GEORGIA EPIC

The Newsletter of the Georgia College of Emergency Physicians

Plan Now! 2007 GCEP Annual Meeting at Hilton Head Island

by Carl Menckhoff, MD, FACEP; Co-Chair, GCEP Education Committee; Associate Professor, Department of Emergency Medicine, Medical College of Georgia

The Georgia College of Emergency Physicians (GCEP) has already begun preparations for its annual educational meeting. It will take place from June 7-10 at the Crowne Plaza Resort on Hilton Head Island.

This conference is ideally suited for both education and recreation. It begins on Friday morning with breakfast and a chance to visit the exhibits, followed by lectures until lunch. The afternoon is then free for golfing, swimming, biking, or just having a cool drink as you soak up the sun. Friday evening there is a complementary cocktail party where you can get to know your colleagues from around Georgia. Saturday begins with breakfast followed by lectures again until lunch. In the evening is the perennial favorite, the Annual Beach Party with great music, food, drink and dancing.

After breakfast on Sunday, you may attend a number of round table discussions until the conclusion of the conference before noon.

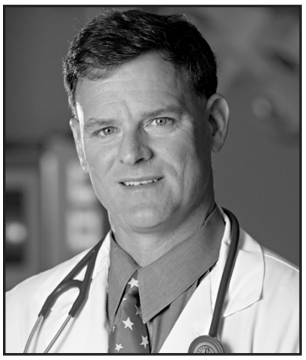
This year, in addition to the lectures focusing on important topics for Emergency Physicians, we will also have a track for pre-hospital providers. This new track will have some cross-over with the physician track, but will include many lectures specifically focusing on pre-hospital issues. All EMS personnel are invited to attend what promises to be one of the best educational opportunities around.

Also, don't forget, this year will mark the 4th annual Emergency Medicine Jeopardy competition, with teams from Emory, MCG and the courageous community docs – the champions from last year.

We look forward to seeing you there. For more information please visit the GCEP web site www.gcep.org

From the President's Desk

No Change to SB-3



Stephen Holbrook, MD
President

The Tort reform legislation, SB-3, passed in 2004 is exceptionally important for all Georgia Emergency patients. There may be an attempt by the trial attorneys to override the "gross negligence" portion of this bill.

This provision specifically assists all of our consultants and allows them appropriate protections when taking call for Emergency patients. The lack of "on-call" coverage is now a national crisis. Georgia is leading tort reform efforts and helping assure our medical staff call providers that call coverage is not an undo burden.

Our national ACEP leadership recognizes that the citizens of Georgia are well served now. You can help by contacting your state representative, discussing this issue, and encouraging NOT changing SB-3 for five years. We need this long to measure the merits of this bill.

Stephen Holbrook, MD
GCEP President

News from EMS

- W. Marty Billings, EMT-P, M.ED. has been appointed as the Director of the Georgia Office of EMS/Trauma. He has worked in the Office of EMS for nine years.

- Did you know that the Georgia Association of EMS had a Medical Director's division? See the web site: www.GA-EMS.org

- EMS Day at the Capitol will be February 22, 2007. Activities will include attending the vote for passing the EMS Day resolution in the House and the annual EMS legislative reception. Plans are being developed to provide a means to educate the legislators about EMS. Efforts are also underway to present AED's to be placed at appropriate locations around the Capital.

- Our Georgia EMS ambassadors to Hong Kong report that all staff members in the Emergency Department wear masks for their entire tour of duty and nebulizers are not being used anymore. All respiratory meds are administered via MDI.

- The Georgia EMS Medical Director's Advisory Council (EMSDAC) is official. The bylaws were passed and appointments are in process.

- EMSDAC recommended that MAST (PASG) be removed from all EMS units and the scope of practice for EMS providers. MAST may still be taught in the curriculum of new EMS classes (as a historical item that should no longer be used on patients) because there is concern that there is still a question about MAST on the National Registry Exam.

- The State EMS protocols are being revised and the effort is being led by Dr. Arch McNeill.

