A Newsletter for the Members of the Iowa Chapter - Winter 2022
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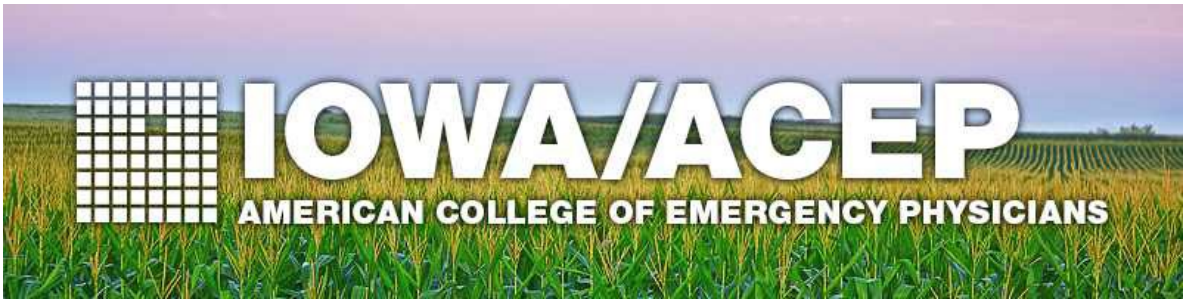

In this Edition

President's Message

Iowa ACEP Members,

I have had quite a few interesting cases over the past six months that perhaps other's can learn from, just as I have. They ALL started with very common complaints that we literally see every single day in the ED - sore throat, headache, fever, etc. I will start in order ascending age (yes, these are all my personal patients).

Case 1: A 3-year-old female presents your ED for the second time in 3 days for sore throat and neck pain. She appears overall not toxic, well nourished. Vitals are remarkable for a temperature of 101. On the first ED visit her exam was documented with the following pertinent findings: normal pharynx, no lesions, uvula midline, shotty cervical lymphadenopathy, normal TM's bilaterally, and normal remainder of exam. Discussion on viral URI given and discharged home. No labs or imaging obtained at initial visit. Represented 3-days later with continued sore throat, decreased oral intake, and continued fever. Mild tachycardia with HR of 150 and temperature of again 101. No respiratory distress, no stridor. Exam remarkable for right cervical "fullness" that was markedly NOT fluctuant and not erythematous but was tender to palpation and the child would not rotate neck. TMs again normal. No rashes. Given degree of immobility and palpable abnormality that did not appear to be a lymph node, CT soft tissue neck with IV contrast obtained. Labs showed a leukocytosis to 22k with left shift. Otherwise, benign labs. CT read provided the diagnosis - Bezold abscess! This was a new one for me. A Bezold abscess is a complication of chronic otitis media that erodes the mastoid and into the lateral mastoid and then into the SCM. It did not feel like a lymph node because it wasn't. It wasn't mobile. It wasn't fluctuant because it was within the belly of the SCM. There were no overlying skin changes. Her neck was immobile because the issue was within the SCM itself. Needless to say I discussed with ENT, who wanted me to drain it. I politely declined and transferred for Peds ENT who drained the abscess in

the OR. She did well with IV abx, then oral, and was discharged in excellent condition.

Case 2: A 14-year-old male (210 lbs., 5'10") presents to your ED, PCP, and UC a total of 7-times in a span of 9 days for headache and fever. He has never been to your ED (or any you can see within the system) before this string of visits. Does follow with his PCP annually and is UTD on vaccinations. On the 5th visit to our ED, I saw the patient. He was clearly ill appearing, febrile, confused, unable to follow simple commands. BP normal, HR 110, no hypoxia or respiratory distress. This is prime COVID-19 time and he had been tested for covid19 4 times in the past 9-days, all negative. The first two visits no labs or imaging were done other than COVID-19 testing. He was documented to have a fever at each of these visits over the 9-days. He was also documented to be neuro intact and well appearing at these visits. On the third visit labs and LP were obtained for continued fever and headache. LP was unremarkable and CSF film array negative. Labs were remarkable for WBC of 12k with left shift, otherwise reassuring. On the fourth visit labs were again obtained and expanded and now he has a WBC of 26k with shift as well as markedly elevated ESR and CRP. Metabolic panel continued to be reassuring. Discussed with pediatrics at that visit and he was ultimately discharged home. The next day on my exam, he was confused and not following commands but moving all extremities and strong throughout. He continued to be febrile. He had a heart murmur, which was not documented in any prior records and mother did not know he had previously. Work up expanded again. Explanation here could be rather long, so to keep it short, he was ultimately diagnosed with bacterial sinusitis with septic emboli to heart, lungs, and brain with multiple brain empyemas. A healthy, strong, not immunocompromised 14-year-old with a very unfortunate diagnosis and outcome. He was intubated for a prolonged period, taken to the OR many, many times for washouts and bilateral craniotomies, and was eventually transferred to long-term care and rehab.

