A Newsletter for the Members of the Maryland Chapter - Fall 2020

Maryland Chapter AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

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In this Edition

President's Message

Maryland ACEP Members,

As we enter a season of thanksgiving, I want to commend all of your efforts over these past 9 months or so.It has been and will continue to be a most unusual year in so many ways. We are seeing an abrupt rise in coronavirus cases and hospitalizations across the country and in the state of Maryland.

It can be argued that we are better prepared this go around since we are more skilled at identifying and managing patients infected with coronavirus. In addition, there are more effective therapeutics to reduce morbidity and mortality. On the other hand, It is a fact that capacity will remain a concern based on what we are

seeing in other parts of the country. Frontline clinician fatigue is a real issue and major concern as we go into the next several months. Please be sure to have a strong support system and be aware of support resources at your institution. Also, be on high alert to recognize any signs of a colleague in trouble. We have to continue to look out for one another and with the good news regarding effective vaccines on the horizon, we certainly can see a glimmer of light at the end of this long pandemic tunnel. I am so proud to serve this organization in such an unprecedented year.

The ACEP national conference took place the week of October 25th. The council was held prior to the conference and along with the conference was held virtually. Maryland ACEP Councillors and Alternate Councillors who participated did a great job this year adapting to the online format, representing the interests of our membership at the national level. This issue of our newsletter is packed with a number of engaging and informational articles. Please enjoy!

A Case Study
The "Sac" is Half-Full…or is it Half-Empty? Either Way, This is Bad!

Yemi A. Adebayo, MD
EMPACt Committee Treasurer

The Case

At approximately 1800 on a bustling weekday evening an emergency department triage nurse urged for the physician to come assess an ill-appearing patient just brought into the emergency department (ED) by ambulance. A 70-year-old woman was found wincing in pain and clutching her chest. She reported a 2-day history of midsternal chest pain that she believed was brought on by 2 cups of coffee she had drank a few days prior to her current visit to the ED. She reported mild dyspnea and lightheadedness without syncope. She denied recent fever, chills, nausea, and vomiting. She reported the chest pain waxed and waned in its intensity but overall a progressive trend towards worsening pain.

Her past medical history as reported included hypertension, hyperlipidemia, and a history of a right bundle branch block. She did not recall her medications but reported compliance with all of them and denied use of any blood thinning or anti-platelet medicines. She reported having smoked for decades but having quit about 5 years prior and denied excessive alcohol consumption or any use of illicit drugs. Obtaining more detailed history was limited given how uncomfortable the patient was and her focus on her severe pain.

The initial physical exam was performed in the hallway demonstrated a pale appearing female in moderate distress secondary to pain. She repeatedly stated that her chest hurt and could not find a comfortable spot in the stretcher. She did not exhibit tachypnea nor any signs of labored breathing. Her initial vital signs were a heart rate of 78 beats per minute, blood pressure of 169/78 mmHg, temperature 36.5 degrees Celsius, respiratory rate of 13 breaths per minute, and an oxygen saturation of 98% on room air. Her lungs were clear to auscultation, she had a normal sounding S1 and S2 without murmurs or rubs. Her abdomen was soft and non-tender, and her lower extremities were non-edematous. Her initial ECG performed upon her arrival showed a sinus rhythm at 78 beats per minute with a borderline left bundle branch block (LBBB) and leftward axis deviation and normal voltage throughout. This ECG was changed from a previous ECG on file showing a MOBITZ II pattern with right bundle branch block (RBBB) just a month prior. The blood work for the patient did not reveal any obvious abnormalities that would have been clinically significant. Her complete metabolic panel, troponin, and hemoglobin

and hematocrit and platelet counts were all within normal limits. Her WBC count was mildly elevated at 14,000.

Upon the physician's initial evaluation of this patient the primary concern was for acute coronary syndrome given the patient's ill appearance, ongoing chest pain, history and new LBBB. The physician contacted cardiology immediately after reviewing the initial ECG showing the LBBB. Activation of the cardiac catheterization team was declined for lack of ECG criteria to warrant activation. The patient was moved into a room shortly after the initial hallway evaluation and repeat ECGs were performed twice over the next hour for continued chest pain, both of which were unchanged from the initial.

The patient had received nitroglycerin from paramedics before arrival and was offered aspirin but declined it given a history of gastrointestinal bleeding. She was given 2 doses of morphine for continued severe pain over the first hour of her visit and persisted to have severe 9 out of 10 chest pain. At that point the provider decided to cancel the pending chest x ray and order a CT angiography of the chest for the patient for concern for acute aortic dissection or pulmonary embolism. About an hour and 20 minutes into the patient's visit, the physician went to reevaluate the patient and the status of her pain and noticed that she was still increasingly uncomfortable. It was at this time the provider performed a second exam on the patient noting she had newly become tachycardic and her blood pressure was considerably lower than it was on arrival.

When the physician repositioned the patient's gown, it was noted that a recent surgical scar was present over the left upper chest which had not been noted during the exam in the hallway. The patient disclosed at this time that she had had a pacemaker placed only 7 days prior at an outside facility. The physician immediately brought an ultrasound device to the bedside to perform bedside echocardiogram. The physician pulled the lever behind the head of the patient's stretcher and lowered the head of the bed. Simultaneously the patient gasped and said, "I think I'm going to pass out, I don't feel that well." The patient was immediately sat back up at a 45-degree angle however continued to appear near syncopal although protecting her airway and being easily awoken by voice. Attempts to re-check a blood pressure using the telemetry monitor were unsuccessful and a manual blood pressure revealed a systolic pressure of only 65mmHg. The provider placed the ultrasound probe on the patient's chest to reveal a large pericardial effusion with strong evidence of cardiac tamponade.

