hampton Hump is a low sensitivity marker for PE that occurs in up to 36% of these patients.[2] The presence of a Hampton Hump (image 1) should further increase suspicion of a PE. The patient in this case presented with shortness of breath and chest pain several weeks after diagnosis of SARS-CoV-2 and pneumonia. SARS-Cov-2, also known as COVID-19, is thought to be a disproportionately prothrombotic condition relative to the hypercoagulability of critical illness. [2]

Visual Case Discussion

A 74-year-old female with a history of diabetes, hypertension, end-stage renal disease, and seizures presented to the ED via ambulance due to altered mental status, shortness of breath, and chest pain. She recently was admitted for pneumonia at another facility, during which time she tested positive for SARS-Cov-2/COVID-19. Since discharge she had missed multiple dialysis appointments and had become progressively more confused. Family reported that she had suffered from similar episodes of confusion in the past which were attributed to uremic encephalopathy and improved with dialysis. Due to the patient's confusion, she was unable to provide a flowing description of her chest pain and dyspnea. On exam she was alert and oriented but slow to answer questions. She was hypertensive, mildly tachycardic, afebrile, with normal oxygen saturation on room air. Her cardiovascular exam revealed a sinus tachycardia with no murmurs, rubs or gallops. Pulmonary exam showed rales with normal effort. Bilateral lower extremity edema was present. Other examinations were unremarkable. Chest radiograph showed signs of a peripherally based, wedged shaped consolidation near the right middle lobe which was concerning for either a right middle lobe pneumonia or a Hampton Hump (image 1). Considering her recent hospitalization, diagnosis of SARS-CoV-2/COVID-19, and concerning radiograph, a CTPA was ordered to delineate if this was a pneumonia or a pulmonary infarct. CTPA demonstrated bilateral pulmonary embolism with clot burden (image 2) and infarction with possible overlying infection (image 3). She was started on broad-spectrum antibiotics for hospital associated pneumonia, anticoagulated with heparin, and admitted to the hospital for further care.

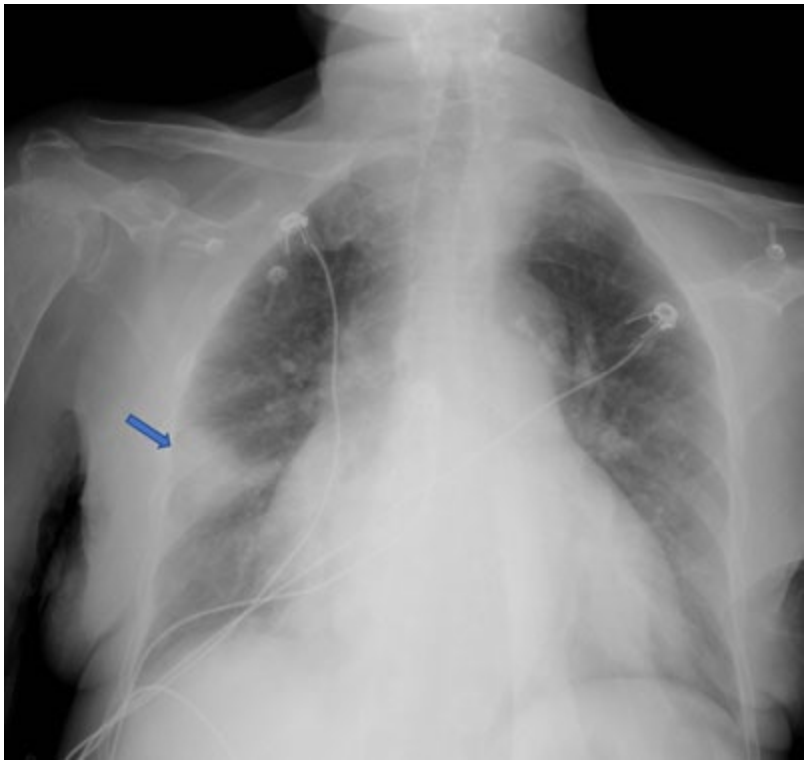

Figure 1. Chest radiograph showing a wedge-shaped area of opacity consistent with a Hampton Hump on the right side (arrow).