- Dr. Art Yancey is leading the effort to close the loop in notifying the out of hospital

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Honorable Glenn Richardson
Speaker of the House
Georgia House of Representatives
P.O. Box 1750
Hiram, Georgia 30141

Dear Mr. Speaker:

As president of the American College of Emergency Physicians, the nation's largest emergency medicine organization with more than 24,000 members, I want to personally express our appreciation to you for your efforts to secure passage of the emergency care provision in the medical liability reform package enacted by the Georgia legislature in 2005. By requiring "clear and convincing evidence of gross negligence" in emergency care cases, Georgia has acted to protect access to emergency care in the state and has taken a fair and equitable approach to the liability issue by recognizing the unique circumstances facing emergency care providers.

Making split-second decisions and acting decisively to save lives, often without any knowledge of the patients' previous medical history, entails extremely high risks. But when lives are at stake, such risks must be taken. Unfortunately, the elevated liability risks and high costs of malpractice insurance premiums associated with emergency care are contributing significantly to a national shortage of subspecialty physicians willing to provide critical on-call services to emergency patients. The reduced availability of these specialists is a growing national problem that can significantly threaten patient access to quality, timely emergency care.

Fortunately, state leaders across the country are beginning to address the unique liability issues specific to emergency care in a way that protects patients' rights as well as their access to life-saving care. Georgia helped lead the way in striking this important balance, through the passage of the emergency care provision in SB-3. South Carolina quickly followed Georgia's lead in enacting legislation that toughens the standard of proof required in emergency cases. Similar legislation has been, or remains under consideration in other states, including Arizona, Utah and Maryland. Additionally, states like Florida, Texas, Oklahoma, West Virginia and Nevada have enacted liability protections for emergency care providers in emergency departments and trauma centers. This demonstrates a growing acceptance among lawmakers that the very special circumstances involved in emergency care warrant special consideration in state liability laws, especially when the lack of such action poses a serious threat to the availability of timely emergency care and subsequent subspecialty care.

We understand that an effort is underway to rescind Georgia's emergency care protection provision in the upcoming legislative session. We encourage you to strongly oppose such efforts, defend the existing law and protect the interests of the residents of Georgia, who deserve and expect immediate access to life-saving emergency care. While opponents of this protection will undoubtedly try to discount the negative impact that liability concerns can have on access to emergency care, emergency physicians know better. To support this point, attached are specific examples cited in reports by the General Accounting Office, the Center for Studying Health System Change and the American Hospital Association that illustrate the significant impact that high liability risks and costs have on the availability of on-call specialists.

Georgia citizens gained substantially when the emergency care provisions of SB-3 were passed. Georgia citizens deserve to see SB-3 upheld so the achievable goals of improved physician recruitment and improved access to care are realized.

The "National Report Card on the State of Emergency Medicine" gave Georgia an overall grade of "C+". While the state received an "A" in quality, it earned a "D" in the "access to care" category. We recognize your leadership in helping pass SB-3 in an attempt to improve Georgia patients' access to care. Your continued strong leadership is critical to ensure the emergency health care safety net for Georgia citizens.

Georgia has been a shining example for the nation as other states have seen the wisdom in following your lead to protect access to emergency care. We urge you to vigorously defend the current statute against repeal efforts that would jeopardize the provision of emergency care for all Georgians. Please let us know if we can be of any assistance to you in this critical effort.

Thank you.

Sincerely,

Brian F. Keaton, MD, FACEP
President
American College of Emergency Physicians

ACEP SA Update

by Ethan Meisel MD, FACEP

Another October has come and gone and you know what that means, ACEP Scientific Assembly. This year's Scientific Assembly and council meeting were a huge success as many of you had the opportunity to witness first hand. Being a part in the revitalization of New Orleans, the election of new board officers, a chance to catch up with friends and colleagues and, of course, the conference (if you have never heard Dr. Gregory Henry or Dr. Jerome Hoffman speak, it is worth going to the conference just for that). While there were many highlights worth mentioning, here are just a few of the truly memorable.

New Orleans could not have been a more perfect venue for Scientific Assembly this year. Emergency physicians were some of the first to respond to the crisis of Katrina and, more importantly, we were some of the last to leave. It was only fitting that we should be the first ones to return. ACEP members came in force to the conference, helping to not only revitalize the economy but to also show the world that New Orleans is still here in a big way. In recognition of the contributions made by emergency medicine to the city of New Orleans, the week of October 15th was proclaimed Emergency Medicine Week by Louisiana Governor Kathleen Babineaux.