Case 3: A 57-year-old male with hx of alcohol abuse presents to your ED for the second time in 3-days for evaluation of sore throat. On the first visit he was tachycardic to 130's, afebrile, reported to be neuro intact and with supple neck and normal pharyngeal exam. He was diagnosed with covid19 and discharged home without any further testing. HR was attributed to alcohol abuse and anxiety. He was noted to be extremely anxious by nursing staff as well as provider. On the second visit he endorsed continued sore throat and now difficulty breathing. His vital signs were remarkable for a HR of 130, as well as a fever to 102. BP reassuring. No hypoxia. RR approximately 30. He was extremely anxious, and the RN initially informed me that she was having a very hard time "talking him down" due to his anxiety. On immediate arrival to the room, I notice a toxic patient with impending airway disaster. He had a very edematous neck, stridor, tachypnea without hypoxia, anxiety, and look of impending doom. This was not anxiety and not COVID-19. Intraoral exam remarkable for posterior pharyngeal edema with midline uvula. Neck rigid and extremely tender to palpation with multiple areas of brawny edema from the submandibular space down to the jugular notch. He was immediately started on IVF, steroids, abx, two large bore IV's, and taken to CT which confirmed multiple abscess, retropharyngeal air, and no airway. I called anesthesiology and general surgery to bedside immediately. Anesthesiology attempted intubation but was unsuccessful and general surgery performed a bedside tracheostomy. The patient's pulse oximeter was down to 0% (yes zero) for a couple of minutes. He was ultimately transferred to a tertiary care center and trach upsized, multiple wash outs in the OR for his multi-planar abscesses with retropharyngeal necrotizing fasciitis that were thought to be due to poor dentition and alcoholism. All teeth were removed, broad spectrum abx were provided for many days. His course was complicated by severe alcohol withdrawal, seizures, encephalopathy, and ultimately, he was placed in long term care with trach and PEG and continued to be severely encephalopathic. Of note, MRI did not show any anoxic brain injury.

How crazy these times have been; however, everything "COVID-19" is not just COVID-19. Be vigilant and keep your differentials broad. Remember to expand on

repeated visits. Do not be anchored to a prior diagnosis or nursing note/triage. Do what is best for your patients, everyday.

Spotlight a Chapter Board Member
Katheryn K. Dierks, DO, FACEP

Iowa ACEP Chapter Position? Immediate Past-President

Where do you practice? Genesis Medical Center in Davenport, IA

What drew you to Iowa? My husband is originally from Iowa. When we met in Arizona, he was an ER nurse and I was a volunteer. He was in the process of applying to med school and wanted to return to Iowa for med school at Des Moines University. He left for med school and we dated for a year. I then applied to med school and was accepted DMU. We always planned on returning to Arizona after residency, but the people and lifestyle in Iowa spoke to our hearts and we knew we wanted to stay in Iowa to help the community.

What is your EDC (Every Day Carry) for a shift? I like to keep it simple during a shift. I carry only my stethoscope and my ID badge. At my desk, however, I carry my reusable water bottle filled with water and ningxia red juice.

