EPIC

THE MAGAZINE OF THE GEORGIA COLLEGE OF EMERGENCY PHYSICIANS

In this issue...

Governor Kemp's Tort Reform Efforts

A breakdown on what SB 68 and SB 69 seeks to address in the legal climate:

Procedural Changes Related to Medicine:

Georgia is one of the few states that requires a motion to dismiss to be filed ***at the same*** time a defendant's answer is due, 30 days after a complaint is served.

- Plaintiff attorneys are using the flaw in current code to create leverage, in unfair advantages at the initiation of litigation. The trend being seen currently is that attorneys will file complaints containing hundreds of pages or more in addition to multiple affidavits, and often against multiple defendants. Additionally, they have also had many months to prepare the complaint. The defense has 30 days to respond and concur.
- If any of the claims could be dismissed, they have to determine that and write those motions in addition to responding to every factual allegation. This creates tremendous burdens on time and on cost.
- Frequently, responses require significant hours to respond to effectively burning physicians time, taking them away from the clinic, and costing tens of thousands of dollars within the first thirty days.

Specific changes to the tort laws include the following:

Anchoring:

Med-mal cases are complex and often involve medically fragile plaintiffs, there is a significant amount of sympathy built in already and the jury understands that. The medical costs are typically very high given the average resolution of claim vs. a physician is $636k. Introducing values regarding pain and suffering tends to create an unfair bias in the mind of the jury.

Trial Bifurcation:

Highly complex cases that require extensive testimony of experts both to causation and damages. If liability and damages are together in a case, it is far too easy for a jury to focus on those damages to the detriment of determining whether there was a failure of the standard of care.

Truth in Damages (Phantom Damages):

As it stands currently, medical bills relied upon regarding medical treatment are almost always highly inflated. If the goal of the jury is to make a plaintiff whole, ***the actual out of pocket costs should be considered and not inflated bills*** that create a windfall for plaintiff and attorney. The secondary effect is inflated bills lead to an unfair increase of non-economic damages as juries are well known to determine non-economic damages by factoring the special damages (in the absence of anchoring).

Double Recovery of Fees:

Complex litigation creates opportunities for penalties in the form of fees to arise. The consistency of filings can create opportunities strategically for unforced errors. Additionally, problems like the mirror image rule in responding to settlements and demands can unfairly create an opportunity to tax costs.

If a plaintiff is successful, then the cost award can be the sum of the contingency fee. The lawyers will also take their fee from the clients award as well.

SENATE FLOOR ACTION

- **SB 5 - Senator Kay Kirkpatrick:** Seeks to provide for health insurers to implement and maintain a program that allows for the selective application of reductions in prior authorization requirements under certain circumstances. On Wednesday, February 12, the Senate voted on SB 5 on the floor that passed with 51 Yeas and 1 Nay. This legislation now moves on to the House where it awaits a committee assignment.

UPCOMING COMMITTEE MEETINGS

- House Appropriations Subcommittee on Health on Tuesday, February 18th at 3:00 PM.
- House Health Committee on Wednesday, February 19th at 2:00PM.

New Bills To Watch

SENATE Bills

- **SB 130 - Senator Mike Hodges**: Seeks to expand medical education funding and the service cancelable loan program.
- **SB 131 - Senator Mike Hodges**: To provide for the establishment of the Georgia Health Care Professionals Data System.
- **SB 140 - Senator Greg Dolezal**: Seeks to provide for doctors of optometry to dispense and sell pharmaceutical agents to patients under certain conditions.
- **SB 142 - Senator Kim Jackson**: Intends to provide for certain licensure for qualifying international medical graduates.
- **SB 155 - Senator Derek Mallow**: Intends to add census tract to the categories upon which insurers may not consider when promulgating standards or rating plans.
- **SB 158 - Senator Gail Davenport**: Seeks to create the Commission for Blind and Visually Disabled Persons.
- **SB 162 - Senator Chuck Hufstetler**: Seeks to provide for the Georgia Composite Medical Board to implement an automated credentialing system for healthcare providers in this state.

HOUSE Bills

- **HB 298 - Representative Trey Kelley**: Seeks to provide requirements for nurse staffing in hospitals. To require a written nurse services staffing plan.
- **HB 323 - Representative Karen Mathiak**: Intends to provide for Medicare supplement policies to be issued and renewed for individuals under 65 years of age who are eligible by reason of disability or end stage renal disease under federal law; to provide for open enrollment periods.
- **HB 326 - Representative Michelle Au**: Intends to mandate that the state health benefit plan provide coverage for qualifying non-opioid pain management drugs that is in parity with its coverage for opioid pain management drugs.
- **HB 329 - Representative Scott Hilton**: Seeks to authorize certified nurse practitioners and physician assistants to perform artificial insemination.
- **HB 341 - Representative Mark Newton**: Seeks to create a tax credit for certain employers that offer individual coverage health reimbursement arrangements to employees.
- **HB 352 - Representative Devan Seabaugh**: Seeks to revise coverage criteria to include Medicaid recipients with gestational diabetes.
- **HB 373 - Representative Lydia Glaize**: Seeks to require major medical coverage for annual prostate cancer screenings for certain men.
- **HB 382 - Representative Ron Stephens**: Seeks to revise a provision relating to psilocybin.
- **HB 419 - Representative Lee Hawkins**: Intends to require the possession of opioid antagonists by units within the Technical College System of Georgia.
- **HB 420 - Representative Darlene Taylor**: Seeks to require certain health benefit policies to cover genetic testing for an inherited mutation and cancer imaging under certain conditions.
- **HB 422 - Representative Derrick McCollum**: To require the state employees' health insurance plan include high deductible health plans.
- **HB 428 - Representative Lehman Franklin**: Seeks to codify the right to in vitro fertilization for individuals.

Senate Health and Human Services Committee

The Senate Health and Human Services Committee had their meeting on Monday, February 10th. This meeting included a vote on two bills.

- **SB 72 - Senator Matt Brass**: "Hope for Georgia Patients Act"; Seeks to expand access to individualized investigational treatments to patients who have severely debilitating or life-threatening illnesses. Passed unanimously out of committee and heads to Senate Rules.
- **SB 101 - Senator Randy Robertson**: Requires testing for Duchenne Muscular Dystrophy in the newborn screening system. Passed out of committee and will now move to Senate Rules.