Discussion

Each year over 100,000 pacemakers and cardiac defibrillator devices are implanted in patients across the United States. Atrial or ventricular (ventricular is more common) lead perforation is a rare but potentially fatal complication of these surgeries. Perforation of the myocardium can lead to formation of a pericardial effusion and if the patient is unfortunate enough, cardiac tamponade could ensue. Cardiac tamponade is a clinical diagnosis that we are likely to encounter at least a few times in our careers as emergency physicians, that is if we are vigilant enough to consider it in the differential diagnosis. Cardiac tamponade is caused when a pericardial effusion accumulates to the point of exuding excess external pressure on the myocardium causing atrial and ventricular filling abnormalities which can ultimately lead to cardiogenic shock.

Diagnosis of this entity can be difficult as many of the classic findings described in emergency medicine literature have very poor sensitivity. Relying on findings such as low voltage and electrical alternans on ECG, diminished breath sounds, or hypotension may cause the provider to overlook the diagnosis without further evaluation steps as these criteria are often late findings if you find evidence of them

at all at the time of the patient's presentation. Echocardiography and pulsus paradoxus have been found in some studies to have greater sensitivity and specificity for this disease. Using relatively basic bedside echocardiography techniques one can find and diagnose a patient with a large pericardial effusion and possible tamponade with the presence of a large anechoic stripe around the heart and presence of diastolic collapse of the atrial and ventricular free walls. As the tamponade progresses then left ventricular collapse can also be seen.

IV fluids and vasopressor therapy are the mainstays of initial management of a patient with cardiac tamponade while obtaining prompt cardiac surgery consultation. If immediate in-house cardiac consultation is not available, then one may try to enlist the assistance of a general cardiologist to assist assessing and dispositioning. the patient. Many patients with pericardial effusions and even mild tamponade physiology may be able to be stabilized on IV fluids and vasopressors, however if hypotension and altered mentation persists then a provider (with proper training in this procedure) must strongly consider performing an emergency bedside pericardiocentesis prior to transfer as cardiac collapse could be imminent. Use of US has become cornerstone for guiding this rare but lifesaving procedure in the emergency department. There are a few different approaches that one can with the US to perform the pericardiocentesis including a subcostal (traditional) and apical (becoming more popular) approaches.

Perhaps the greater points to glean from this case, beyond the limited reliability of ECG findings and presence of hypotension in suspecting this diagnosis, is the consequence of obtaining (or not obtaining) ALL of the key components of the patient's history whenever possible, even when seemingly pressed for time. In this case, the initially missed history of the recent pacemaker placement proved critical in re-organizing the provider's differential diagnosis, casting pericardial effusion to one of the top possible diagnoses. Similarly, the limited physical exam performed in the ambulance hallway upon arrival delayed the ability to fully assess the patient's skin of the chest which also would have alerted the physician to the presence of a fresh surgical scar. Many physicians have heard of cases where a simple component of routine past medical history or physical exam leads to an eye-opening advance in the diagnosis of a case. This particular case aims to serve as a reiteration of that reality and hopefully can act as a reminder of the utility of some of our most basic tools available to us in emergency medicine: our ability to obtain a great history and perform a thorough physical exam.

Case Resolution

After the bedside ultrasound confirmed presence of a very large pericardial effusion with signs of diastolic collapse of the atrial and ventricular walls, immediate calls were placed out to cardiology and the patient's cardiac electrophysiologist who implanted the device. IV fluid boluses were initiated, and norepinephrine was started through a peripheral IV. Simultaneously the ED physician gathered materials for an emergent bedside pericardiocentesis as there was no immediately available cardiac surgeon at the hospital. The patient continued to remain hypotensive with no improvement in her waning mental status. The general cardiologist came into the ED and assisted with performance of an US guided pericardiocentesis in the emergency department. After a few unsuccessful attempts, pericardial blood was successfully aspirated from the pericardial sac. A total of 330 mLs of frankly bloody aspirate was removed and immediately the patient's pallor improved in addition to decreasing vasopressor requirements. The pericardial drain was sutured into place and capped off. Immediate arrangements were made for the patient to be transferred to a higher level of care to receive diagnostic and therapeutic cardiac surgery for a repair of what was determined to be a pacemaker lead perforation through the right atrium. The patient did well post operatively and was discharged a few days later.

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Useful Resource
Video on Pericardiocentesis

The Coin

Kerry Forrestal, MD, FACEP
Chapter Board Member & Alternate Councillor

Her eyes bore through me the moment I walked in the room. She knew me, but I did not recognize her. Such is a lot of people who do our work. We see tens of thousands of people each year and there are only a few of us. She is not the patient, however, and it is unclear yet if the patient, her husband, is truly sick or one of the worried well. Middle aged, a smoker, hypertensive, high cholesterol, bad family genes. Spared only from diabetes by virtue of the physicality of his job. The concern? Chest pain, that enduringly treacherous diagnosis that can end with a belch of a remnant of dinner or in death.

The workup progressed well, but the woman in the room was still "off". Not hostile, but unnaturally intense. I can honestly say I cannot recall her even blinking. She seemed worried that, if she did, I would disappear for all time. I thought perhaps it was nothing more than the concern she had for her husband of 3 weeks. "We finally found each other and started our new life together." She had said, with that tone that bespoke lost time.

The workup completed, and the patient passed with flying colors. Discharge was the pronouncement with follow-up in the morning with the cardiology service for stress testing. "Yes, it is safe." "Yes, I understand how valuable he is to you." (Maybe I do not?) I bid them farewell, and the eyes continued to bore through me. What was I missing? I turned to leave, and the wife stood to follow me out.

Here it comes.

"You don't recognize me."

"I'm sorry I don't."

"About a year ago I came in seeking drugs and I was on heroin."

I was struck by the statement, most people won't inform you of drug seeking behavior or heroin use, let alone both. I was already on guard, but now did not know what to expect.

She said we fought. I tried to get drugs and you refused. But more than that you talked to me like a human being instead of an addict. I do not remember what you said exactly, I can recall you told me to respect myself and that I was worthy of respect. I argued with you and left, but it started me on a different road.

She has been clasping something tightly and finally turned out her hand opening it to reveal a 1-year sobriety coin.