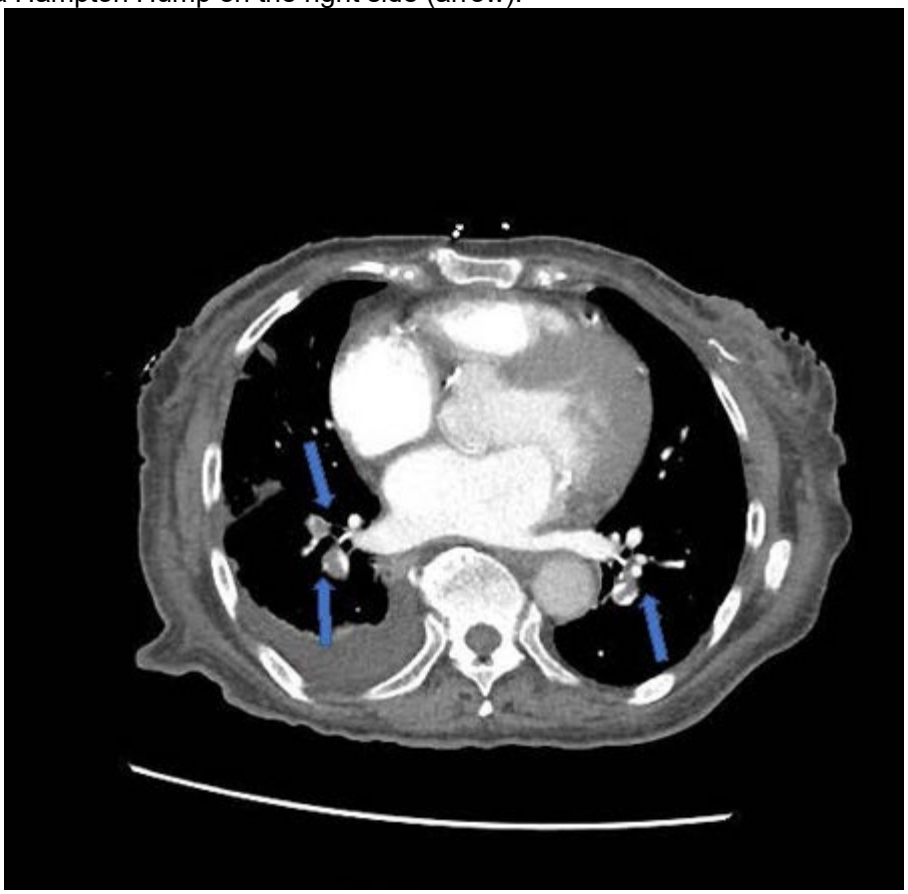

Figure 2. Computed tomography pulmonary angiogram confirms PE with clot burden at the bifurcation of the descending pulmonary arteries bilaterally (arrows). A left sided pleural effusion and bilateral airspace opacities are also noted.

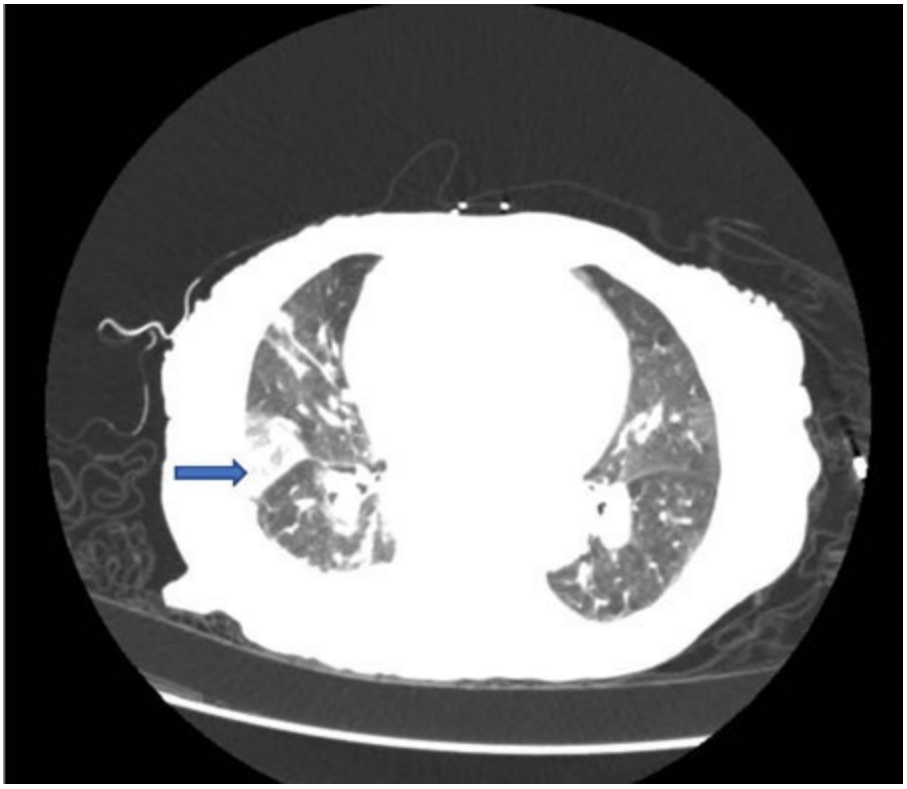

Figure 3. Computed tomography pulmonary angiogram showing wedge-shaped airspace opacity likely representing pulmonary infarction with possible overlying infection (arrow). Diffuse airspace opacities noted bilaterally, concerning for further infection.