The Senate HHS Committee held their routine second meeting of the week on Wednesday, February 12.

- **SB 30 - Senator Ben Watson**: Seeks to prohibit prescribing or administering certain hormone therapies and puberty-blocking medications for certain purposes to minors. After nearly an hour of testimony from both support and opposition, committee members took a party line stance resulting in a do pass and now moves on to Senate Rules.
- **SB 91 - Senator Blake Tillery**: Seeks to prohibit the Board of Community Health from entering into, executing, or renewing a contract or contracts with any pharmacy benefits manager that owns or has an ownership interest in any retail pharmacy or any legal entity that contracts with or uses such pharmacy benefits manager. Committee members motioned for a do pass and now moves onto Senate Rules.
- **SB 95 - Senator Ben Watson**: To revise an exemption from certificate of need requirements concerning life plan communities. Senate Health and Human Services issued a hearing only for SB 95 for public comment.

House Public and Community Health Committee

- **HB 173 - Representative Darlene Taylor**: Seeks to require the Department of Education to provide to parents and guardians of students entering the sixth grade information regarding recommended adolescent vaccinations in print or electronic form. The committee added an amendment and voted for a do pass and now moves onto House Rules.
- **HB 291 - Representative Darlene Taylor**: Intends to provide for the certification of community health workers. The House Public and Community Health Committee tabled the bill.

House Health Committee

- **HB 196 - Representative Trey Kelley**: Seeks to require that drugs dispensed to a covered person for self-administration under a state health plan be reimbursed using a transparent, index based price, plus a dispensing fee; to provide for definitions. The committee favorably motioned for a do pass by substitute and now HB 196 will move to the Rules Committee.
- **HB 197 - Representative Lee Hawkins**: Intends to detail the effort that shall be made by treating health care provider to respond to a private review agent or utility review entity's attempt to reach such provider to discuss the patient's care; to provide for related matters. The committee favorably motioned for a do pass and will now be sent to the Rules Committee.
- **HB 218 - Representative Katie Dempsey**: Seeks to lower the age from 50 to 18 years old at which hospitals shall offer inpatient vaccinations for the influenza virus prior to discharge. The Health Committee favorably motioned for a do pass and is off to the Rules Committee.

Friday Weekly Updates

Be sure to mark your calendars as we will be sending out weekly legislative updates on Friday's.

To find any bill, go to **www.legis.ga.gov** and use the search box at the top left of the page. There is also an advanced search option that allows you to find bills by keyword or sponsor.

LM LAWMAKERS

For legislative highlights and review, watch **Lawmakers**, which airs on Georgia Public Broadcasting at 7PM every night the Georgia General Assembly is in session.

More information: Please reach out to our office at 770.435.5586 or reach out to us personally via our cell phones.

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Emory University School of Medicine
Department of Emergency Medicine

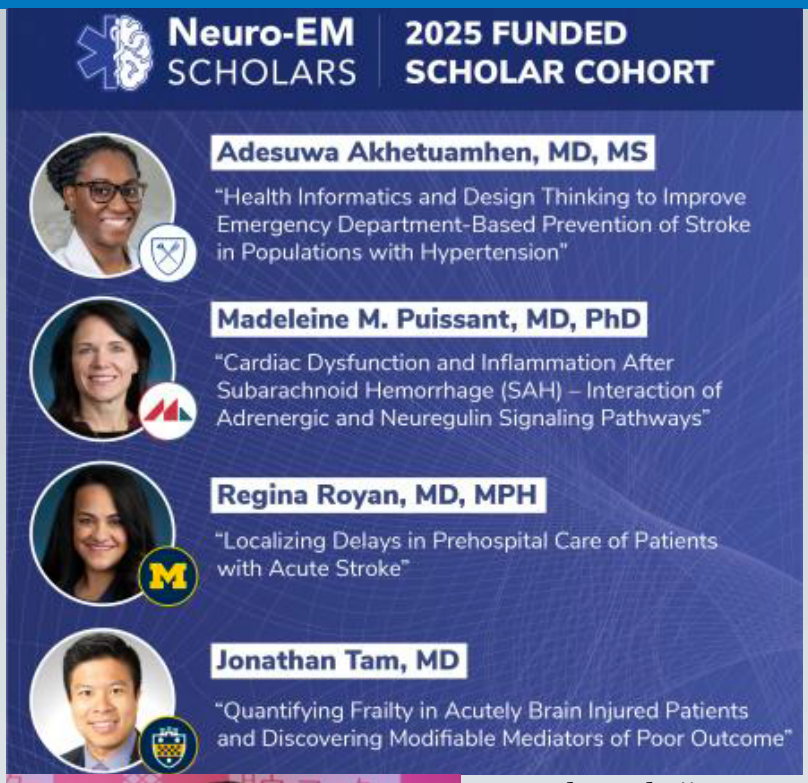
Dear GCEP,
Ahead of National Doctor's Day, celebrated on March 30, Emory EM extends our heartfelt appreciation to all the Emergency Medicine teams working through the quademic surge with flu Covid, RSV, and norovirus. The theme for this year's Doctor's Day is Wings & Stethoscopes: Healers of Hope. Thank you for all you do for your patients, colleagues, and family. To help with happiness and wellness, take a look at this **article on the science of gratitude**. It's an older article, but still very relevant today.

Residency News

- Emory EM's Dr. Antonio Jackson received the GCEP In-Training Service and Professionalism Award! The GCEP ED In-Training Professionalism and Service Award is presented to a Resident or Fellow who demonstrates outstanding patient care in a professional and compassionate manner, and who has provided significant service to the Chapter or their community.
- The Residency Program celebrated 50 years in 2024 and has planned a big 50th Celebration in Atlanta on October 3-5, 2025. If alumni would like more information, please reach out to Dr. Melissa White at **mhwhite10@gmail.com**. We are also celebrating the 25th Anniversary of the Toxicology Section.
- The residents joined Emory EM's Dr. Sar Medoff and Dr. Naomi Newton at the Capitol on January 29 for the annual Emory EM Advocacy Day. Dr. Shamie Das joined via zoom to share additional advocacy insights he's gained as a Robert Wood Johnson Foundation Health Policy Fellow in D.C. After walking three blocks to the Gold Dome, the residency group met with lobbyists and Rep. Dr. Michelle Au. Standing outside the Speaker's office, they were surprised to run into their Pediatric EM colleagues in the hallway.