What's on your ED playlist? I don't typically listen to music while I work because music pulls me in making it hard for me to focus on anything else other than music. When I am not working, I listen to Sofi Tukker, Rufus du Sol, Tame impala, Bob Moses, Gorgon City, Camel Phat...house and deep house music that makes you move and elevates your mood!

What's your favorite thing about EM? My favorite part about emergency medicine is that we get to be there for people during the most difficult time of their life. We care for anyone and everyone, regardless of who they are or their ability to pay.

Interesting fact about you? I am learning how to DJ house music. I am also an avid endurance runner and have finished 11-marathons.

Goal in your position as Immediate Past President or as a chapter member? My goal as immediate past president is to understand and address how the corporatization of medicine has led to physician burn out and inferior quality of care.

Resident Corner

Samuel J. Irving, MD, PhD

Winter is almost over and with warmer weather we can say goodbye (at least for a period) to the accidental hypothermic patient. From a resident perspective, these can be some of the most difficult patients to manage. These patients are often found outside in the early morning and on arrival cannot tell us how long they have been exposed. To treat these patients, we need to know what to expect with the accidental hypothermic patient.

The definition, clinical manifestations, and management of the cold patient helps ED providers correctly manage this difficult illness.

What is hypothermia? There is accidental (found outside) and secondary hypothermia (medication, underlying pathology, basically hypothermia at room temp). For the purposes of this blurb, I'll stick to accidental. Any body temperature below 35°C is considered hypothermia. 32-35°C is considered mild, 28-32°C is moderate, and anything below 28°C is severe. A subset of severe hypothermia is called profound hypothermia and what separates the two is the presence of vital signs. Profoundly hypothermic patients will likely have weak or no pulse, will not be breathing and can have pseudo-rigor due to stiffly cold or frozen extremities.

Management centers on removing cold, wet clothing and warming the patient. In mild and moderate hypothermia, warm blankets, warm fluids can go a long way. Allowing the patient to move and warm through activity can help if they do not start sweating or remove the warming methods in place. Severe and profound patients will need warmed IV fluids, airway support and subsequent warmed air, and other aggressive warming methods. Providers may need to utilize bladder irrigation, chest tubes with warmed fluids irrigation, and blood products. Warm blood products are necessary since blood products are cooled/frozen while stored.

For profoundly hypothermic patients, ACLS should be used with the caveat that epinephrine and other medications along with defibrillation have significantly less effectiveness below 30°C. Resources within the US recommend 3 doses of epinephrine in patients under 30°C during CPR and if not responding, then hold meds until the patient is warmed to 30. This is part of the reasoning behind the adage "you aren't dead until you're warm and dead." The other side of the coin is that hypothermia is neuro protective. By cooling the brain, metabolic demand drops, and even when the patient has no pulse and is not oxygenating, the body and brain are protected. Management therefore focuses on warming at around 1°C per hour and correcting metabolic derangements. Profoundly hypothermic patients should be strongly considered for extracorporeal membranous oxygenation (ECMO). Patients who receive ECMO have significantly improved outcomes (number needed to treat ~2). Transfer to facilities that have ECMO capabilities should strongly be considered.

Stopping CPR in these patients should be considered when the patient is >/= 32°C and not responding to management. Additionally, a potassium >12mmol or a euthermic arrest and subsequent hypothermia (e.g. patient witnessed collapse at room temp and subsequently became hypothermic) are also considerations to stop CPR. In austere environments or severe weather these patients can be very taxing

on the ED staff and resources as a resuscitation may take hours when rewarming at 1°C per hour.

For those of us studying for the boards/in training exams – Osborn or J waves are classically seen on EKG and patients will often be hyperglycemic since the pancreas stops secreting insulin at cold temperatures.
References.

1. Tintinalli, Judith E., et al. Tintinalli's Emergency Medicine: A Comprehensive Study Guide. Eighth edition. New York: McGraw-Hill Education, 2016.
2. Extracorporeal Life Support in Accidental Hypothermia with Cardiac Arrest – A Narrative Review. Smol J., et al. ASAIO J. 2022 Feb 1; 68(2): 153-162.