References

1. Thompson, BT., Kabrhel, C., Pena, C. Clinical presentation, evaluation, and diagnosis of the nonpregnant adult with suspected acute pulmonary embolism. UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2020.
2. Beeching, N., Fletcher, T., Fowler, R. Coronavirus disease 2019 (COVID-19). The BMJ, 2020: 51-87.
3. Piazza, G., & Goldhaber, S. Z. (2010). Fibrinolysis for Acute Pulmonary Embolism. Vascular Medicine. 15(5), 419-428.

Written By: Jonathan K. Williamson, Joe Brown, MD and Jason Arthur, MD

Medical Student Corner
Thromboangiitis Obliterans Resulting in Amputation: A Case Report
Rachel Grider Cook

Abstract

Thromboangiitis obliterans, also known as Buerger's disease, is a rare disease of the arteries and veins of the extremities. This is a case of thromboangiitis obliterans in a 49-year-old male who presented to our emergency room complaining of acute onset of pain and gangrenous changes in two fingers of his right hand. The orthopedic surgeon was consulted. The result was amputation of the right index and long fingers.

Introduction

Thromboangiitis obliterans (TAO), also known as Buerger's disease, is a rare disease of the arteries and veins of the extremities. The small and medium sized vessels become inflamed resulting in segmental thrombotic occlusions.[1]

This disease is most commonly seen in males and is strongly associated with tobacco use.[2]

Clinically, you will see distal ischemia and increased amputation rates in young adults. This case report will summarize a clinical picture and treatment of TOA.[1]

Case Report

A 49-year-old male with a known history of thromboangiitis obliterans presented to our emergency room complaining of acute onset of pain and black discoloration of the index and long fingers of his right hand. This patient is a life-long smoker with a history of right below-knee amputation and digital amputation of several fingers and toes on the left extremities, as well as bilateral stents in the iliac arteries. He visited the emergency room one week prior due to his fingers being “red and sore” and was put on antibiotics However, it rapidly progressed over the week. He was admitted, placed on a heparin drip and IV antibiotics, and the orthopedic surgeon was consulted.

Upon exam with the orthopedist, the patient’s right index and long fingers appeared to be gangrenous and swollen from the distal portion of the middle phalanx to the nail and volar tips. The 4th and 5th digits of the left hand and left great toe seemed to be well-vascularized with no evidence of frank ischemia. Labs revealed increased c-reactive protein and erythrocyte sedimentation rate, 2.43 mg/dL and 58 mm/hr, respectively. The orthopedist recommended amputation of the two gangrenous fingers at the PIP joint. Risks, complications, benefits, alternatives, and the procedure were explained to the patient, his questions were answered, and informed consent was given.

Following anesthesia, the affected fingers were one at a time addressed with a common digital and ring block for perioperative analgesia. A #15 blade was used to dissect around the bone at the proximal middle phalanx, extensor and flexor tendons were excised, and the amputation was performed through the PIP joint. Cautery was utilized to obtain hemostasis. The edges of the bone were smoothed, and the area was profusely irrigated. The soft tissue flap, which was healthy, was sewn over the end of the amputation using interrupted nylon suture. This same process was repeated for the next finger. A light sterile bulky compression dressing was applied. Following removal of the tourniquet, the distal tips seemed to be well-perfused. The patient tolerated the procedure well and was transferred to recovery then back to the general medical floor. The next day, the patient was doing well, and the bandage to the hand was clean, dry, and intact. Blood cultures revealed no growth. The patient was counseled on the importance of continuing his blood thinners and absolutely no tobacco use. He was discharged to a nursing home for post-operative care and management and was instructed to follow up with the orthopedist in one week.

Discussion

Most studies agree that the best management of thromboangiitis obliterans includes smoking cessation, vasodilators, anticoagulants, and amputation in severe situations.[3]

This case report represented a classic case of TOA in non-compliant patients. Due to the gravity of this disease and potential consequences, early recognition and treatment compliance are key.