Distinctions

- Dr. Nicole Franks is the Interim Medical Director of Emergency Medicine at Emory University Hospital Midtown (EUHM)
- Dr. Mike Carr is an Atlanta Business Chronicle Rural Health Care Champion of the Year. He was recently interviewed by The JEMS Report for his work in telemedicine. Telemedicine Connects Rural Paramedics to Physicians.



The Neuro-EM Scholars Program has announced that it will fund 4 scholars including Emory EM's Dr. Adesuwa Akhetuamhen starting in 2025. This is the first year for the program and scholars will receive up to 3 years of K12 funding to support their research and career development, with 75% of their effort dedicated to research and research training. Learn more about the program here: https://www.saem.org/research/national-institutes-of-health-(nih)/neuroEM-scholars-program

- Dr. Katrina Gipson was accepted into the 2025 AAMC Healthcare Executive Diversity and Inclusion Certificate Program

Dr. Yuko Nakajima was selected as one of Japan's 2025 Women of the Year! The award is supported by the Cabinet Office of the Japanese Government. Dr. Nakajima is President of Médecins Sans Frontières Japan (Doctors Without Borders). This is an award that recognizes women who have had remarkable achievements throughout the year and honors them as role models for working women. It awards women who have made groundbreaking accomplishments in their respective fields, while maintaining their own unique way of working and staying true to their mission.

- Dr. Marta Rowh received an SAEM Foundation education research grant

Emory EM News

Emory University's Center for Advanced Emergency Care (CAEC) hosted its inaugural conference, Frontiers in Advanced Emergency Care, on September 12-13, 2024 in Atlanta. **Click here** to read a summary of the conference.

The next **Frontiers in Advanced Emergency Care Conference** will be held on **October 3, 2025**. The conference will coincide with the 50th Anniversary Celebration of the Department of Emergency Medicine's Residency Program and the 25th Anniversary of Emory EM's Toxicology Section.

- Dr. Andy Pendley is needing help with a new study group regarding the importance of physical activity. If you are a parent with a student in grades 3-5 between the ages of 7-11, please consider joining the study group regarding the importance of physical activity. **You can learn more here**.

Publications

Kuai D, Rivera Blanco LE, Krotulski A, et al. **Identification and Health Risks of an Emerging Means of Drug Use in Correctional Facilities**. JAMA Netw Open. 2024;7(12):e2451951. doi:10.1001/jamanetworkopen.2024.51951

Ghimire, R., Sharma, R., Bajracharya, S. R., Yadav, M., Kazzi, Z., Acharya, B., ... Kharel, R. (2025). Challenges, progress, and opportunities in clinical toxicology in Nepal: a narrative review. Toxicology Communications, 9(1). **https://doi.org/10.1080/24734306.2025.2452670**

Kakutia N, Caudle WM, Kazzi ZN, Sturua L, Davit Zarnadze S, Mebonia N.BMC Nutr. 2025 Jan 13;11(1):9. doi: 10.1186/s40795-024-00974-3.PMID: 39806469. **Prevalence and Predictors of Overweight and Obesity Among School-Aged Children in the Country of Georgia: A Cross-Sectional Study, 2022**.

Georgia Public Broadcasting Interview with Dr. Ziad Kazzi: Months after BioLab Fire in Conyers, residents still face health issues

Managing Opioid Use Disorder in the ED

Tori Ehrhardt, MD; Emily Kiernan, DO

Introduction

Provisional data released this year by the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics showed a decline in the number of opioid overdose deaths from 2023 to 2024. However, opioid overdose remains a leading cause of death in the United States. Barriers to accessing primary care services results in individuals with opioid use disorder (OUD) seeking care in the Emergency Department (ED). Patients can present in a variety of ways: opioid overdose, opioid use-related complications (e.g., withdrawal, trauma, infection), or an unrelated medical or psychiatric complaint. In any of these situations, it is best practice to determine the nature of the patient's opioid use and, when indicated, provide treatment options from the ED.

General Management & Adjunct Medications

As clinicians in the ED, it is important to rule out any immediate life-threatening condition. Patients who arrive after an acute opioid overdose should be given naloxone, a mu-opioid receptor antagonist, if there is evidence of respiratory depression. This should be followed by continued supportive care and monitoring before considering long-term management options.

Patients in opioid withdrawal require a different approach. As mentioned above, patients who have received naloxone may subsequently enter acute withdrawal in the ED, or patients may present in various stages of withdrawal hours to days after last opioid use. For all patients in physical distress from withdrawal symptoms, there are many adjunct medications which can be used for symptom management (Table 1).

There are also medications specifically designed for long-term management of OUD. These include methadone, buprenorphine, and naltrexone. These are all in emergency practitioner's arsenal of medications to initiate in the ED for patients in whom the DSM V criteria for OUD are met. These criteria encompass several major domains: impaired control of substance use, physical dependence, social or inter-personal impairment, and high-risk use. There are circumstances in which a patient may not meet the criteria for OUD (e.g., long term pain management without disordered use) and medications for opioid use disorder (MOUD) are not indicated. Patients who do meet these criteria should still have their opioid use addressed and naloxone should be provided at discharge.

As with many chronic conditions, a major factor in ED management of OUD is access to outpatient management. There is significant variability of resources available through specific healthcare systems and the surrounding community. Some patients will have access to a robust bridge program providing outpatient counseling and access to medication, while others will have limited options. It is important to know what local resources are available and where patients can be referred to after acute management in the ED.

Medications for Opioid Use Disorder: Public Policy

As noted above, there are several options for MOUD. Naltrexone, a mu-opioid receptor antagonist, **can be prescribed by any practitioner licensed to prescribe medications**. Buprenorphine, a partial agonist at mu-opioid receptors, can be prescribed by all practitioners with a DEA license that allows prescribing of Schedule III medications. This has been the case since the **Consolidated Appropriations Act of 2023** was passed in December 2022. This **eliminated the requirement for practitioners to apply for a DATA-waiver**, also known as the X-waiver, to be eligible to prescribe these medications. **Regarding methadone prescribing from the ED, legislation allows** for the "dispensation of narcotic drugs for the purpose of relieving acute withdrawal symptoms from OUD." Referred to as the "Three-Day" Rule, this states "practitioners, in accordance with applicable State, Federal, or local laws relating to controlled substances, are allowed to dispense not more than a three-day supply of narcotic drugs to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both)". Unless otherwise restricted by local laws, this bypasses the limitation that methadone can only be prescribed by an Opioid Treatment Program (OTP) or those with specific allowances from the Drug Enforcement Agency (DEA). It effectively allows ED clinicians to prescribe methadone to serve as a bridge to treatment or access to alternate follow-up which has been **shown to improve patient follow-up**.