Autumn
Thomas E. Benzoni, DO, FACEP

I'm not sure what to call this column. I picked Autumn for a start but I'm open to suggestions. With the kind permission (but not endorsement) of Iowa ACEP, I'll generate an occasional column of thoughts, ideas, opinions. It is likely to be irregular and, I trust, controversial. If I'm successful, it will also be thought provoking. As EM physicians, we don't shy from controversy; many of us welcome it. I think collegial controversy is a good thing. It demonstrates that you're listening and care.

Topics will vary; sometimes stories, sometimes reflections, sometimes rants. I would like it to trigger a discussion. If the idea is presented intrigue or offends you, good; you're paying attention. Engagement is the idea. I'm no social media maven but that's my understanding of the business model of social media. (Hint: if you ever want me to delete an email from you, have a social media link in it. Maybe I'll make one of the future columns my lessons in social media; I'm not impressed.) Column ideas are welcome and, if you disagree with my not-so-humble opinions, good; write your own column!! ("...more speech, not enforced silence…" Justice Brandeis). Another view. Maybe I'll tell the story of why I did that (another opinion), just now…

I did my first EM rotation in Des Moines General (RIP) in 1981. It's been a fascinating ride. I think I'm coming to the end of the line. While I don't feel old, I probably look it and I'm sure my orders reflect it. For instance, I still do an occasional physical exam and I don't order the most CTs in the group. (I saw the death of pneumoencephalography; loved to see its backside). I can read plane tomography; try it! I watched one of the first CTs produce images in Detroit. It's a wonderful technology and I'll never forget those first magic moments: an 8-slice head CT, 1 centimeter thick, took an hour. But it was magic.

Let's talk.

How to help in the Ukraine
Thomas E. Benzoni, DO, FACEP

Knowing that I do international work, I have had several physicians ask how they can help with the situation in the Ukraine. And a few years ago, we had a couple of Ukrainian physicians visit us. It was during the primary election season. We have a great picture of them with Joe Biden. I reached out to those physicians to ask. Below is their response:

How to help Ukrainian citizens and Army with drugs and medical devices?

If you are a private person or a company, here is the best way to help Ukrainians with drugs or medical devices. The help Ukraine initiative was organized by Ukrainian logistics companies and volunteers. It effectively delivers drugs and medical devices to Ukraine from its warehouse in Poland. Then they distribute shipments according to the needs of the Armed forces and civil medical system. You can find the list of items needed on the website. They update it regularly.

There are two ways you can help:
1. Deliver drugs or medical devices you already have. To do this, you have to arrange a shipment to the warehouse in Chelm, Poland. The contact information is here.

2. Donate money for purchasing drugs and medical devices. There is a bank account for that purpose. Both private people and companies can donate any amount they wish. Then volunteers make the procurement according to the list of needs. Go here to donate.

Please share this information with people or companies who wish to help. My personal recommendation is the second suggestion, the sending of money. It is a lot cheaper to send money than stuff and it lets the people on the receiving end decide where the needs are.

Will keep you updated. I'm sure you can keep yourself updated as well.

In Memory of Eugene A. Rodemich, III, MD
Written By: Roadie's Residency Family

Sincere condolences to Dr. Eugene "Roadie" Rodemich's family for the sudden and unexpected passing of a highly respected PGY-3 Resident member of the Iowa ACEP Chapter. He passed away on Saturday, February 19, 2022.

Dr. Rodemich was a beloved member of the University of Iowa's residency program. He attended medical school at SIU Carbondale, graduating with his medical doctor degree. Roadie then started his residency at University of Iowa Hospital and Clinics, specializing in Emergency Medicine. He was the first physician in his family and his town, and they remain so extremely proud of his accomplishments.

The very first time Roadie met his new co-residents, they knew he was going to be the one who was always taking care of them no matter what life brought. From his

personally-prepared "family dinners" to gaming nights, podcasts, trivia, and late night phone calls, Roadie took care of his crew. He was known for his amazing breadth of knowledge, always having a book recommendation, and being able to correct his faculty on the minutiae of not only medicine, but also history, politics, and literature. He was also known for his solid hugs, ability to make anyone and everyone erupt with laughter, compassionate end-of-life care, and always having the right words.