During the council meeting several important resolutions that addressed key issues were passed. We were also able to help instrument defeat of several resolutions which we did not feel would help advance our cause. Overall, the Georgia council was extremely pleased with the council meeting and the results.

Doctors in the college who have obtained fellowship status and are concerned about losing it should they not continue in the specialty or renew their boards need not worry. The resolution, 'once a fellow, always a fellow' passed overwhelmingly. There was overall consensus that the future of healthcare was heading for a single payer system and it was felt by the council that ACEP should explore any possibility to this end; however, it was felt that at this time ACEP should not support any one 'movement'. One of Georgia's most dedicated champions for emergency medicine was also honored. A resolution was passed to commend Dr. Arthur Kellerman for his outstanding service, leadership, and commitment to the College, its members, and the patients they serve.

Other overriding themes at the conference had to do with the overcrowding issue and access to care. Many resolutions had to do with creating solutions or at least ideas to face the medical sub specialty on call crisis. The council instituted a mechanism to publicly deal with those expert witnesses found to give egregious testimony. Fair reimbursement for the services we render was of paramount importance to everyone, as well as the question of where that reimbursement will be coming from in the future. Medical malpractice issues were of vital importance, something we know of very well in Georgia. In fact there were several references applauding what Georgia has accomplished with tort reform.

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New board members as well as officers were elected, and as a college the Georgia chapter is very excited to welcome Linda Lawrence as our new president elect. Linda is very enthusiastic and energetic and we are sure that she will do an excellent job furthering the cause of emergency medicine during her tenure. Also Dr. Brian Keaton officially started his term as president of the college, targeting issues such as ED overcrowding and access to care as just a few of his goals over what will surely be an exciting term. And of course, we said goodbye to Dr. Rick Blum, as his extremely successful term came to an end, a term that will be remembered for groundbreaking accomplishments such as the IOM report and the state of emergency medicine report card. Also re-elected were incumbents Angela Gardner MD, FACEP and Nicholas J. Jouriles, MD, FACEP. We also will be welcoming new board members Alexander Rosenau, DO, FACEP, and Robert Solomon, MD, FACEP.

The nation's top health policymaker, U.S. Health and Human Services Secretary Michael O. Leavitt, took time to address ACEP members during a 45 minute address followed by a 15 minute question and answer session. Among the issues Secretary Leavitt discussed were the integration and standardization of computerized health information services and centralizing patients' medical records.

The Georgia reception was a huge success. Hosted by Emory, Medical College of Georgia and GCEP, this is always a highlight. The reception offered old friends and colleagues a chance to catch up, mingle, as well as a chance to network and meet new people. We hope to continue to grow this event, continuing to make Georgia's presence known at the council meeting and the scientific assembly. Next year's Scientific Assembly in Seattle on October 8-11 will be here before you know it so make sure to save the date now.

Emergency Medicine Residency Medical College of Georgia

by Brad Reynolds, MD, Assistant Residency Director, Department of Emergency Medicine, Medical College of Georgia and Larry Mellick, MD, FACEP, Residency Director, Department of Emergency Medicine, Medical College of Georgia

Another year has passed, another residency class has graduated, another exciting Masters Golf Tournament, a new face on the E.D. and, most importantly, another nine new faces have entered the residency. Our Emergency Medicine residency is now in its 18th year, with a full complement of nine residents in each of our three classes. Our class of 2009 has reached the midpoint of their first year of residency and, as always, we are excited by their energy and hunger to learn.

In addition to many other changes, 2006 has brought about a change in our residency leadership. Dr. Carl Menckhoff, who has led the Medical College of Georgia's (MCG) Emergency Medicine residency for the past five years, stepped down as residency director in July of this year. While we are sad to see Dr. Menckhoff leave as residency director, we are very happy to say that he is staying on at MCG and will continue to remain active in resident education. Taking over the residency director position is a familiar face, Dr. Larry Mellick.