She said that she met him after I had been clean a while, he knows all about that time and he has helped me so much. We married three weeks ago.

Thank you. She hugged me and went back inside to her new life.

I walked back to the main area from the side rooms stunned. We are pretty good in this line of work at suppressing anger when we are treated poorly, sadness when we see something tragic, but we are in no way well practiced when we find out in an unexpected way that the fruit of our labor, that seed we planted and forgot about, yield something so sweet.

I am as tightfisted as they come with narcotic, but when people ask me why I am kind to drug abusers as I say "No.", I now think about a newlywed, her husband and a coin.

Reusable Respirators, a Proven, Sustainable PPE Solution
Theresa Tassey, MD, FACEP
Public Policy Committee & EMPACt Committe Chair

Maryland's Emergency Physicians remain dedicated to caring for patients and expect the same dedication from our employers to prioritize our safety. We are now facing the second wave of the COVID-19 pandemic and witnessing surging cases in Maryland and nationwide. Our Emergency Departments and hospitals are overflowing with patients and beds are becoming scarce. Now more than ever, WE NEED PPE.

In the beginning of the pandemic, supply chain issues and limited production of protective equipment presented a challenge to all frontline workers. Nearly 10 months later, there are ever-dwindling excuses for not having adequate PPE. Mask manufacturers have increased production of N95s, hospital systems have had ample time to locate new supply chains, institute engineering controls, and evaluate reusable solutions, such as elastomeric N95s (eN95s) and ENVO masks. Nevertheless, too many of our emergency medicine colleagues across the country continue to lack access to appropriate protective gear.

Inadequate PPE contributes to frontline worker stress and burnout. A recent article in Medscape found that "Lack of PPE has been identified as one of the most significant contributors to burnout and stress among physicians and other healthcare professionals."

According to Sharm, M. et al., "Insufficient PPE access was the strongest predictor of feeling that the hospital is unable to keep providers safe and worries about transmitting infection to families/communities. […] Addressing insufficient PPE access, poor communication from supervisors, and community stigma may improve provider mental well-being during the COVID-19 pandemic."

In May of this year, Maryland ACEP conducted a survey to determine the availability and reuse of PPE throughout the state. The survey found over 95% of all respondents reported having access to N95 masks, gowns, gloves, and eye

protection. However, 91% of respondents stated that they still had to reuse PPE. Nearly 37% of survey responses stated they were expected to use N95 masks indefinitely while 41% stated they were given one to two N95 masks per week. At that time, around 20% of respondents had no access to Powered Air Purifying Respirators (PAPRs). While the Maryland survey has not been re-administered, reports from Emergency Physicians in the state and nationally indicate that, overall, PPE supplies have improved.

Maryland ACEP recently participated in the National ACEP Council, where council members were polled regarding PPE supplies. Over 81% polled at council said they have an adequate supply of PPE, still leaving almost 20% of Emergency Physicians not adequately protected. Nearly 30% of EM physician councilors reported they are not allowed to use personal PPE, despite JCAHO, OSHA, CDC, ACEP and other national specialty societies' issuing statements supportive of personal PPE.

Does your primary place of EM practice have an adequate supply of PPE?

	Votes	%
YES	296	81.10
NO	69	18.90

Does your primary place of EM practice allow the use of PPE provided by you personally?

	Votes	%
YES	247	71.18
NO	100	28.82

Emergency Physicians from various hospitals across Maryland were recently interviewed and most reported adequate PPE. Unfortunately, employees from a few hospitals in the region have witnessed a regression in their PPE compared to earlier in the year. In some cases, they stated previously having at least one N95 respirator per shift but are now being issued a single N95 per week. The reports from these same hospitals indicate that there are not adequate supplies of PAPRs nor other reusable respirators, and the utilization of personal PPE is not permitted. This leaves many Maryland emergency physicians unprotected at the worst possible time: in the midst of the second COVID-19 wave.

The most concerning practice is extended reuse of N95 respirators. There is growing evidence showing that reuse of disposable N95s is unsafe. One article, published in JAMA, found that failed fit tests of reused N95s were related to increased instances of donning and doffing and hours worn. The study examined both 3M 1860s and Halyard duckbill N95s. Duckbills have a higher failure rate at baseline. 3M 1860s are more durable, but the structural integrity and fit of both N95 styles was compromised after 3-4 shifts (assuming limited donning/doffing and proper storage).

Another study presented at *ACEP20* last month found that when N95s were "reused for more than 2 days, nearly half of the N95 masks failed [fit testing]". Although each of these studies were small, almost every emergency physician can attest to the finite reliability of an N95 worn for an extended period, let alone multiple shifts. Emergency physicians need reliable protective equipment so they can be confident in their own safety and continue caring for all patients.

Many innovative hospitals and health systems recognized the need for a sustainable solution for respiratory protection early on, understanding that the constrained supply of disposable N95 respirators may persist for the duration of the pandemic. One popular solution has been the investment in reusable or elastomeric N95s (eN95s). A New York Times article, They Evoke Darth Vader, but These Masks May Save Your Doctor's Life, discusses how hospitals adopted reusable respirators to protect their employees and reduce reliance on a tenuous supply chain of disposable N95s.

A Harvard Business Review article stated, "elastomeric N95 masks (eN95s) are the best alternative to N95s, which continue to be in short supply even in health care settings. They are reusable, offer N95-level protection from both small particles (aerosols) and larger droplets, and are widely available for at least the immediate future". Key Federal agencies - JCAHO, OSHA, the CDC and the VA - have issued statements recommending elastomeric respirators for frontline health workers. They have found them to be safe, economical, and ideal in periods of severe respiratory PPE shortages.

One larger health system, the Allegheny Health Network (AHN) shared in one article in the Journal of the American College of Surgeons by Chalikonda, S. how they implemented elastomeric respirators across their hospitals in Pennsylvania and western New York. They found that the elastomers were not only safe and cost-effective but preferred by clinicians. After trialing the elastomeric respirators for a month, no one chose to return to using disposable N95s. A smaller hospital in Texas had similar results after adopting elastomeric N95s within the first few months of the pandemic.