References

1. Klein-Weigel PF, Richter JG. Thromboangiitis obliterans (Buerger’s disease). VASA Zeitschrift Fur Gefasskrankheiten. 2014;43(5):337-346. doi:10.1024/0301-1526/a000371. Accessed April 11, 2020.

2. Elfarra M, Rădulescu D, Peride I, et al. Thromboangiitis obliterans - case report. Chirurgia (Bucharest, Romania: 1990). 2015;110(2):183-187. Accessed April 12, 2020.
3. Mohler ER III, Olin JW. Thromboangiitis obliterans (Buerger's disease). UpToDate. 2012. Accessed April 10, 2020.
4. von Elm E, Altman DG, Egger M, Pocock SJ, Gøtzsche PC, Vandenbroucke JP; STROBE Initiative.The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: guidelines for reporting observational studies.J Clin Epidemiol. 2008 Apr;61(4):344-9. PMID: 18313558.

Welcome New Members!

A special welcome to the new members of the Arkansas Chapter. We are excited to have you.

Bryce Thomas Lord **Teresa Clare Fletchinger**

You may wonder if you should get involved with Arkansas ACEP or EMRA or at the national level? We encourage you to please get involved!

If you are unsure about how to get involved, feel free to contact the chapter directly.

FROM NATIONAL ACEP

American College of Emergency Physicians®
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ACEP COVID-19 ALERT

Stay current with the COVID-19 Center. It's your one-stop-shop for clinical and legislative updates. **Quick Links:** Physician Wellness Hub | COVID-19 Field Guide

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Get PPE through Project N95
With member concerns about the quality of N95 masks on the open market, ACEP has joined with Project N95 to offer PPE to you at volume prices. This exclusive benefit for ACEP members is available only through August 26. Registration opens at 4 p.m. ET today Wednesday, August 19 and is only available to members in the 50 states of the US, DC and Puerto Rico.

ACEP & EMRA Launch Diversity Mentoring Initiative on August 15
This collaboration between the ACEP Diversity, Inclusion and Health Equity Section (DIHE) and EMRA's Diversity & Inclusion Committee that supports leadership and career development for diverse medical students, residents, fellows, academic attendings and community emergency physicians in the EM community. The first 200 mentees have been matched with 100 mentors from across the EM community.

If you're interested in being part of the next cohort, slots will open up in six months. Follow #mentorsofEM and #menteesofEM on Twitter to keep tabs on the program's progress, and learn more at mentor.acep.org.

New Policy Statements and Information Papers
During their June 2020 meeting, the ACEP Board of Directors approved the following new policy statements and information/resource papers. For a full list of the College's current policy statements, consult the ACEP Policy Compendium.

New Policy Statements:
Antimicrobial Stewardship
Expert Witness Cross-Specialty Testimony for Standard of Care
Leadership and Volunteers Conduct Policy
Medical Neutrality

Revised Policy Statements:
2020 Compendium of ACEP Policy Statements on Ethical Issues (page two of the Code of Ethics)
Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department
Role of the Emergency Physician in Injury Prevention and Control for Adult and Pediatric Patients

New Information/Resource Papers (Smart Phrases)
Antitussive Medications for Children
Asthma Exacerbation
Asymptomatic Hypertension
Coronavirus Concern — Confirmed or Suspected
Ethanol Intoxication
Influenza-Like Illness
Injection Drug Use
Motor Vehicle Crash

ACEP20 is a CME Jackpot + Announcing Special Guest: Dr. Anthony Fauci!
ACEP20 will include more than 250 hours of CME education, but here's the best part: Attendees get access to this education and **CME for THREE YEARS** after the event! All of the live events will be debuting during the original dates: Oct. 26-29. We are happy to announce our **first special guest at ACEP20 - Dr. Anthony Fauci,** NIAID Director. We'll be unveiling other celebrity keynote speakers throughout August, so follow ACEP's social media channels for those exciting announcements. Click here for more information and to register.

Upcoming Webinar: The Long and Winding Road of an Epidemic: Prescription Opioids, Heroin, and Beyond

Join us on August 31, 2020 from 1pm - 2pm CT for the first installment in a 6-part **free** webinar series on opioid use disorder, federal and state regulations/regulatory considerations and state initiatives. Click here to register.

Moderator and Panelists:

- Chadd K Kraus, DO, DrPH, MPH, FACEP, Director, Emergency Medicine Research Core Faculty, Geisinger Medical Center, EM Residency Associate Professor of Medicine, Geisinger Commonwealth School of Medicine
- Harry Monroe, Director, Chapter and State Relations, ACEP
- Jeffrey Davis, Regulatory Affairs Director, ACEP

The webinar will be recorded and link to recording will be made available to all registrants. For more information, please email Mari Houlihan at mhoulihan@acep.org.