While clinicians should feel empowered to use these medications to help their patients manage OUD, they should also remain mindful of some important pitfalls when prescribing MOUD from the ED.

Medications for Opioid Use Disorder: Clinical Practice

When choosing what works best for a patient, a clinician should first consider the duration of time that has elapsed since the patient's last opioid use and what options are available for outpatient follow-up. Both factors are important in determining the safest and most effective MOUD for an individual patient.

Naltrexone's mechanism of action presents the challenging requirement of a substantial gap between the patient's last opioid use and initiation of this medication. This interval is **recommended to be at least 7-10 days**, but patients previously taking long-acting opioids such as methadone may require up to 14 days to avoid precipitated withdrawal. This makes naltrexone a difficult medication to initiate in the ED and is often a suboptimal choice for MOUD in the ED.

Buprenorphine requires a shorter duration since a patient's last use, but the interval can vary from hours to days depending on the substance and frequency of use. Various dosing strategies are available and the decision to start a patient on buprenorphine requires a shared decision-making discussion to determine the optimal dosing strategy and time of initiation. Of note, long-acting formulations of buprenorphine are available, and dosing strategies for this medication typically employ a shorter-acting oral "test dose" before the injection is administered to avoid prolonged precipitated withdrawal.

Short courses of methadone can be given in the ED, as described above, either as an initial dose or a continuation of treatment. Prescribers should remain mindful of local regulations and specific patient characteristics that may affect dosing strategy such as patient age, pregnancy, and continued concurrent use of opioids.
Another factor to consider is whether the MOUD initiated in the ED can be continued on an outpatient basis. This is especially important for medications with a shorter duration of action. Ultimately, knowing the options for outpatient follow-up after discharge will help inform MOUD selection to ensure a patient has continued access to care.

Avoiding precipitated withdrawal

Once an appropriate medication is selected, there are nuances to consider when initiating MOUD. A major reason for uncertainty regarding initiation of buprenorphine is the fear of precipitating withdrawal. This can be an agonizing experience for the patient and may affect their medication adherence or receptiveness to re-starting the medication in the future. For this reason, it is important to establish the severity of a patient's current withdrawal before giving them a medication that could abruptly precipitate withdrawal. A useful tool to determine a patients withdrawal severity is the Clinical Opioid Withdrawal Scale (COWS). This allows a practitioner to categorize the severity of a patient's withdrawal as mild, moderate, or severe. The COWS score can help guide management but should be considered alongside the patient's last reported opioid use and any personal experience with precipitated withdrawal.

Georgia OUD Resources

Clinicians in Georgia who have questions regarding the initiation of MOUD for a patient in the ED or who would like assistance in managing precipitated withdrawal can call the Georgia Poison Center for an addiction medicine consult 24/7/365. Select rural hospitals are also enrolled in the Emory Rural Expanded Access to OUD Care & Linkage Using Toxicologists for Telehealth Initiated TreatMEnt (REAL TTIME) program. This program works with the Georgia Poison Center to connect clinicians directly to Emergency Medicine trained, board-certified Addiction Medicine specialists, and the Georgia Council for Recovery to provide linkage to a virtual peer recovery coach from a local Recovery Community Organization while in the ED. The patient is then linked into established outpatient resources for continuity of care. As this telehealth network expands to the entire state of Georgia, it will provide a structure for efficient evidence-based management of OUD in the ED, expedited referral to local outpatient resources, improved patient outcomes, and a reduction in ED visits for patients with OUD.

Conclusion

Opioid use disorder affects patients in all of our families and communities. Though ED management can be challenging, using the above guidance while maintaining an empathetic and non-judgmental tone can significantly improve patient, community, and hospital-based outcomes and ultimately restore a person's ability to achieve a healthier life.

Table 1. **Medical Management of Opioid Withdrawal Symptoms** in Adult Patients

Symptom	Medication	Dose
Irritability and anxiety	Clonidine	0.1 mg q4h
Anxiety	Hydroxyzine	50 mg q6h
Insomnia	Diazepam	10 mg PO once
Nausea/Vomiting	Ondansetron	4 mg q6h
Pain/myalgias	Acetaminophen	1000 mg q8h
Abdominal cramping	Dicyclomine	10 mg q6h

Table 2. FDA- Approved Medications for Opioid Use Disorder

	Route of Administration	Duration of Action	Typical Maintenance Dose*
Buprenorphine Formulations – partial agonism at opioid receptor			
Buprenorphine-Naloxone	PO tabs or films	Hours up to one day	8-2 mg twice a day
Buprenorphine	PO tabs	Hours of to one day	8 mg twice a day
Buprenorphine extended-release**	Subcutaneous injection	Days up to one week	32 mg, 300 mg
Methadone Formations- full agonism at opioid receptor			
Methadone hydrochloride	PO concentrate or tabs for oral suspension	One day	10 to 30 mg
Naltrexone Formations- full antagonism at opioid receptor			
Naltrexone extended-release	Intramuscular injection	One month	380 mg

*General guidelines for chronic therapy as provided in **SAMHSA Treatment Improvement Protocol for MOUD**; refer to full document for further considerations to determine therapy for an individual patient

**Weekly and monthly formulations of extended-release buprenorphine are available

Managing Acute Sickle Cell Pain in the PCP Office

Beatrice Gee, MD (beatrice.gee@choa.org)

February 2025

Case: The nurse receives a phone call from the parent of a 9-yr old child with Hemoglobin SS who is having a pain crisis. They are out of pain medications and request a refill. What should you do?

INTRODUCTION

Sickle cell anemia, or homozygous Hemoglobin (Hb) SS, is a blood disorder in which a person has inherited two beta globin mutations (Hb S) which cause hemoglobin polymerization when exposed to low oxygen, acidosis, dehydration. Other forms of **sickle cell disease (SCD)** result from inheriting a combination of Hb S with another beta globin mutation, such as **Hb S-beta thalassemia and Hb SC**.