Maryland Emergency Physicians working where elastomeric respirators are used, for example in the University of Maryland or Johns Hopkins health systems, reported more reliable supplies of disposable N95s in their departments but stated they were less likely to need or use them. In other Maryland hospitals where disposable N95s are being rationed and extreme reuse policies are in effect, administrators should not delay in acquiring reusable respirators and/or allow personnel to use their own NIOSH certified reusable respirators. Investment in reusable respirators, even now, would prove economically beneficial, reduce reliance on disposable N95, and ensure emergency physicians remain protected during this imminent COVID-19 second wave and beyond.

ACEP Council Meeting Update

Jonathan L. Hansen, MD, FACEP (Councillor)
Arjun S. Chanmugam, MD, FACEP (Councillor)

Not too long ago, ACEP was a small organization, struggling for a voice to represent the fledgling specialty of emergency medicine. Today, ACEP is one of the largest, most influential organizations in the house of medicine. It is governed, in large part, by the ACEP Council. During the annual ACEP Council meeting, important issues facing our specialty are deliberated in the form of council resolutions. These resolutions are debated, followed by a vote. Each councilor has a voice, and there are nearly 500 representatives from all 50 state chapters and the ACEP sections.

This year, the ACEP council was like none other. Important debate occurred, but because of the pandemic, everything was conducted virtually. In some ways, the online platform allowed for greater efficiency in the deliberative process. For example, the ability to provide asynchronous testimony ahead of the actual meeting was very successful, so hopefully that will continue for future meetings. On the other hand, the actual Council debate was less compelling and interactive. We missed the oft-inspiring soliloquies of years past, as the great orators in emergency medicine argued their points. The ability of councilors to socialize, meet new acquaintances, and rekindle friendships were very limited.

Nonetheless, it was a successful Council Meeting. It was very apparent that Maryland is a leader in emergency medicine. We are represented by two members on the Board of Directors, Jon Mark Hirshon and Gabor Kelen. Aisha Terry, who currently practices in DC but has ties with Maryland, was re-elected for another term as a Director. Bill Jacquis also completed his year of service as the ACEP President; while he currently lives in Florida now, he still hales from Maryland.

Notable resolutions adopted and sent to the Board for approval include counting fellowship time toward FACEP eligibility, procedures for addressing possible ethical violations and other misconduct, rules governing the use of the term “resident” for clinical training programs, expansion of telemedicine, and promotion of a culture of anti-discrimination in the nation’s EDs and hospitals. Also, Jon Mark Hirshon was commended for his service to our specialty.

As we look forward to a - *hopefully, in-person* - Council meeting in 2021, please reach out to any of the Councillors, Alternate Councillors, or Maryland ACEP leaders with issues that are important to you, so that we can be your voice at this important event!

Make Your Voice Heard
Gregory N. Jasani, MD

Amazingly, the 2020 Presidential election is behind us. Whether your preferred candidate won or not, many of us will likely be thankful that our news programs and television ads will no longer be consumed by the campaign. As the election fades from the public discourse, it may be tempting to disengage from discussions about issues facing this nation. We must not let this happen. As physicians, we must continue to be involved in these conversations.

The 2020 election cast a spotlight on many of the issues facing this nation: racial inequality, the pandemic response, and the future of the Supreme Court to name a few. While many of us used our votes to signal our support of these views, we must be cognizant that these issues will outlast this election. The triumph of one

candidate or party over another will not be a panacea that will bring about rapid solutions to these problems. Crafting and implementing policy is a much more nuanced and lengthy process than making campaign speeches. As our leaders' transition from campaigning to governing, we need to make our voices heard and contribute to actively shaping the policies.

As emergency medicine physicians, we have an invaluable perspective to lend to these discussions. Every day, we interact with some of the most vulnerable members of society. We have seen the devastating effects of food and housing insecurity, untreated mental illness, addiction, and even systemic racism on our patients. Many of our patients are not able to advocate for themselves - but we are. We can speak to their condition and, unfortunately, can bear witness to their suffering. Continuing to be engaged on these issues is one of the most important ways that we can advocate for our patients.

Additionally, there are issues being debated that affect us professionally. There are currently bills in Congress that address balanced billing, workplace violence prevention in healthcare, due process protections for emergency medicine physicians and even hero pay for frontline healthcare workers. Locally, there will undoubtedly be many issues that affect healthcare in Maryland that will be debated during the next legislative session. Given that the vast majority of legislatures in this country are not physicians, it is imperative that we weigh in on these discussions.

There are many ways we can participate in these conversations. Obviously, working directly with elected officials on policy is one of the most direct methods. Officials may seek your input on certain policy directives or ask for advice on crafting legislation. Similarly, many non-profit and advocacy organizations may seek out your expertise as they make their pitches to officials. Working with elected officials and advocacy organizations is a great way to use your expertise to help shape policy.

There are also many ways that you yourself can make your voice heard, even if you are not working with elected officials or a group. The COVID-19 pandemic has caused many physicians to become actively engaged with various forms of media. Whether it is television, radio, podcasts, or even writing op-eds, making your voice heard on a media platform is an excellent way to add your voice to a debate. Similarly, many politicians, even after the election, will hold town halls with their constituents to stay engaged. Going to these events to interact with your politicians is another way to contribute your expertise to a discussion of policy.

The election may be over, but the issues it highlighted will persist for years if not decades to come. Our medical expertise and ability to speak to the personal, human aspect of these issues is a rare combination that makes our voices incredibly unique. We can take an active role in shaping these issues. Our continued involvement on these topics at the local, state, and even federal level is one of the best ways we can advocate for our patients.

From the Nominations Committee
Orlee I. Panitch, MD, FACEP
Chair

As chair of the Nominations committee, I would like to speak to our entire membership.