Regulatory Updates

Check out our Regs & Eggs blog for the latest regulatory updates.

2021 Physician Fee Schedule Proposed Rule: What You Need To Know
ACEP recently published a new comprehensive summary of the 2021 Physician Fee Schedule Proposed Rule and its potential effect on emergency medicine. Last week, we sent a letter expressing our concerns with the proposed cuts and calling on Congress to waive budget neutrality requirements to avert the cuts that pose a significant threat to EM physicians and the health care safety net. Voice your concerns by joining the thousands of ACEP members who have urged their legislators waive the budget neutrality requirement for calendar years 2021 and 2022 by signing on to a bipartisan “Dear Colleague” letter.

HHS Reopens Application Process for Provider Relief Funding
Most EM groups were eligible to receive funding from the Medicare General Distribution. If you missed the original June 3 deadline, you may be eligible to apply now. Note: If you already received funding from the "General Distribution" and kept

it, you cannot apply for additional funding. The cap in funding is still 2% of your annual patient revenues.

CMS Delays AUC Program to 2022
CMS recently announced that it would delay the full implementation of the Appropriate Use Criteria (AUC) program until at least the start of calendar year (CY) 2022. ACEP has long advocated for emergency physicians to be exempted from this program. Learn more about the AUC program.

As of Aug. 1, all laboratories must report certain data elements for all COVID-19 tests (including patient demographic data). The responsibility of collecting this information may fall on emergency physicians.

What President Trump's Executive Order on Rural Health and Telehealth Means for EM
On August 3, President Trump issued an executive order (EO) that calls on the Department of Health and Human Services (HHS) to develop new payment models aimed at transforming how clinicians practicing in rural areas are reimbursed under Medicare. Further, the President states in the EO that he believes that many of the telehealth flexibilities available during the COVID-19 public health emergency (PHE) should be made permanent and asks HHS to issue a reg that would examine which services should continue to be provided to patients via telehealth after the PHE ends. On the same day the EO was issued, the (CY) 2021 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed reg was released, which includes a robust set of proposed telehealth policies. Last week's regulatory blog digs in to the telehealth proposals and what they could mean for emergency physicians.

Related News: New Analysis Reveals Worsening Shortage of Emergency Physicians in Rural Areas

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Urge Congress: Please Support Mental Health Resources and Protections for COVID-19 Health Care Providers
ACEP applauds last week's introduction of the Lorna Breen Health Care Provider Protection Act in the Senate. We worked closely with the legislators on the development of this bill and encourage ACEP members to contact their legislators to ask for their support. Read our latest Member Alert for information about this legislation and the other bills ACEP is supporting that advocate for the wellbeing of frontline health care workers.

Marking Physician Suicide Awareness Day
Physician Suicide Awareness Day is coming up on Sept. 17. ACEP will be providing updates on the Dr. Lorna Breen Health Care Provider Protection Act and additional tools and resources to mark this solemn occasion. As we advocate against barriers that prevent EM physicians from seeking mental health care, ACEP encourages members to visit the Wellness Hub at acep.org/wellness-hub for multiple pathways to help you find the support you need during this challenging season for our profession.

The **Innovation in Suicide Prevention Award** recognizes promising and innovative acute care activities in the area of suicide prevention that improve patient outcomes and improve lives of patients and/or providers. Nominations are due Sept. 1.

NEMPAC Charity Match

For a limited time, your NEMPAC contribution of $100 or more will be matched 10 cents on the dollar by ACEP to a charitable cause that provides resources to the COVID-19 front lines. The more you give, the more we give back! You can choose from one of three charities after making your contribution online: EMF COVID-19 Research Fund, GetUsPPE.org or the American Foundation for Suicide Prevention. Click here to join your fellow ACEP members today to support meaningful **political and charitable** involvement.

Be Accredited to Provide Pain & Addiction Care in the ED
Show your community that your ED is part of the solution. ACEP is now accepting applications for the Pain & Addiction Care in the ED (PACED) Accreditation Program, developed for EM physicians by EM physicians.

PACED, the nation's only specialty-specific accreditation program, will provide the education, tools & resources you need to provide better care for patients in pain & those with substance misuse.

Elevate the quality of patient care with innovative treatments, alternative modalities, and impactful risk reduction strategies in a collaborative team setting, resulting in positive outcomes for your patients, families, providers, and communities. Learn more at www.acep.org/PACED or contact us at paced@acep.org.

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