Dr. Mellick was the first chairman of the Department of Emergency Medicine at MCG, from 1996-2002. During Dr. Mellick's tenure as chairman at MCG, the faculty grew from four full-time physicians to over 25 and several core components of the program were implemented (e.g., the ED observation unit, the Center for Operational Medicine, the Pediatric Emergency Medicine program, and the Emergency Medicine ultrasound program). Dr. Mellick returned to the Medical College to assume the role of residency director after spending the past two years working with the FBI in the capacity of medical consultant at the FBI Academy in Quantico, Virginia.

Dr. Mellick graduated from the Medical College of Ohio at Toledo in 1977 and completed both Pediatric and Emergency Medicine residencies in the military. He is board certified in these two specialty areas as well as Pediatric Emergency Medicine. Dr. Mellick's first academic chairman role began in 1993 when he took over leadership of the Department of Emergency Medicine at Loma Linda University Medical Center in San Bernardino County, California. During that time, he started the pediatric emergency medicine program and the pediatric emergency medicine fellowship.

Dr Mellick considers teaching emergency medicine residents his "first love" and looks forward to continuing and building on the hard work of former director, Carl Menckhoff, MD.

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In terms of the department's sections and programs, we have had a successful year in several areas. The Emergency Ultrasound section at MCG continues to be a world leader in emergency ultrasound research and education. The director of Emergency Ultrasound at MCG, Mike Blaivas, past chair of the ACEP EM Ultrasound Section, is current president of the Second International Congress on Emergency Ultrasound & Critical Care in New York, N.Y (2006). At the Second Congress, Dr. Blaivas gave two plenary lectures, a pre-congress course in advanced emergency ultrasound, and four lectures. MCG's emergency medicine ultrasound department presented four abstracts. At home in the E.D., our third ultrasound fellow has just finished his training. Over the past two years, under Dr. Blaivas' direction, our residency has won the ACEP Young Investigator Award (2004), ACEP Excellence in Research Award (2004), and SAEM Best Resident Research Paper (2005).

Event Medicine activities continue to provide a unique and exciting educational component to MCG's residency. Both residents and faculty take advantage of the opportunity to provide medical care at regional events such as the Masters Golf Tournament, Augusta Southern National Boat Races, Sky Fest, and many more. This spring marked the 6th year of our coverage of the prestigious Masters Golf Tournament. For more information on our Event Medicine activities contact Dr. Hartmut Gross at hgross@mcg.edu.

The MCG Center of Operational Medicine (COM) has now been active for three years. It encompasses the offices of tactical medicine, disaster medicine, wilderness medicine, international medicine and our EMS academy.

The International Emergency Medicine program at MCG allows Emergency Medicine residents the opportunity to travel to third world countries and provide medical care to those underserved by modern medicine. The trips are generally 1-3 weeks in duration, and most involve care of poor and disadvantaged citizens. Starting in August 2006, trips are planned for Mexico, Trinidad, Panama, East Asia, Nicaragua, the Arabian Peninsula, Senegal, Myanmar, Bangladesh, Ecuador,

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Medical College of Georgia continued

Vietnam, and Central America. For more information on any of the International Medicine trips, please contact either Dr. Hartmut Gross at hgross@mcg.edu or Dr. Ted Kuhn at wkuhn@mcg.edu.

The Office of Tactical Medicine oversees tactical and homeland security initiatives as related to medical support. These initiatives currently include training, educational, and operational support to local, state, and federal government agencies (including the FBI). Currently, faculty and residents provide medical support to Columbia County Sheriff's Office SRT and Aiken County Sheriff's Office SWAT. Our physicians participate in training exercises including firearms training, self-defense, and all aspects of tactical training. The program is designed to teach residents interested in tactical medicine the concepts required to build a Tactical EMS program, provide preventive medicine, and operate as Tactical EMS providers.

The Office of Disaster Medicine has oversight responsibilities for the Disaster Medical Assistance Team GA-4 (www.mcg.edu/ems/dmat). MCG Center of Operational Medicine (www.mcg.edu/ems/COM) faculty created the National Disaster Life Support (NDLS) Programs (www.bdls.com). These programs consist of:

- Basic Disaster Life Support™ (BDLS®) (http://66.160.8.45/bdls.asp)
- Advanced Disaster Life Support™ (ADLS™) (http://66.160.8.45/adls.asp)
- Core Disaster Life Support™ (CDLS®) (http://66.160.8.45/cdls.asp) and the
- Core Disaster Life Support - Decontamination™ (CDLS-D™) (http://66.160.8.45/cdls_d.asp).