We do not have the right words.

He will be greatly missed by so many, and the void of his passing is only filled by the knowledge that he would want everyone to love, and laugh, and eat, and be the best human beings they can be.

Read more about Roadie below:

Twitter
Twitter

Go Fund Me
Obituary

Welcome New Members!

A special welcome to the new members of the Iowa Chapter and to those that renewed their membership with the chapter. We are excited to have you!

Contact the chapter if you would like to get involved at chapter or national level. We can help!

Adam Herrick, DO
Alan Wilson, DO
Alex A. Davis, DO
Angela Wild
Benjamin Michael Wilkinson, MD
Carlin Michael Situmeang
Chellise Kemis
Daniel Stanton Kinker
David Ruehlmann, MD
Edward Alexander Rekart, MD
Emily E. Falch, MD
Emily Mills, MD
Jamie Lee Candler
Jenna Marie Lizzo
Kaila Pomeranz, DO
Kathryn Bartlett
Kelee S. Peyton
Lauren Rowan
Marina Mandich Ignatowski
Melissa Katherine Sheber
Michael Robert Wallum, MD
Morgan Laurin Forgette
Natalie A. Boone, MPH
Nate C. Troll
Tyler J. Fisher, MD, MHPE
William Byrd Lynn, II, MD
William McDowell

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FROM NATIONAL ACEP

American College of Emergency Physicians®
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ACEP Resources & Latest News

Black History Month: Don't miss this week's *Frontline* episode featuring Dr. Ray Johnson and Dr. Sandra Coker discussing their experiences working in EM. Dr. Coker founded the Black Girl White Coat nonprofit, and Dr. Johnson's been a leader in EM for more than 30 years. Find more BHM22 resources related to this year's theme, Black Health & Wellness.

Get New Point-of-Care Tools in emPOC App

Advocacy:

South Dakota scored an important scope of practice victory (2/23/22)

ACEP applauds the Texas court ruling that the No Surprises Act implementation fails to follow the letter of the law. The concerns validated by this ruling are some of those shared by ACEP, ASA and ACR in a separate lawsuit currently in a Chicago district court (2/24/22). Amplify on Twitter, Facebook.

- **The No Surprises Act:** What You Need to Know

ACEP Applauds Passage of Dr. Lorna Breen Health Care Provider Protection Act: On Feb. 17, 2022, the Senate passed the ACEP-supported "Dr. Lorna Breen Health Care Provider Protection Act" (H.R. 1667) by voice vote. It now heads to President Biden for his signature into law. Read the full press release and additional background about ACEP's efforts to develop and progress this bill through the legislative process.

ACEP and EMRA Send Workforce Statement to Senate HELP Committee: ACEP partnered with EMRA to submit a statement for the record for a Senate HELP Committee hearing on workforce shortages (2/11/22). Read more

Regulatory Updates:

- ACEP Provides Feedback on New Emergency Medicine Cost Measure (2/24/22)
- CDC Releases Long-Awaited Revised Opioid Prescribing Guideline: Open for Public Comment (2/17/22)
- The Flip Side of the Coin: A Look at the Increase in Health Insurer Consolidation (2/10/22)
- Update on ACEP Actions to Address Physician Mental Health Needs and Wellbeing (2/3/22)
- Recent Federal Efforts to Address Provider Consolidation (1/27/22)

Upcoming ACEP Events and Deadlines

March 8: Deadline to apply for ACEP Leadership Awards
April 11-12: Virtual Advanced Pediatric EM Assembly
April 1 – May 31: ED Directors Academy, Phase I
April 15: Deadline to apply for ACEP Teaching Awards

May 1-3: Leadership & Advocacy Conference - ***REGISTRATION IS OPEN!***
May 15: Deadline to apply for ACEP committee involvement
May 18: Deadline for submissions to the ACEP22 Research Forum
May 23-25: SIM Training Course

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