Acute pain episodes (commonly called "crises") are the most common SCD complication. Pain occurs when tissues and organs have reduced blood flow and oxygenation, due to the occlusion of blood vessels by sickled red blood cells (RBCs), often in the setting of conditions that cause inflammation, such as acute infection.

Sickle cell pain can be very intense and should be treated aggressively to relieve distress and improve physical functioning. Ineffectively treated pain can cause physical, mental health, and social dysfunction, and reduced quality of life, including reduced school and work engagement.

TRIAGE

- First, it is important to **review the patient's medical history, current medications and pain treatment plan**.

- SEND PATIENTS DIRECTLY TO THE ED ASAP FOR THESE SYMPTOMS OF POTENTIALLY SERIOUS PROBLEMS!

Pain may be associated with life-threatening SCD complications, such as bacterial infection, acute chest syndrome, splenic sequestration and/or stroke. These possibilities should be kept in mind when managing SCD pain in the PCP office.

- **Fever:** All children and adolescents with SCD have reduced splenic function (aka functional asplenia), which increases the risk of bacterial infection. Patients with fever should not be treated with anti-pyrectics at home but go directly to the ED for evaluation with blood cultures and empiric antibiotic treatment.
    - **Relevant PMH**: The risk of sepsis is even higher in infants, if there is a history of splenectomy, past bacterial infection, under-immunization, non-adherence with prophylactic antibiotics, or a central venous catheter is in place.

- **Risk of lung problems: Acute chest syndrome (ACS)** is the presence of a new infiltrate on chest Xray, and can be accompanied by **fever, cough, shortness of breath, or pain in the chest, abdominal or back**. Patients with several days of **URI symptoms** may develop pulmonary infiltrates. Lung disease can cause hypoxia, which leads to increased sickle RBC formation, vaso-occlusion, and can cause rapid progression of ACS. Patients with these symptoms should go directly to the ED and be evaluated and treated for infection, hypoxia and may need blood transfusion.
    - **Relevant PMH:** Patients who have **past episodes of ACS**, particularly severe cases needing positive pressure ventilation, RBC transfusion or ICU care, are at risk for developing recurrent ACS.

- **Severe anemia or enlarged spleen**: chronic hemolytic anemia is common in SCD but can be worsened during acute illness. Splenic sequestration is the swelling of the spleen associated with a significant drop in hemoglobin concentration, which can be triggered by infection or inflammation. Acute splenic enlargement may cause **left upper quadrant pain** or tenderness. Some viruses can reduce bone marrow red cell production. Parvovirus B19 incidence has been higher in 2024 than in past years. Any cause of anemia can lead to **pallor, fatigue or lethargy, or poor feeding in infants**.
    - **Relevant PMH:** When determining the severity of a patient's anemia, it is necessary to know their baseline hemoglobin concentration. Patients who have had past splenic sequestration have about 50% chance of having recurrent episodes.

- **Stroke symptoms**: About 10% of children with sickle cell anemia may develop stroke in childhood due to reduced cerebral artery circulation. Strokes in SCD can present with typical symptoms of **weakness of one side of the face or body, difficulty speaking or vision changes**. Older children and adolescents may also develop cerebral hemorrhage, which can present as the **worse headache they have ever had**. Pain can reduce mobility, but **patients with weakness and/or severe headache should always be evaluated for possible stroke**.
    - **Relevant PMH:** patient with a history of past stroke or cerebrovascular disease are at risk of future new stroke.

HOME PAIN TREATMENT: If the patient has none of the worrisome symptoms listed above and their pain is not severe, home treatment can be tried.

- **Evaluation**: what are the locations of the pain? Are these areas where they have had pain before? Was there any recent trauma? How severe is the pain? How much is the child's function affected?
    - **Significant trauma warrants ED evaluation for fractures**. Pain in typical locations without trauma does not routinely require Xray evaluation.

- **Medications**: Are there any pain medication allergies? What does the child usually take at home for pain and is there a personalized Pain Plan? How often have they taken pain medications, when were the most recent doses, and has it helped at all? Are the doses appropriate for the current weight and are they taken at the correct interval?

    - Follow the patient's Pain Plan, if one is available for review.
    - Adjust dosing and frequency of medications as needed, such as avoiding excess acetaminophen or NSAIDs, and properly dose opioids for current weight.
    - For patients who have never had a home opioid prescription, hydrocodone/acetaminophen (0.1 mg/kg opioid) every 4-6 hours PRN is the recommended "entry level" medication due to lower potency than oxycodone or hydromorphone.
        - **Codeine is not recommended** due to metabolic variants which can result in very high levels of active drug.
        - **Tramadol is not recommended in children under 12 years old**, has low potency relative to hydrocodone, and also has been associated with respiratory depression after T&A or in children with obstructive sleep apnea
    - Refill pain medications as needed. Patients who don't have frequent or chronic pain may receive up to 20 doses of opioid medication.

- Treat pain according to the World Health Organization **Pain Ladder**:
    - **Mild intensity pain** should be treated with non-opioids (acetaminophen or NSAIDs) and non-pharmaceutical treatments, such as warm packs, baths, or topical anesthetics (such as lidocaine). Fluid intake should be encouraged.
    - **Moderately intense pain**: oral opioids can be added, based on what the child has at home and/or tolerated before. A laxative should be added if opioid treatment is needed for more than a day,
    - **Severe pain**: pain not relieved with home pain medications may need treatment with IV fluids and pain medications in the ED.
    - **Prolonged pain**: not improving after 4-5 days at home may also need ED treatment.

FOLLOW-UP: Infrequent pain (less than once a quarter) does not need additional hematology follow-up beyond regular clinic appointments. Patients with increased pain frequency or severity should be seen by their SCD Team within 1 month for evaluation and possible adjustment of their pain treatment plans.
If home medications are not effective, but the patient doesn't have symptoms warranting ED treatment, or if you have any other questions, please consult with the patient's hematologist or SCD team (Arthur M. Blank 404-785-1200, Hughes Spalding 404-785-9800).

Below is the link to the Children's Emergency Medicine Community Outreach January 2025 Webinar: Meet the Children's Emergency Department/Urgent Care Directors and Learn About Our New Arthur M. Blank Hospital. Access helpful information on service lines and to facilitate the smooth transfer of patients to Children's Urgent Care and ED departments.

View the recording here: Webex Recording Link. The password for this recording is *hF9P5Wa4*.