These nationally recognized programs have now been adopted by the American Medical Association. The National Disaster Life Support Foundation (www.ndlsf.org) is a not-for-profit foundation that has been established to oversee and administer the program. MCG COM faculty serve as editors and contributors for the NDLS Programs.

The Section of Pediatric EM had a very busy year, setting a new record for volume. The pediatric census has doubled since the Pediatric ED opened in January of 1999. Seven PEM faculty are boarded in Pediatric EM, and two others are boarded in Pediatric Critical Care. The PEM faculty's primary educational focus is the training of emergency medicine residents, pediatric residents, and MCG medical students. A new Pediatric Emergency Medicine Fellowship was added in 2005, and the first ABEM pathway fellow recently completed his first year of training. The fellowship program will participate in the match for the coming year. Dr. Jim Wilde, medical director of the Section of Pediatric EM, continues as statewide medical director of GUARD (Georgia United Against Antibiotic Resistant Disease), a CDCfunded program to address unnecessary antibiotic use and increasing antibiotic resistance. See the web site at www.guard-ga.org for more information. Dr. Wilde is also one of two GCEP representatives on the governor's task force for pandemic flu pre paration, and, in June, presented a lecture on Pandemic Flu for members of the legislature in Atlanta. Dr. Lynne Coule is heavily involved with PALS instruction and serves as National Faculty for the state of Georgia. Dr. Natalie Lane is the PEM Fellowship director and has developed an educational program to update pediatric residents and emergency medicine residents in PALS protocols on a regular basis using simulators.

Our emergency department observation unit continues to provide great new educational opportunities for our residents while providing state of the art medical care for our patients. In addition to a well-established chest pain evaluation program (evaluating approximately 100 patients per month with serial enzymes and stress echo testing), we also have clinical pathways for asthma, abdominal pain, allergic reactions, altered mental status, back pain, COPD, DVT, pyelonephritis, and anemia.

The Office of EMS develops and manages training programs for pre-hospital medical providers. The Department of Emergency Medicine currently runs several nationally recognized courses such as the Critical Care Emergency Medical Transport Program, (CCEMT-P) (www.mcg.edu/ems/ccemtp). The EMS Academy at the Medical College of Georgia offers, EMT-Basic, Intermediate and Paramedic Level training programs as well as numerous EMS Continuing education programs. We offer quarterly EMS continuing education conferences that are open to the public as well as ACLS, BTLS, First Responder, Pediatric Advanced Life Support, and many other EMS educational programs.

MCG's Emergency Medicine Physician Assistant (PA) residency program was created in 2000 and implemented in 2001. The core curriculum is patterned after the MCG Emergency Medicine Residency program and the current American College of Emergency Physician guidelines. The program incorporates didactic instruction and clinical rotations to provide PAs with the knowledge and skills necessary for any emergency medicine setting. We have two residents in our PA emergency medicine class of 2007, and we are interviewing now for the class of 2008.

For more information on the MCG Emergency Medicine Residency please call Yvonne Booker at (706) 721-2613 or visit our web site, www.mcg.edu/resident/em/ www.mcg.edu/resident/em/.

Political Grapevine

by Maureen Olson, MD, FACEP

Elections are over! Now the fun begins. There appears to be a serious effort by some in the Georgia legislature to take out the phrase "clear and convincing evidence of gross negligence" for emergency care that is currently in the tort reform bill. ACEP and GCEP are working very hard to make sure this does not occur. It is extremely important that all of you inform all of your consultants that this applies to them as well if called upon to treat a patient with an emergent condition. We have developed a task force to collect data to support the benefits of tort reform that have already occurred such as the number of new liability insurance companies coming to Georgia to quote rates. Competition is a good thing. We are asking you to contact GCEP and let us know if you have had improvement in your on call physician status, insurance rates etc. We need to have an organized set of specific data to present to congressional leaders. You may email your information to matthew_keadey@emoryhealthcare.org or Tara Morrison at taramorrison@bellsouth.net.