Maryland ACEP is a vibrant organization with a high profile in the State. We have been active with the State - in both regulatory and legislative matters. We are a leader in advocacy. We are active in practice management, and physician wellness. We liaise with National ACEP. In short, we are the organization that affects the daily practice of every emergency physician in Maryland.

The strength of Maryland ACEP comes from the diversity of its leadership. We have representation from most areas of the state, and most practice disciplines. This is crucial to making sure that your voice is heard.

As we are about to enter 2021, we will soon be at our Annual Conference. Every year, we use this time to elect new leaders. We would like for you to consider putting yourself on the ballot! Or, if you know of someone who you believe should run, please approach them, and ask them to run. We need Councillors, Board members, and Executive Committee members. Contact us here.

Everyone is welcome. Everyone is encouraged. We need your VOICE!

From the EMPACt Committee
Theresa Tassey, MD, FACEP (Chair)
Yemi A. Adebayo, MD (Treasurer)

The Maryland ACEP Chapter EMPACt Committee continually strives to improve the committee process of utilizing donations made by you for key lobbying and advocacy fundraiser events that will benefit emergency physicians in Maryland.

With that in mind, the EMPACt Committee and the Maryland ACEP Chapter Executive Board meets no less than once a month to review what is call a “PAC Memo”. In the memo that is provided by Danna Kauffman, Chapter Lobbyist there are a list of fundraiser events that Danna recommends the chapter donate to and attend. A donation is then processed via check or online by Dr. Adebayo, EMPACt Treasurer.

A chapter leader, or a member of the Public Policy Committee, or Danna (schedule permitting) attends the event and advocates for Maryland emergency physicians.

During each fundraiser, the Maryland representative finds every opportunity to discuss the needs of the chapte with the legislator. To make this task easier and with the help of Danna, the chapter has finalized the 2021 Policy Priorities. This document lists important talking points that are of major concern across the state and are topics that important legislators are open to discuss.

After the Maryland representative or Danna attends the fundraiser, he or she will present a brief summary of the event. These updates will be shared with chapter members via email, during a chapter meeting, or via the chapter newslettter.

You can read the 2021 Policy Priorities here. More information can be found in the Chapter Lobbyist article, found below, and provided by Danna.

From the Practice Management Committe
Chirag R. Chaudhari, MD, FACEP
Chair

Thank you to everyone who took the Practice Management Survey on emergency department time outs, telehealth, and environmental services. Below are the results of that survey:

 # Responses: 45

There were 27 different hospitals represented

- 17 Hospital Employees
- 17 Independent Groups
- 6 CMG / Staffing Company
- 5 Other (national partnership, university employee, school of medicine employee, retired, and medical student)

Do you use time outs in the Emergency Eepartment?
Yes 36 and No 2

- 13 said for all procedures
- 23 said for some procedures most commonly being: central lines, procedural/moderate sedation, chest tubes, thora and paracentesis. Least common mentions for time outs were LPs and laceration repairs.

Are you using Telehealth?
Yes 15 and No 21

What are you using Telehealth for?

- 11 said Triage
- 6 said F/U Appointments/Calls
- 2 said SNF Transfer Avoidance
- 4 said Other (ED Psych, telestroke/neuro and EMS medical oversight)

What has been your experience with Telehealth?
14 responses - even 7/7 split with positive/negative experiences

Positives: Convenient, limits exposure and reduces PPE needs
Negatives: Quality on the receiving end of patients that have triage workups started via telehealth is highly variable, could be more efficiently performed by an in person physician, some providers talk for extended times in triage and slow the process when they are going to be seen by another provider anyway.

Is the cleaning of your common areas of the ED done by environmental services (EVS) or by the staff in the ED?
30 say EVS and 6 say staff in the emergency department.

Has EVS changed the way they clean common areas of your department?
Yes 17 and No 13
Most say the frequency of cleaning has increased - most people said this occurred 4-5 times a day. A few people stated they have been more intensely cleaning

If anyone has any topics of interest that they would like to have surveyed or potentially have a meeting set up to discuss in more detail, please let us know. We are more than happy to help set up speakers or facilitate a meeting to discuss.

From the EMS Committee
Timothy Chizmar, MD, FACEP
Chair

What is the status of EMS in Maryland?

- EMS has remained dedicated throughout the pandemic
- We continue to transport 120-130 PUIs and 10-20 known COVID positive patients per day, statewide
- Ketamine - memo sent widely to EMS and base stations, requiring consultation unless there is an immediate and imminent danger to patient or EMS clinician.
- EMS licensures have been extended during COVID-19 emergency
- Clinical rotations: essential that hospitals and EMS services re-open to EMT and Paramedic students, bottleneck created and need for continued education to replace those lost through attrition.
- Provisional EMS: brought 1000 approx. on board during COVID, for increased staffing levels
- Disparate Offloading and PPE policies - please work with EMS, seeing development of disparate offloading policies/prolonged wait times in ambulances awaiting rooms in the ED
- EMS may partner with health dept or hospitals to deliver flu or COVID vaccine to the public (Public Notice 6 - under the Exec Order). Must be in partnership.
- Evaluating several protocols, including viral pandemic triage protocol, limited fluid resuscitation in burn patients, IV infusion pumps for optional 911 jurisdictions
- New alert system in near future (early 2020) to replace CHATS; simplified compared to CHATS

Please let me know if you would like more details about any of the above.

In the future, we will be setting up an EMS tab in the chapter website. I will be working closely with Adriana Alvarez, Chapter Executive Director on this task. If there is specific information you would like included in the tab, please let us know.

From the Pediatric EM Committee
MIS-C Multisystem Inflammatory Syndrome in Children
Suzanna Martin, MD, PhD, FACEP
Chair

First described in April 2020 as a Kawasaki-like illness associated with recent COVID-19 infection.