2025 Winter MCG Update

The Department of Emergency Medicine is undergoing several changes with the turn of the New Year. Dr. Richard Schwartz is stepping down with over 25 years of service here at MCG, 20 years of which has been as chair. We will miss his leadership, though congratulate him on a well-deserved retirement. Dr. Dan Kaminstein who serves as the Assistant Dean for Ultrasound Education at the medical school will be taking on the role of Vice Chair of Education. He comes with many years of experience both with educational and administrative experience at our medical school. We look forward to his leadership in the coming years.

As we close out our recruitment season, we learned that our regional neighbor Piedmont Macon has sadly lost its accreditation, and we offer our sympathies to their residents. We are offering up one PGY2 and one PGY3 residency position to help alleviate the stressors of them finding a new home.

We look forward to sending competitive teams this spring to SAEM to participate in Sonogames and MedWAR. We have historically performed very well in each event and are excited to see what accolades our residents will bring back home with them.

Dr. Nick Musisca will be cohosting a New Chief Resident Seminar at Coastal Emergency Medicine with Dr. Nikki Binz, Program Director at UNC. It will be held on Friday June 6th for one day. We anticipate a $50 registration charge per registrant. We hope you consider sending your incoming chiefs to participation. Registration is here.

We hope to see you to see you at the GCEP Rural Emergency Medicine and Critical Care Practice course which we will be hosting in Augusta February 22nd – 23rd.

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Wellstar/Medical College of Georgia
Augusta University

Pediatric Emergency Medicine at the Medical College of Georgia Update

Greetings from Augusta, city of blue roof tarps and downed trees. Yes, we are still reeling from the effects of Hurricane Helene in many of our lives. We learned that we all need generators, cell phones are not the answer to connection and people still get sick during disasters. Now that we are almost four months post the disaster, we can say that travel to and from our homes are easier and more predictable. Now we face the onslaught of influenzae.

We welcomed our new fellows in July of 2024. Meredyth Shaffer, DO, our first EM trained resident since 2014, completed her residency at Prisma Health in Columbia, SC. Sarah Hendrix completed her pediatric residency at SUNY Upstate Medical University.

Dr. Shaffer's academic interests include curriculum development for the use of Nitrous Oxide in the pediatric ED population and quality improvement. She will complete her fellowship in two years as opposed to three for our pediatric graduates

Dr. Hendrix will be pursuing our internal Pediatric Emergency Medicine US Fellowship and her research focus is time to US diagnosis of Pyloric Stenosis. She is additionally an impassioned social media proponent. Check out our CHOG ED posts @pemaugusta on Instagram.

Meredyth Shaffer, DO

Sarah Hendrix, MD

Match was a flurry as usual. We enjoyed meeting many qualified candidates. We will welcome our first EM home graduate, Nicole Fuller, MD to our program in July of 2025.

Fellows and Faculty Accomplishments:
Recent Publications:

1. Optimizing Triage: Assessing Shock Index, Pediatric Age-Adjusted as an Adjunct to Improve Emergency Severity Index Mistriage, 2025 Jan 1;41(1):11-16. doi: 10.1097/PEC.0000000000003171. **Eilan Levkowitz , MD (2024 grad), Desiree Seeyave, MD (Faculty)**
2. Acute opioid overdose in pediatric patients, Stephen Sandelich, **George Hsu (faculty)** et al. J Am Coll Emerg Physicians Open, 2024 Mar 7;5(2):e13134. doi: 10.1002/emp2.13134.

Recent Presentations:

AAP National Conference and Exhibition, Orlando September 2024

1. Natalie Lane, MD : Comparison of two pediatric (over)crowding scores in a pediatric emergency department, **Natalie E. Lane, MD**, Will Cagle, MD*, **Eilan Levkowitz, DO**, Thad Wilkins, MD, MBA, poster
2. Gary Prusky, MD (3rd year fellow): A Rapid Progression of Amebic Meningoencephalitis, poster and Does BMI Play a Role in Diagnosing Tubo-Ovarian Abscess posters

American College of Emergency Physicians, Scientific Assembly , Denver October 2024

Oral Presentations

1.Gary Prusky, MD (3rd year fellow): Does BMI Play a Role in Diagnosing Tubo-Ovarian Abscess?

Poster Presentations

1.Natasha Bennett, DO (3rd year fellow) : Social Determinants of Health within Pediatric Trauma: Is There a Trend Using Geospatial Technology

Southern Regional Meeting , New Orleans February 2025

Poster Presentation

1.Gary Prusky, MD (3rd year fellow) and Desiree Seeyave, MD (faculty): From a scary imaging scan to a not-so-scary diagnosis

2.Kevin Allen, MD (faculty). Orbital Myositis and Crohn's Disease

Other Academic Pursuits

1.Megan Musisca, MD (faculty): Access Bridge Fellowship (supported through ACEP) i a 10-month long fellowship designed to promote change in the ED around access to reproductive services/contraception and early pregnancy care.

Over the years, as program director I have continued to encourage involvement with education and engagement in the Emergency Medical Services for Children program and prehospital providers.

Recently several fellows: Natasha Bennet (3rd year), Joe Holjencin, (2nd year) and Gary Prusky (3rd year) participated in two training days for our neighboring community medics. We presented a great way of engaging in simulation using the ACEP Simbox product **https://www.emergencysimbox.com/emstelesimbox**.

The state of Georgia, through Emergency Medical Services for Children and the Office of EMS and Trauma in the department of health are facilitating volunteer pediatric facility designation. This is part of the national pediatric readiness initiative that tries to assure that children receive excellent pediatric care in the emergency setting. The first three hospitals have been designated as Pediatric Readiness Centers Level II and III in the Northeast Georgia Health System at hospitals in Barrow, Braselton and Gainesville as of the end of January 2025. For any emergency department wishing to pursue designation for their institution please contact the program manager Samantha Sindelar at **Samantha.sindelar@dph.gov**. You can visit the following website to learn more about the program and process **https://dph.georgia.gov/EMS/emergency-medical-services-children-emsc**

Finally, 2024 and the beginning of 2025 have reminded us of the vulnerability we all have for being a provider and or a victim in a disaster. The National Pediatric Pandemic Network has launched a Pediatric Response Disaster Collaborative where children's hospitals can work within and around the nation in improving certain areas of disaster readiness in our organizations. CHOA, Hugh Spalding and The Beverly Knight Olson Children's Hospital in Macon have registered teams. Children's Hospital of Georgia will join the collaborative with a focus on evacuation. You can find information on this program and opportunities in research at this site **https://pedspandemicnetwork.org/**.