YOU ARE INVITED!!! Mark your calendars now for January 30, 2007. You are invited to join the GCEP board at Legislative Day down at the Capitol, 8 am until 1:30 pm for breakfast with the board and lunch with legislators. This is your opportunity to meet your legislators and discuss specific concerns regarding emergency medicine, reimbursement, access to care, trauma network and other concerns. Email Tara Morrison to reserve your place and for further information. This is free to you. So there is minimal input with maximal benefit. Who could resist such an offer!!

On the national level we are continuing to ask doctors to contact their representative and senators to ask them to sign on and support the Access to Emergency Care bills. They did not come up for a vote this past session and with the new election results it is important for all of us to let our voices be heard. If you don't know how to contact them go to www.mag.org and type in your address and it will give you both state and national representatives and senators. There are even letters already written that you can download and make the necessary changes before you email them. Remember when emailing to put your wish in the subject heading as this is often all that is seen. They do count how many emails they get on any given topic and keep track of the pro or against numbers. Your actions count!!! You deserve to have your voices heard!

Off the Record Treatment in the ED

by Pete Steckl, MD, FACEP, Risk Management Director, Emerginet, LLC

We would all be hard pressed to find a physician who has not, at one time or another, provided care to family, friends, or colleagues "off the record." This can take the form of curbside consultation by colleagues or favors asked by nurses, hospital employees, and medics. These requests can range from writing a simple prescription to administration of off the record fluids and/or antiemetic medication. Though we try to be helpful in complying, we are often unaware that it is frequently a violation of hospital policy and that, when performed within the confines of the building housing the ED, the obligations and liabilities are especially high.

To put this in legal terms, any time a person presents to the ED asking for care, paying or nonpaying, a legal duty ensues to treat the would be patient. Along with this duty come the attendant obligations to practice within the standard of care. The hitch with these curbside consultations is that they almost always, by definition, constitute care outside the standard. No chart is produced, no vital signs are performed, the patient generally doesn't undress, the physical exam, when performed, is generally scant, and follow-up is generally not arranged.

Other concerns include potential liability and EMTALA issues. A common misconception is that we cannot be sued for care that is not compensated. This is unfortunately a fallacy. A patient who receives care free of charge can just as easily file suit as a patient who is registered and pays the requisite fees. All the associated legal obligations remain in force. Taking it one step further, the EMTALA implications of treating the unofficial patient differently (quicker, more conveniently, and cheaper) than another can be difficult to explain to would be investigators. Lastly, professional liability coverage may only cover the physician in the context of his or her employment, which insurance companies often restrict to the care of registered patients.

It is thus not without hazard that we undertake these benevolent favors. It is understood that it can be uncomfortable to refuse these requests, but one must realize the associated risks of these actions. If against better judgment, one does decide to treat, the common wisdom would be to do it outside of the ED and to write a descriptive note to be kept in one's personal file.

"This statement is for informational purposes only. Nothing contained herein should be construed to state a 'standard of care.' We recognize that each patient encounter is unique with variable circumstances requiring independent physician discretion and judgment."

Good News for Reimbursement

by Rick Pettigrew, CPC, President, Pettigrew Medical Business Services, ACEP Reimbursement Committee

GCEP Reimbursement Column, November 2006:

The last working day for this congressional session was a fine day for emergency medicine! On that day, the House and the Senate passed bills that once again froze Medicare payments to physicians at the 2005 rates rather than allow them to be cut by over 5% as scheduled under the "sustainable growth" formula. The really good news for us emergency physicians is that, with the increase in the relative value of work for our evaluation and management services in the ED, we will see an approximate 7% increase in Medicare reimbursement to emergency physicians in 2007!! That's a one-day turn-around of 12%!!!!!! Wow!

The freeze was a result of physician lobbying of congress, including lobbying by ACEP. The increase in the RVUs was a result of the sole efforts of ACEP via its Reimbursement Committee. That RVU change will hold fast for the next five years.