Case Definition (per the CDC)

- An individual <21y with fever for >24hrs, laboratory evidence* of inflammation, and evidence of 2+ organ system involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic, or neurologic) **AND**
- No alternative plausible diagnosis **AND**
- Positive for current or recent SARS-CoV-2 infection OR exposure to suspected/confirmed COVID-19 case within the prior 4 weeks (only 15% are positive for viral test, but 85-98% are positive for COVID antibodies)

*Elevated CRP, ESR, fibrinogen, procalcitonin, d-dimer, ferritin, LDH, IL-6, hyponatremia, thrombocytopenia, neutrophilia, lymphopenia, and hypoalbuminemia

Incidence (in the US, per the CDC mid-Sept)

- 935 cases and 19 deaths (MD had >31 cases) in ages <1y to 20y (average age 9y)
- 70% Hispanic, 55% male, >50% overweight/obese
- Less than 2% mortality

Clinical Presentation

- Persistent fever (>24hrs), abdominal pain, vomiting, diarrhea, skin rash, mucocutaneous lesions, neurologic complaints, and possibly hypotension and shock.
- GI COMPLAINTS (abd pain, vomiting, diarrhea) ARE THE MOST COMMON (87%) AFTER FEVER!!!
- About half (50%) have conjunctivitis or rash
- Tachycardia, heart block on EKG, hypotension, syncope
- Cough/rhinorrhea as low as less than 10-20%

Differential Diagnosis

- Kids with fever - look for the usual suspects: Viruses known to us, UTI, Pneumonia, appendicitis…
- COVID-19 (not MIS-C), Kawasaki Disease, Toxic Shock, Tick borne infections (RMSF), acute abdominal process (appendicitis), Myocarditis, Sepsis, Malignancies (ALL, etc), other vasculitis, MAS (macrophage activation syndrome), Hemophagocytic Lymphohistiocytosis (HLH), etc

Lab/Imaging abnormalities (let us feed the vampires!)

- ***MOST recommend starting with CBC, CMP, ESR, CRP (I also add Troponin & BNP & UA)
- Imaging/Etc: CXR, EKG, abdomen imaging if warranted (often shows ascites, inflammation)
    - Cardiac echo can show decreased EF (45% incidence) and coronary artery aneurysms
    - "Second Tier": Ferritin (JHU likes this as 1st tier), d-dimer, SARS CoV2 PCR
    - "Third Tier": LDH, Fibrinogen, Triglycerides, PT/PTT/INR, UA
- Elevated inflammatory markers: CRP, Ferritin, LDH, IL-6, Procalcitonin, Creatinine kinase
- Cardiac: troponin, BNP (predictor of "badness" per CNMC ID)
- Coagulation: ESR, d-dimer, fibrinogen, thrombocytopenia
- Heme: elevated WBC, elevated neutrophils, low lymphocytes, mild anemia
- CMP: low sodium, low albumin, elevated creatinine, elevated LFTs, elevated lipase

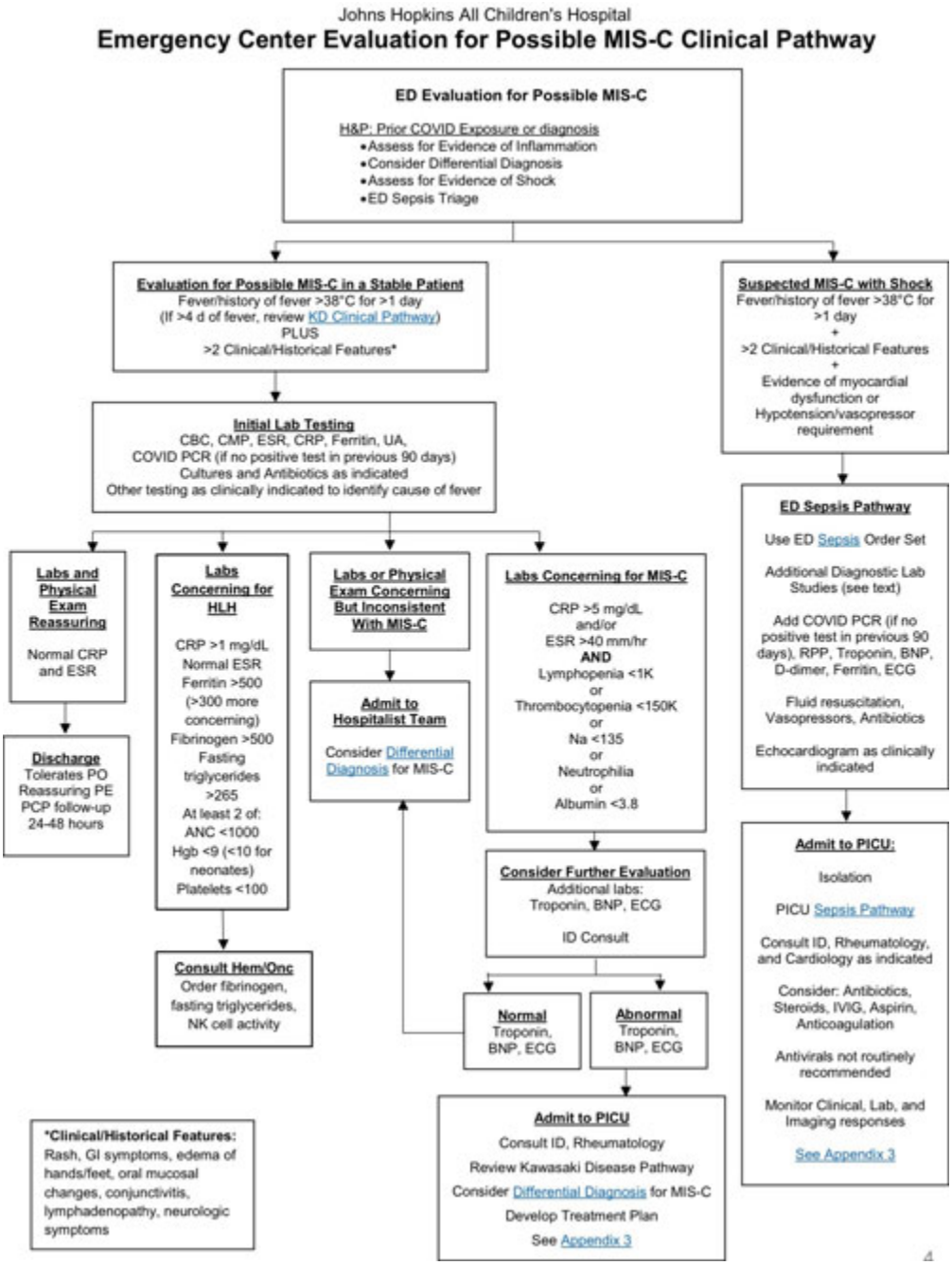
Treatment (in the Emergency Department)