Our program is not always all work, we do have fun. Check out some fun times! We do have an open position for a PGY4 in PEM Fellowship 2025 if interested. Please visit our website for more information regarding our program or contact me directly. **https://www.augusta.edu/mcg/em/ed/fellowships/pediatric/index.php**

Birthdays! Sonogames! July Orientation!

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Fellowship Director PEM
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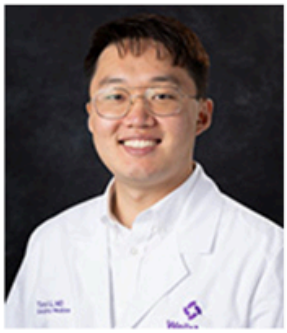
Wellstar Kennestone Emergency Medicine Update

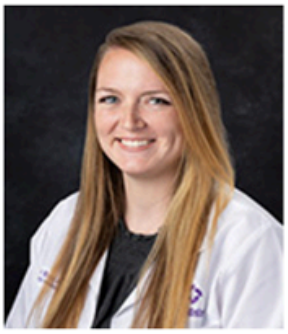
Like many of you, we have been experiencing record volume and acuity over the last few weeks at Kennestone. Our residents, APPs, and faculty continue to perform at an extraordinarily high-level in caring for this extremely complex population. Despite extremely difficult conditions, including unprecedented admission holds, departmental morale remains high, and our residents continue to impress with their knowledge, commitment, and performance.

A few updates from some of our sections:

Graduate success…
Our residents continue to do incredibly well with their job and fellowship matching. In addition to our strong track record of EMS and Administrative fellowship matches, we have our first two graduates joining Sports Medicine and Critical Care programs.



Tom Li, MD
Wellstar/Apollo Administrative



Charity Bray, MD
Vanderbilt EMS

Reymaulde Danger, DO
Medical College of GA Critical Care Medicine

Alex Cantral, MD
University of Tennessee Knoxville Sports Medicine

Their classmates have secured jobs around the country, and I am proud of their success in landing the positions they want.

- Alaa Alghalayini, DO - Wellstar Cobb/Douglas/Paulding
- Aaron Bowersox, DO - Wellstar West Georgia
- Rebecca Beaudry, DO - Piedmont Medical Center, Rock Hill, SC
- Omar Lopez, MD - Piedmont Medical Center, Rock Hill, SC
- Josh Sylvan, MD - University Hospitals, Cleveland, OH
- Jay Tyson, DO - Piedmont Walton, Monroe GA
- Jacob Rosenfield, MD - Fort Sanders Regional Medical Center, Knoxville, TN
- Humberto Salazar, MD - Ascension Seton Hays, Kyle, TX
- Yashaswani Moparthi, DO - UVA Prince William, Manassas, VA
- Logan Martin, MD - (pending contract)

…and EM2 leadership
Please join me in congratulating two of our second-year residents on their election to leadership positions. Sydney James, MD was selected by her peers as the Wellstar Residency Council Vice-President, and Jamil Wiliams, MD has been appointed as a resident member of the GCEP Board of Directors. Well done all!

Administrative fellowship:
Under Dr. Dany Accillien's leadership, ApolloMD's Emergency Medicine Administrative Fellowship continues its partnership with Wellstar as two more physicians will be joining the fellowship.

Dr. Amna Jamshad was raised from in Marietta, GA and is completing her residency at St. Barnabas Hospital in the Bronx. She's plans on receiving her MBA with the Emory University's Goizueta Business school and hopes to increase access to care across the metro Atlanta area and give back to the local community.

Dr. Tianyi Li obtained his undergraduate degree from Vassar College and attended the Medical College of Georgia for his M.D.. He is completing his Emergency Medicine residency at Wellstar Kennestone Hospital. He will be pursuing a Master of Business Administration from Emory University's Goizueta School of Business. He is looking to explore his interests in ED operations, contract management, and entrepreneurship.

Medical Student Education:
It was another record-breaking year for our student rotation. With 121 applications from well over 60 medical schools around the country, we were able to provide 41 students with sub-internship opportunities. This was by far the strongest group of visiting auditions students we have seen, and we are excited about the prospect of many of them joining us next year as interns. In addition, we had three students join us in only our second year hosting an EMS rotation.

Division of EMS:
Dr. Infanzon continues to grow our EMS educational program. In addition to presenting a poster at NAEMSP in San Diego on his research in online medical direction in academic and community ED settings he has overseen numerous important changes and developments. He is involving our residents in numerous innovative program that provide valuable services to the community. Paige Yeager, DO assisted in the development of a novel prehospital antibiotic protocol for open fracture, while fellowship-bound PGY-3 Dr. Bray participated in education and training for prehospital blood administration with Cobb County Fire. Finally, several of our residents are participating in a new EMS Special Operations elective to learn more about tactical medicine, disaster medicine, and technical rescue.

Division of Toxicology:
As with the emergency department in general, they toxicology services volume continues to grow at extraordinary rate. Dr. Kleiman and Dr. Punja continue to provide invaluable consultation services at Kennestone, working closely with the Poison Center to enhance direct patient care. They are also collaborating with a multidisciplinary group to initiate Narcan availability directly from the ER, which will be launching soon, as well as creating a substance use disorder ED and outpatient pathway for a critical and vulnerable population.

Ok, time for me to unwind from our rank list meeting and have some dinner. I look forward to introducing you to our newest residents in our next update. Until then, be safe!

Ted Stettner, PD
Emergency Medicine Program Director
Kennestone Regional Medical Center
Associate Professor, Augusta University

Northeast Georgia Health System Update

Residency and Education Updates

It's a super busy time of year for the NGMC residency. We are preparing to transition into a brand new emergency department in a few days, and we're all super excited and nervous and anticipating all the unanticipated changes that are on the way!

"We're also excited to announce that we are about to graduate our first class of residents! Out of our first class of twelve residents, we have four residents who have matched into fellowships — critical care at Stanford, EMS at Utah, PEM at Wake Forest, and Disaster at San Antonio. We also have two residents who will be fulfilling military obligations, and the rest will be taking community jobs in Georgia, and surrounding states.