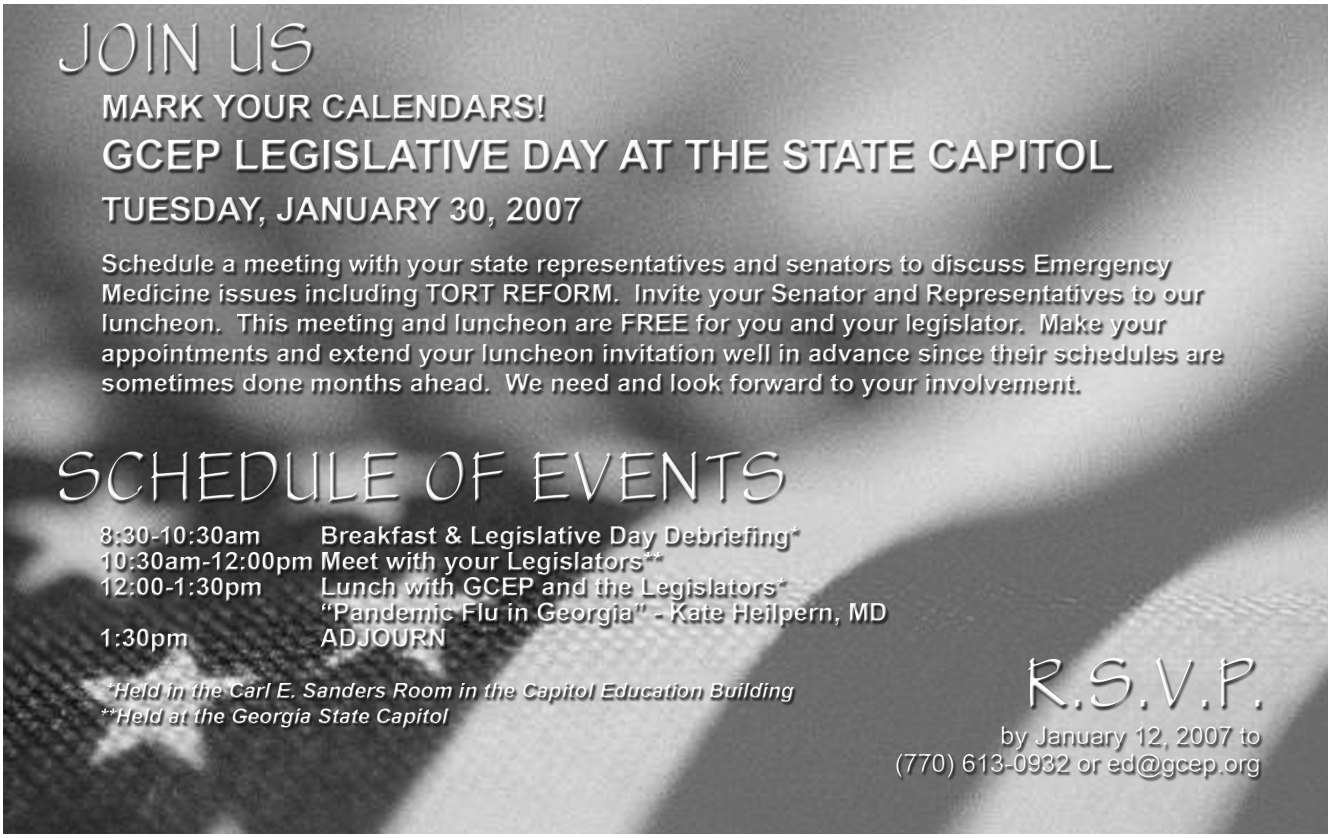
In addition to a "freeze" in reimbursements for Medicare at the 2005 rates, emergency physicians will be eligible for a 1.5% "bonus" for voluntarily participating in a yet-to-be-defined quality reporting system. This system is to be up and running by July 1, 2007, but don't count on it. There are significant problems to be overcome with the implementation of this program. More on that later as information becomes available.

The Centers for Medicare and Medicaid Services (CMS) has proposed that outpatient services have five levels instead of the current three. This will greatly benefit hospitals (their EDs in particular) as the current mechanism leads to much controversy in the cross-over templates for determining the level of facility services provided. This change will likely happen late in 2007. . . but it is going to happen and your ED needs to be preparing for this.

There are more changes coming down the pike for IV infusions. Medicare will be sending out a clarification that there is no professional component for this service. So, don't bill Medicare for this service, and do not use the -26 modifier (professional component only) for IV infusion services.