- Fluid resuscitation (10ml/kg saline boluses) - beware of cardiac overload
- Inotropic support (Shock with poor perfusion): Epinephrine, consider milrinone
    - (Shock with normal perfusion): Norepinephrine, consider vasopressin
- Respiratory support (use airway protection regardless of COVID results!)
- After admission: IVIG (2G/kg, max 100G), steroids (2mg/kg Methylprednisolone)

Admission/Advice

- Call upstairs to the PICU/Peds ID doc (lucky you!)

- Call your closest referral center (JHU, CNMC, CHOP, Pitt, etc)



From the Membership Committee
Benefits of ACEP Membership: Education
Nicole Ciminio-Fiallos, MD, FACEP
Chair

The Scientific Assembly this year lived up to its title, “Unconventional.” Although the format was different and I missed meeting up with my ACEP colleagues who live in other parts of the country, the education provided was as high caliber as ever. I enjoyed the celebrity cameos (shoutout to Matthew McConaughey who congratulated the new ACEP fellows and Dr. Fauci who stopped in to drop some

COVID knowledge), but I most appreciated the talks from stellar EM doctors who shared their expertise to keep all of us on the cutting edge of our field. Some of the best lectures came from MD ACEP members, like Dr. Mike Winters who presented the Critical Care Updates for 2020. I have already used the information he provided to advocate for the early initiation of pressors in patients with septic shock in my ED. I also picked up some procedural tips from the trauma lecture. Although I have put in more chest tubes than I can count, I was eager to try out my new tricks on my last thoracostomy. To round out my educational experience, I popped in on some wellness talks at this conference. Listening to prominent ER physicians talk about their personal and mental health struggles during these difficult times offered some insights into my own state of mind. The best part of this conference is that the lectures are still available, and I can still earn CME on my time.

This “unconventional” conference highlighted many of the challenges we face during the uncertain times of a pandemic. The conference also showed that ACEP understands our needs and wants to provide education and resources that support us as working clinicians. The content of the lectures did not just apply to providers working in elite tertiary care centers, but also addressed the needs and interests of community doctors like me. This conference showcases many of the ways ACEP works towards the advancement of our field and I appreciated the efforts of so many members, which made this unique conference come together. The scientific assembly is an enjoyable experience for me each year and 2020 was no exception. It is just another reason I continue my membership with ACEP.

From the Chapter Lobbyist
Danna Kauffman

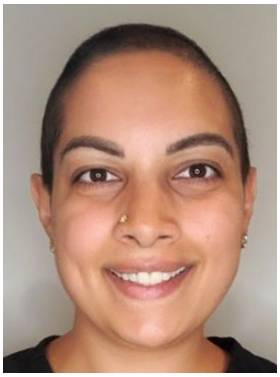
The 2020 Legislative Session ended early on March 18th because of the COVID-19 pandemic, and the 2021 Legislative Session will continue to be upended because of it. The 2021 Legislative Session is set to begin on January 13, 2021. But, unlike past years, there will be no opening day receptions, no families gathering on the floor of the chambers, and no handshakes. While this situation remains fluid as the virus continues its grip in Maryland and the nation, here is what you can expect so far.

Introduction of bills: Legislators were strongly urged to pre-file bill requests by November 1st to facilitate a greater number of bills being ready for introduction on the first day of Session. Plans are to skip the countless briefings that typically occur in the first few weeks of Session and to move directly into bill hearings on January 14th. For MDACEP, this means that many bills will be available in December and early January for review and the MDACEP Public Policy Committee will be making those adjustments to its weekly bill review meetings. In addition, the Senate has capped the number of bills that an individual Senator may introduce to 25 bills. The House has not followed suit with an actual cap but has requested that Delegates be judicious on bill introduction. On that note, it is expected that the scope of bills will be more limited this Session, with emphasis on legislation related to COVID-19, police reforms, education, and minority disparities.

Process: As expected, this Session will be held almost all virtually. Committee hearings and workgroups will be held through Zoom and testimony could be limited. While legislators will still need to report to in-person chamber sessions, Delegates will be spread out among two locations (the State House Chamber and Rooms 170/180 of the House Office Building) to allow for appropriate social distancing. Plexiglass barriers will be assembled for each desk in the Senate

chamber and desks will be distanced from each other. It is also anticipated that floor sessions will be shorter in length due to ventilation issues.

Advocacy: The traditional receptions and dinners have already been cancelled this year. However, MDACEP is working to have a "virtual advocacy day" which will focus on MDACEP members meeting virtually with individual legislators to discuss key issues. In addition, MDACEP encourages all its members to reach out now to their individual legislators and share with them your stories in providing care during the COVID-19 pandemic. Information on legislators (either your home or place of employment) can be found here. An email or a call before Session can open the door much easier for you during Session.



Maryland ACEP Chapter
Social Media Ambassador

Kavita S. Jackson, MD

New Social Media Ambassador. Read more below.

I am Dr. Kavita Jackson and I am thrilled to be Maryland ACEP's first Social Media Ambassador. My relationship with social media began as a personal venture when I started blogging through my journey with breast cancer this year and has now flourished into a passion.