"Interview season has gone well. We continue to get a large pool of applicants including from around the state. We're in the process of conducting all of our second look visits, but we anticipate a strong match season. We remain committed to producing doctors who will stay in the state after graduation, and in future years, we strongly encourage state students to apply.

"Finally, in our continued effort to highlight the scholarship coming out of NGMC, I'd like to congratulate senior resident Ziad Faramand for his publication on machine learning in ECGs in the European Heart Journal (**https://academic.oup.com/eurheartj/advance-article-abstract/doi/10.1093/eurheartj/ehae880/7953183?redirectedFrom=fulltext**

Administrative Division Updates

GEDS is leading focused sessions for PGY 2's and 3's on the business of Emergency Medicine and system approaches to care and quality. As the largest independent democratic group in the state, GEDS wants the NGMC EM residents to have the skills when they graduate to continue growing independent democratic groups in GA and beyond. GEDS has partnered with our GME team to create a business of EM curriculum to teach our graduates a working knowledge of business concepts in medicine to allow them to graduate with the skills to communicate, negotiate and navigate the healthcare system.

Pediatric Medicine

NGMC Emergency Departments First in State to Earn Pediatric Readiness Designation
Dr. Hersh Mathus, Medical Director, Pediatric Emergency Medicine

Three NGMC emergency departments are now the first in the state to be accredited as Pediatric Readiness Centers (PRC) by the Georgia Department of Public Health.
Georgia's Pediatric Readiness Centers program ensures hospitals meet rigorous standards for pediatric-specific training, equipment and resources, helping to improve outcomes for young patients in emergency situations.
NGMC Barrow and NGMC Braselton are designated as Level III centers, which the state defines as being "capable of the initial evaluation and stabilization of a critically ill child and can provide appropriate, timely transfer to a higher level of care if needed."
NGMC Barrow recently unveiled its newly renovated emergency department waiting area.
The ED waiting area now has more seats, improved triage areas and enhanced security all designed to minimize wait times.
NGMC Gainesville is designated as a Level II center, which includes the same capabilities as Level III but adds access to the hospital's onsite inpatient pediatric unit.

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Jason Konzelmann, MD, FACEP
Observation Units Medical Director
Director of Administrative Division, Northeast Georgia EM Residency
Clinical Asst Professor, Dept of Emergency Medicine, MCG-Augusta
Georgia Emergency Department Services (GEDS)

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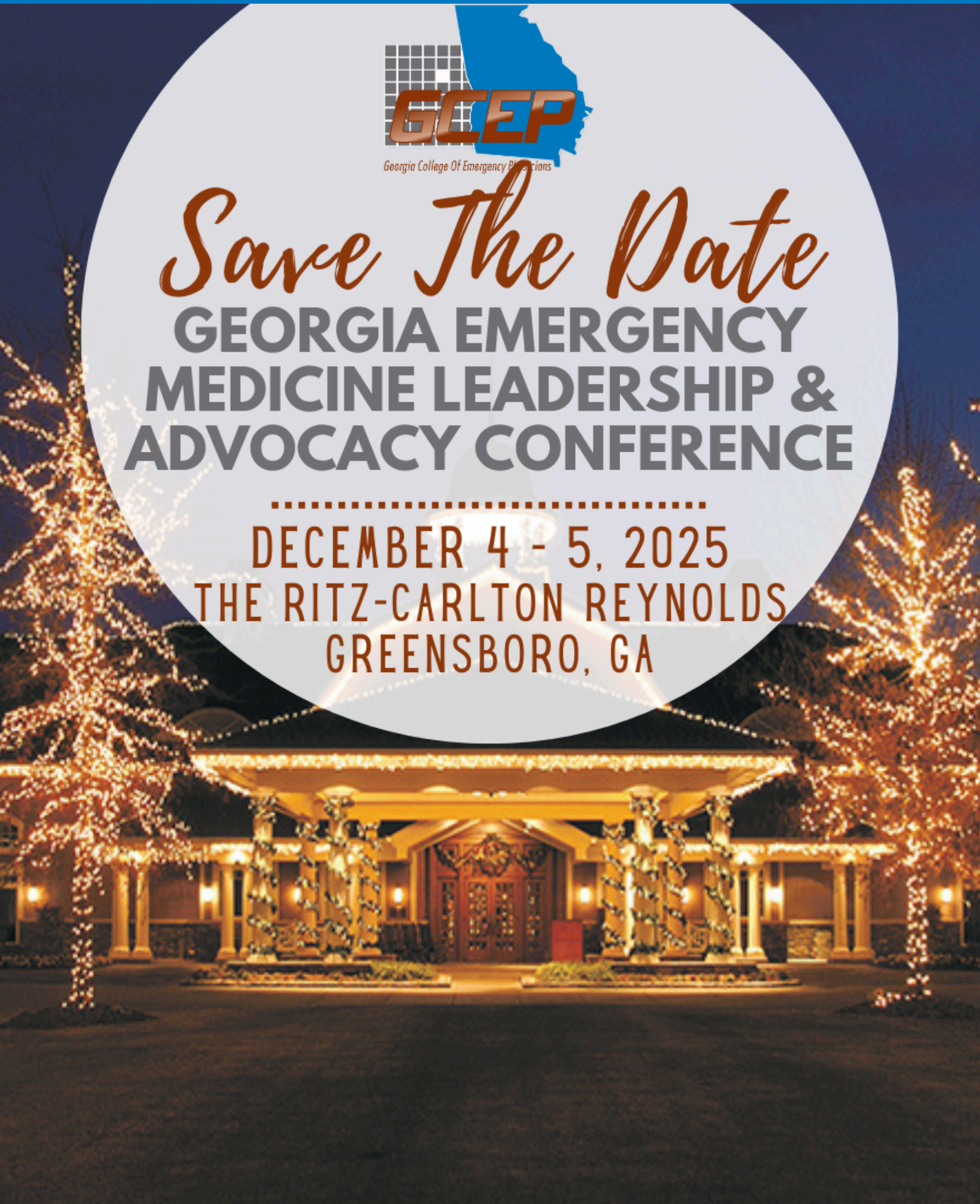
If you are interested, please click HERE and fill out the form

(takes less than 30 seconds)


Register Now!
CEMC
Coastal Emergency Medicine Conference
Jointly hosted by
GCEP, NCCEP, and SCCEP
Thursday, June 5 -
Saturday, June 7, 2025
Kiawah Island, SC
Register HERE!



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