Finally, the end of the geographic index for Medicare payments is in sight. In the not-too-distant future, all geographic factors will be fixed at 1.000, thus eliminating the varying different factors that had caused reimbursement differences from region to region, and hospital to hospital (rural vs. urban, for example).

That's all for now!



Ped's Corner: The Wheezing Infant – New Guidelines for the Management of Bronchiolitis

by jeff Linzer Sr., MD, FAAP, FACEP, Chair GCEP Pediatric Task Force, Assistant Professor of Pediatrics and Emergency Medicine, Emory University

Bronchiolitis is the most common cause of lower respiratory infection in children under two years of age with up to 40 percent of the cases due to the respiratory syncytial virus (RSV). While the peak RSV season is between December and March, the virus has been recovered in parts of Georgia throughout the year. RSV bronchiolitis leads to over 90,000 hospitalization annually at a cost of more than $700 million per year for children under one year of age.

The clinical presentation of bronchiolitis is essentially the same whether due to RSV or other viruses including human metapneumovirus, influenza, adenovirus, and parainfluenza. There is an acute inflammation that results in edema and necrosis of epithelial cells lining small airways. Cold-like symptoms of fever, rhinitis and cough combine with an asthma-like picture of tachypnea, wheezing, crackles, nasal flaring and accessory muscle use.

What is the best way to manage this problem in the busy ED? The American Academy of Pediatrics has just published new evidence based guidelines for the acute management of bronchiolitis. Here is a brief summary of recommendations for patients in the ED:

Bronchiolitis is a clinical diagnosis; laboratory and radiographs should not routinely be used to make the diagnosis.

Bronchodilators should not be used routinely in the management of bronchiolitis; a carefully monitored trial of adrenergic or ß-adrenergic bronchodilators is an option. Inhaled bronchodilators should be only continued if there is a documented positive clinical response. (Note: In head-to-head comparison studies nebulized epinephrine has been shown to be more efficacious than albuterol).

Corticosteroid should not routinely be used. (Note: The results of a mutlicenter, double-blind placebo control study presented at the AAP national conference this October showed that systemic corticosteroids were no more effective then placebo in bronchiolitis).

It is important to access the child's hydration and ability to adequately take oral fluids.

Antibiotics should only be used in children with bronchiolitis who have specific findings of a coexistence bacterial infection. (Note: The rate of serious bacterial infections, especially in children over 60 days of age with bronchiolitis, is very low. UTI was the most commonly found bacterial co-infection).

In previously healthy infants, supplemental oxygen is indicated if SpO2 falls persistently below 90 percent. When required the goal should be to maintain a SpO2 at or above 90 percent and may be discontinued if SpO2 is at or above 90 percent and the infant is feeding well with minimal respiratory distress.

At Children's Healthcare of Atlanta the primary initial treatment is for deep nasal suctioning. If the child does not improve with that there is a trial of bronchodilator. Previously healthy children without a history of significant cardiac or cardiac disease, prematurity or immune compromise are considered for admission if they are unable to maintain their secretions, have poor feeding, or are unable to maintain a SpO2 of 90 percent or more while awake or 88 percent or more while awake.

So this winter consider
more suctioning and less bronchodilators
avoid routine use of systemic steroids
decrease the amount of labs and x-rays
tolerate lower O2 sats

To see the full AAP recommendations go to (www.pediatrics.org/cgi/content/full/118/4/1774) and (www.pediatrics.org/cgi/content/full/118/4/1774)

To see the CHOA bronchiolitis and other disease guidelines (including fever) go to (www.epgatlanta.org).

News from EMS: continued from page 2

providers about their exposure to potentially communicable diseases during the out of hospital phase of the patient's care. Most hospitals have an infection control person to assure all hospital workers are protected from potentially harmful exposures (i.e. meningococcus). The system developed must be able to identify all individuals at risk including first responders, firefighters, law enforcement and others on the scene.

- Rules and Regulations for EMS Helicopter transportation in Georgia are in process and should be available for review soon.

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Save the Date!

GCEP Annual Meeting

June 7-10

Crowne Plaza Resort

Hilton Head Island