I look forward to combining my newfound interest with the advocacy and growth of emergency medicine. I plan to keep you up to date on important events, like CME, current emergency medicine education, and relevant MD ACEP chapter news. I am excited to engage with you all via social media and, hopefully soon, in person, too.

Please go follow us on Facebook (@MarylandACEP) and Twitter (@MD_ACEP) and email me with information to be shared with our chapter or if you would like to be featured.

New Honorary Member
Sandy Schneider, MD, FACEP
Associate Executive Director for Clinical Affairs - National ACEP

Maryland has a new honorary member - **Jane D. Scott, ScD, MSN**.

This year Dr. Scott was awarded Honorary Membership with ACEP for her work in supporting and developing young researchers in EM. Jane currently works as the Director of the Office of Research Training and Career Development, Division of Cardiovascular Sciences (DCVS), National Heart, Lung, and Blood Institute, National Institutes of Health (NIH). The office provides oversight to more than 700 individual and institutional training grants to develop cardiovascular scientists nationwide. She has a particular interest in emergency care research training and provides oversight for the current NHLBI K12 and T32 programs in emergency care research. In doing so, she has increased the number of trained emergency researchers, assuring the future of emergency care research.

Jane started her career as a researcher. In fact, she presented one of her early papers at an SAEM conference. In addition to her work with the K12 and T32 training programs, she participates every year in the ACEP/SAEM Grantee Workshop, attended by about 20 young researchers, and provides insight into applying for, and obtaining NIH funding.

In recognition of her outstanding work to build an emergency care research foundation, ACEP recognized Jane with Honorary Membership with National ACEP and Maryland ACEP.

New **Fellow Designation!**

Congratulations to:

Fahad Abuguyan, MD, MBA, FACEP
Yitschok Applebaum, MD, FACEP
Nicole Cimino-Fiallos, MD, FACEP
Casey Collins, MD, FACEP
Nathan Irvin, MD, FACEP
Neeraja Murali, DO, FACEP
Jeanhyong Park, MD, FACEP
Jordan Rogers, MD, FACEP
Kami Michelle Hu Windsor, MD, FACEP

See the *ACEP20* Awards Brochure here.

EARN 1.0 CME CREDITS

Changing Course:
Reversing Direct Oral Anticoagulants in the Emergency Department

How effectively are you managing DOAC-associated life-threatening bleeds in your emergency department?

Management of patients who require rapid reversal of urgent DOAC-associated bleeding is challenging. This CME activity will provide you with the tools you need to deliver individualized, safe, and effective care for these patients.

Program Overview

The development of direct oral anticoagulants (DOACs) has advanced the therapeutic landscape for the management of thromboembolic events. Specific agents that rapidly reverse the effects of DOACs are now available and offer safe and effective options for patients who experience an emergency DOAC-associated bleeding event. This ACEP Chapter Educational Lecture Series will offer:

- Clinical pearls for the assessment of bleeding severity in patients receiving DOACs
- Expert-guided insights to rapid reversal of urgent DOAC-associated bleeding
- Clinical decision support tools to optimize outcomes in patients requiring reversal of DOACs

Target Audience

- Emergency medicine physicians and physician assistants

Learning Objectives

Upon completion of this activity, learners should be better able to:

- **IDENTIFY** the signs and symptoms of severe bleeding in patients receiving DOAC therapy
- **ASSESS** anticoagulant activity in individuals who present with DOAC-associated bleeding or who require emergency surgery
- **DETERMINE** appropriate reversal agents based on the type of anticoagulant, dose, timing of last dose, and indication
- **IMPLEMENT** local protocols for evaluating patients and managing DOAC-associated bleeding

Accreditation and Credit Designation

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American College of Emergency Physicians, Spire Learning, and the Maryland Chapter of the American College of Emergency Physicians. The American College of Emergency Physicians is accredited by the ACCME to provide continuing medical education for physicians.

The American College of Emergency Physicians designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for 1.0 hour(s) of ACEP Category I credit.

There is no fee to participate in this activity.

Tuesday,
January 26th, 2021
10:00 AM – 11:00 AM

CLICK TO REGISTER
https://bit.ly/3iBwzk9

Faculty Presenter

Christian T. Ruff, MD, MPH
Director of General Cardiology
Cardiovascular Division
Thrombolysis in Myocardial Infarction Study Group
Brigham and Women's Hospital
Assistant Professor of Medicine
Harvard Medical School
Boston, MA

Jointly provided by

American College of Emergency Physicians® ADVANCING EMERGENCY CARE

SPIRE LEARNING

This activity is supported by an educational grant from Portola Pharmaceuticals, Inc.

Welcome New Members!

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

Alexander Ziyu Goay
Allison Farrell
Amanda L Bauer, DO
Angelica Christine Johnson
Arshom Foroutan
Bradford E Schwartz, MD
Kavita S Jackson, MD
Kevin Patrick MacKrell
Margaret-Ellen Johnson
Maria Dorothy Jones
Michael David Sullivan
Mohammad Amin Hadavand

Brandon Navin Singh
Casey Weller
Chibuzo N Opara
Damian Sidorski
David Hirsch Gordon, MD
Emily S Bartlett, MD
Hannah Terefe
Ikechukwu Elvis Eze
Jacqueline Lucia Addona, BS
Jane D. Scott, ScD, MSN
Jennifer Wang
Jessica Carullo
Julie Ann Fifer, MD
Nia Chantelle Rush
Nicolas Gonzalez
Olivia Candace McReynolds
Robert A Heller, MD, FACEP
Robert David Greenwald
Roohali Ahalya Sukhavasi
Rosemary Thomas-Mohtat, MD
Sharon Lisa Day, MD, FACEP
Sonia Sugumar
Timothy Ryan Traynor
Vanessa Redd, MD, FACEP
Wendell Cory Pierson, MD

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

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

Maryland Chapter
c/o National ACEP
4950 West Royal Lane
Irving, Texas 75063-2524